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:

The impact of the COVID-19 impact on the health care industry has been stunning. Health care workers first were celebrated as heroes in 2020 and now they are almost forgotten as they continue to battle the worst public health crisis we've seen in over a century. Here is a summary of how the pandemic has affected our providers and staff:

As our patient care activity changed to meet the priority needs, we started to re-deploy staff with essential skills as needed. Our Human Resources teams created an expanded labor pool to support coverage. When Gov. Baker made the decision to close all schools as part of the state's social distancing strategy, UMass Memorial responded to support our essential employees who needed to come to work by creating a child-care strategy which included emergency child-care resources, services, and coverage and an invitation-only social media platform to share child-care ideas.

As part of our own social distancing strategy, UMass Memorial deployed a mandatory work-from-home policy for non-clinical staff who can perform their duties remotely, and further limited in-person meetings. We also increased our internal communications to ensure employees were informed about the evolving pandemic and any changes in policies and procedures that were made as part of our response.

The safety and well-being of our caregivers remained a top priority and continued to be at risk because of dangerously low supplies of PPE. The last two weeks of March, our COVID-19 activation escalated even further as we started to treat COVID-19 positive inpatients who required considerable medical care. Because of this escalation, we went to a universal mask policy to help protect all of our employees – clinical and non-clinical – at any patient care site throughout the system. While supplies of N95 masks, face shields, gloves and gowns continued to be low, we benefited from an outpouring of donations from local businesses and individuals to help supplement our precious PPE supplies. We received more than 1 million pieces of donated PPE from the community.

Because our caregivers were working around the clock to meet the demands of the first surge of the pandemic, UMass Memorial implemented a "Caring for the Caregiver" program to offer stress-reduction and respite resources to our employees. To care for the financial health of our employees who cannot work from home and whose work had ceased because of service

closures, we committed to pay those employees – unless they can be re-deployed to other areas – with administrative pay, so that they do not need to use their paid time off. In addition, we committed to continue the base pay of our employed physicians through the end of the fiscal year (October) so that their focus can remain on patient care rather than financial needs.

Many health care organizations were hard hit financially by the first surge – so were we. In fact, we lost $200 million in revenue during the first 10 months of the pandemic. But because of our swift recovery from June to October – along with federal stimulus funding – we were able to rebound like no other health care system in the state and break a two-year cycle of operating losses and end the year with a $15 million operating margin.

It's important to note that even during the early stages of the pandemic with the fast drop in revenue, UMass Memorial made the decision to not lay-off or furlough any employees or change any benefits. In fact, we were the only health system in the state that made that decision. Out of respect for each and every member of our family, we did not want to cause them undue harm or stress by making these drastic decisions. While we could have saved millions of dollars by doing so, this decision to keep our workforce intact paid off during our recovery period by having our teams work quickly to get patients into our clinics once hospitals were allowed by the state to reopen. We also were one of only a handful of hospitals that gave all of our employees an appreciation bonus (ranging from $250 to $500 depending on employment status) after our recovery from the first surge. Standing by our employees during the worst public health crisis of our lifetime was more important to our senior leaders than meeting margin targets.

These actions helped our recruitment efforts considerably in 2020 as word spread that UMass Memorial stood by our employees during this incredible crisis. For example, in fiscal year 2020 (October 2019-September 2020), we had 2,525 new hires. In fiscal year 2021, we had a 16 % increase to 2,824 new hires.

As our recovery continued in the Fall of 2020, unfortunately, we experienced a second surge of COVID cases in the winter of 2020 and into 2021 that was actually worse than the first surge in Central Massachusetts as it relates to the number of inpatient cases. In the first surge, we hit the peak of COVID-19 in Central Massachusetts on May 1, 2020, with a total of 341 hospitalized patients and hit the second peak on January 5, 2021, with 386 inpatients. UMass Memorial had to open a field hospital at the DCU Convention Center during both surges to help offset the inpatient capacity not only for UMass Memorial hospitals but for 30 hospitals across the state. Since this crisis started, we have cared for more than 26,000 COVID-positive patients throughout our system and were able to do so safely with minimal operational disruptions. Because of the organization's success during both surges, UMass Memorial offered another appreciation bonus this year, that ranged again from $250 to $500, for the now 16,500 employees across the system.

Now that we've emerged from these two surges, however, the impact on our people – frontline clinical caregivers as well as non-clinical employees – has been profound. Many of our staff have taken early retirement or quit to take other jobs in other industries. Caregiver burnout is

now one of our top two concerns – the other is staffing in general. How do we retain our current employees who are exhausted, working tirelessly with very little time to revive and rejuvenate? We've experienced an increase in the number of our frontline caregivers who have taken early retirement or left the organization to pursue work in a different field – largely due to the toll this pandemic has taken. According to Pew Research Center, 2 million baby boomers retire each year. In 2020 the number grew to an historic high of 3 million. This is exacerbated by the fact that boomers are not being replaced. In less than 15 years the number of adults aged 65+ is projected to surpass the number of children under 18 in the U.S.
And how do we now recruit new employees to help offload the work of our current employees during a nationwide workforce shortage?

Our recruitment and retention efforts now are even further hampered by the federal COVID-19 vaccine mandate. While we applaud President Biden's efforts to get more people vaccinated by instituting national vaccination mandates, this action poses an equally difficult challenge in health care – do we make our mandate a condition of employment and potentially exacerbate our current staffing challenges? All hospitals across the country are grappling with the concerning reality that losing more clinical staff during a pandemic might cause even more harm to patients by not having enough clinicians – doctors, nurses and other allied health care providers – to actually provide direct patient 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):

We hit the peak of COVID-19 in Central Massachusetts on Friday, May 1, 2020, with a total of 341 hospitalized patients and continued to plateau for several weeks as the number of COVID-positive patients remained high. Since this crisis started, we have cared for more than 26,000 COVID-positive patients throughout our system. Fortunately, our surge planning enabled us to take advantage of additional ICU space across the system in post-operative areas and elsewhere to manage the increased volume of critically ill patients. That space, in addition to the DCU Center field hospital and the Beaumont Rehabilitation Center, created a safety valve to keep us from being completely overwhelmed with this high number of patients who needed us.

Telemedicine: Our IT department engaged in herculean efforts to immediately stand-up telemedicine capability for hundreds of our caregivers so they can effectively care for our patients who had issues and needs unrelated to COVID-19. Of particular note is that our behavioral health provider, Community Healthlink, now has over 600 of their providers communicating with behavioral health patients through telemedicine platforms that did not exist before the crisis.

COVID-19 Testing: As testing capabilities evolved and states were allowed to conduct their own testing rather than working through the CDC, the UMass Memorial in-house Pathology/Lab

Services department started to process the PCR swab tests, ramping up to processing 1,000 tests per day. Testing tents were opened at the UMass Memorial Medical Center campus, at Marlborough Hospital, at HealthAlliance-Clinton Hospital's Leominster campus and at Community Health Link. In addition, UMass Memorial created "pop-up" testing events at the state's request after large crowd gatherings (rallies and protests) in June and in underserved neighborhoods as part of the "Stop the Spread" free testing effort. Marlborough Hospital also was selected as one of the first "Stop the Spread" locations.
Through geospatial mapping analysis, our analytics team identified specific census tracts with the highest recent number of COVID-19 cases. This office produced reports of infections in Worcester and surrounding communities on a weekly basis with further breakdown by age, sex/gender, race/ethnicity, and census tract using data from the state of Massachusetts' MAVEN system (integrated case tracking system of record). We additionally obtained information from hospitalized patients, as well as available data from community testing. Based on these analyses, we identified several census tracts with the highest rates of infection in our community. Additionally, we identified the impact of COVID-19 in communities of color. For example, Hispanic/Latinx individuals made up 37% of persons with COVID-19 infections despite making up 21% of the population in February 2021. As such, any testing programs or prevention/ outreach efforts would necessarily be provided in English and Spanish. Of note, the census tracts with the highest rates of COVID-19 infection ranked within the top 10% of communities based on the CDC Social Vulnerability Index; two of these census tracts are within the top 1% using this measure (9).

Utilizing the geospatial mapping, we were able to hone in on the census tracts with the highest number of COVID-19 infections at a street level view within census tracts. We subsequently identified potential testing venues in high-traffic areas in each target census tract. Sites included churches, the grounds of city hall, local schools, large housing developments, and a community development center. Task force leaders traveled to each potential site, meeting with community stakeholders to discuss suitability and acceptance. We based decisions regarding suitability in part on accessibility to pedestrians and those using public transportation to mitigate this barrier. We selected sites based on accessibility of each site to facilitate walk-up (no appointment necessary) testing, distinguishing our approach from many public testing initiatives. Through outreach into BIPOC neighborhoods alongside community organizations, we were able to identify sites that promoted culturally appropriate services, fostered a sense of trust within their existing networks, and ultimately provided safe, accessible, and comfortable physical environments.

All of this was then employed to distribute vaccines when the time came.

Innovations in Treatments: As we neared the first peak last year, the UMass Memorial providers and caregivers who were not on the front lines worked diligently behind the scenes to search for treatments for this dreaded disease.

- **Convalescent Plasma:** Under the leadership of Jonathan Gerber, MD, medical director for the UMass Memorial Cancer Center, we were the first in the state to use

convalescent plasma – using plasma from recovered COVID-19 patients – to treat severely ill patients with the disease.

- **Remdesivir:** In addition, UMass Memorial was one of three hospitals in the state to conduct the early clinical trials for Remdesivir and currently is seventh in the world for the number of patients enrolled in the trial of this life-saving drug.
- **Monoclonal antibody therapy:** UMass Memorial partnered with the U.S. Department of Health and Human Services to launch a mobile monoclonal antibody therapy clinic that has now treated more than 1,000 patients with this novel treatment for those who test positive for COVID-19 and are at high risk for developing severe illness.
- **Helmet Ventilator:** A multi-disciplinary team at the Medical Center introduced a promising new technology – a CPAP helmet ventilator – to help treat our critically ill patients by providing both pressure support and oxygen so there is no need to intubate. We were the first hospital in the state and one of only a few hospitals in the country to use this technology to treat COVID patients.
- **Saliva Testing:** For anyone who has been tested for COVID using the PCR swab, it is an uncomfortable test that is time consuming to administer. UMass Memorial was one of the first hospitals in the state to conduct saliva testing, which is easy for patients to simply spit saliva into a cup for testing. This method also has saved the use of swabs, which is one of the medical supplies that was limited.

Caring for the Underserved: As a health care system, we discovered early on in the pandemic that the COVID-19 virus was disproportionately affecting communities of color in the region UMass Memorial Health serves. In Worcester, Latino community members accounted for 37% of positive tests, despite representing only 21% of the population. Similarly, African Americans made up nearly a quarter of the city's cases at the beginning of the pandemic but represent just 13% of the Worcester population. To help address this disparity with immediate mitigation strategies for vulnerable populations, UMass Memorial joined with the City Department of Public Health to form a COVID Health Equity Task Force. One of the most important mitigation strategies has been the deployment of the UMass Memorial Ronald McDonald Care Mobile team, as an outreach project to provide education and resources to neighborhoods that were hard-hit by COVID. Since April, 2020 the team distributed thousands of education kits (in six languages), free masks and hand sanitizers in more than 20 neighborhoods in Worcester, Marlborough, Fitchburg and Leominster. The task force worked with the Worcester Department of Health and Human Services on a community COVID testing strategy, supported by funding from the "Worcester Together" Fund of the United Way and Greater Worcester Community Foundation.

This same kind of racial disparity also happened as the COVID-19 vaccines were rolled out in early 2021. Between December 2020 and the end of June 2021, UMass Memorial Health administered more than 100,000 doses of COVID-19 vaccines to individuals in our community — including patients and UMass Memorial Health staff. As early as January 2021, UMass Memorial knew that the organization would be one of the primary providers of vaccines in Central Massachusetts. That meant setting up clinics in central locations that could reach broad

swaths of the population, as well as coming up with innovative solutions to reach populations that had been disproportionally impacted by the COVID-19 pandemic. In Worcester, that included communities of color and those that were considered low-income.

UMass Memorial found that many in under-resourced neighborhoods were not able to get the vaccine at the large "mass vax" sites because of barriers like lack of transportation, lack of childcare, etc. To address this issue, UMass Memorial created the Mobile Vaccine Equity Enhancement Program (MVeeP) to ensure the initial limited vaccine supply still could reach our most vulnerable patient populations, particularly for communities of color. Since it started Feb. 5, 2021, UMass Memorial has partnered with local agencies, faith leaders and community organizations to help educate under-resourced populations about the importance of the vaccine and have administered more than 6,000 vaccines, some to homebound patients who otherwise would remain unvaccinated. Considerable education has been put into place as well to help address vaccine hesitancy, including a Health Equity Open Forum (held as a Facebook Live event).

Patient Experience: Even in a pandemic, improving the patient experience has been a top priority for UMass Memorial Health. Even when we locked down our hospital locations to not allow visitors and stopped most ambulatory care services, we needed to ensure the patient's experience with our health system remained "high-touch." Some of the strategies put into place in one of our hospital settings included implementing an ambassador program in which employees redeployed from other areas visited inpatients in person who felt isolated by visitor restrictions; and a telephone patient rounding program so that inpatients were regularly checked on for emotional support. One of the most heart-wrenching by-products of the COVID-19 crisis is that so many patients died alone in the hospital, not able to see their family members because of the precautions put into place to stop the spread of the virus. At UMass Memorial, we found a way to allow family members to visit dying COVID patients. Offering this kind of patient-centered care during a pandemic speaks to who we are as an organization. The Worcester Business Journal wrote a nice article about the program, which we believe is the first of its kind in the state and one of only a few in the country.

These are just a few examples of the patient-centered interventions that were put into place. The metric for success that we use the most to track patient experience is the HCHAP survey question: Would you recommend hospital to family and friends? According to Press Ganey (the survey administrator), we had elevated scores during the first COVID surge and remain stable through the second surge with 74.4% in this category for the year and 89.0% for inpatient surveys. It is also worth noting that we have sustained a steady improvement year after year for the last 7 years in this category, which Press Ganey notes makes us an outlier compared to most organizations across the country as this is a challenging survey question to create momentum for improvement.

Behavioral Health: Nationally and statewide, the current behavioral health care system is not adequately designed to address behavioral health needs in a timely manner. Recent analyses

conducted by the Kaiser Family Foundation found a 20% increase in reported mental health, stress, and increased substance use concerns from sample polling in the first four months of the COVID-19 pandemic (53% in July 2020 vs. 32% in March 2020, when the study began tracking behavioral health self-reported concerns).[*]

In Massachusetts, including what we are seeing in Worcester, the demands upon the health care system as well as behavioral health resources are currently untenable – and anticipated to continue increasing. The need for care exponentially exceeds the availability of services, and the current structures in place create additional barriers to access for individuals at increased risk. Currently, clients face months-long wait times to see therapists and psychiatrists as a result of the demand for services being drastically higher than the available service providers and treatment spaces.

The longstanding unaddressed challenges of accessing behavioral health services have created a situation in which the clear impacts of shelter-in-place policies due to the COVID-19 pandemic (such as increased depression, anxiety, substance use, loss of income, and loneliness) have now created unprecedented needs for services for those with severe mental illness. Additionally, the loss of employment and the increased levels of uncertainty across various aspects of life, have added even more stress to individuals within our communities, leading to higher rates of anxiety, depression, and substance use.

At UMass Memorial Health we provide outpatient, community based, and inpatient care for behavioral health and addiction treatment programs at UMass Memorial Children's Medical Center and at Community Healthlink**.** Our multi-disciplinary team of child/adolescent trained specialized physicians, clinicians, nurses, and paraprofessionals provide evidence based behavioral and addiction treatment across the Central Massachusetts region.

Emergency Mental Health Services are available 24 hours a day and include on-campus resources in the Duddie Massad Emergency and Trauma Center, as well as our mobile crisis evaluation teams through Community Healthlink that can assess youth at their homes, schools or other community-based sites. Since 1977, Community Healthlink has been helping adults, children, and families recover from the effects of mental illness, substance use and homelessness, serving more than 22,000 adults, children, and families annually.

Bed Capacity: Now UMass Memorial Health struggles to keep up with inpatient demand, mostly caused by delayed care that now has advanced to significant illness and disease, which requires inpatient care. Central Massachusetts has the lowest inpatient bed/population ratio in the state. For example, Central Massachusetts has 1.90 beds per 1,000 people compared to Eastern Massachusetts with 2.19 beds per 1,000 people and Western Massachusetts with 2.28 beds per 1,000 people. This data came from CHIA 2019 data, which was pre-COVID. Add to this limited inpatient bed availability in our region a higher volume of inpatient demand caused by delayed care, COVID-19-related illness and a growing staffing crisis and the closure of up to 100 inpatient beds at the only other acute care hospital in Worcester as a result of the Commonwealth's longest nursing strike at St. Vincent Hospital This is truly a perfect storm that

[*] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use

is causing an enormous strain on UMass Memorial and other hospitals in our region. These inpatient bed capacity constraints have caused us to implement our emergency operations plan at our academic medical center – mostly due to a high volume of non-COVID-19 patients who are critically ill because of delayed care, coupled with our ongoing staffing issues.. We are working diligently to address the bed capacity issues with other levers such as a comprehensive digital medicine strategy, which includes an increase in telehealth visits and a new Hospital at Home program that was launched in the summer of 2021 to provide hospital-level care in patients' homes, using state-of-the-art remote monitoring systems and a mobile health care workforce. And maximization of all our community hospitals which are also at capacity.

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 lasting impacts on our healthcare system and the industry overall are innumerable and some still evolving as we are not done. Some of the tangible areas where innovation and collaboration during the pandemic has changed or improved our operations are:

- The creation of the COVID-19 Clinical Care Council, which is a multi-disciplinary, multi-specialty group that has adjudicated COVID policies and will continue to review other clinical policies and priorities such as our SAFER teams (large performance improvement teams).
- Expanded use of telehealth will continue and is here to stay provided regulators and payors support the transition. Our practices have longer range plans to maintain telemedicine and other innovations introduced during the pandemic. Our practices plan to target implementation in specific specialty areas that could benefit from telehealth encounters. There are special considerations around patients with low social economic status, limited English proficiency or poor access to technology to identify barriers to adoption of telehealth. Practices will continue to monitor telehealth platforms for user-friendliness and make changes as needed. Practices also plan to continue to focus on use of the patient portal as an option for completion of questionnaires and forms prior to visits. Telehealth adoption has spawned greater use of digital medicine concepts which paved the way for things like hospital at home.
- We have dramatically expanded our footprint of the hospice program during the pandemic. This has led to more access to this vital service for patients/families. This will continue.
- During the pandemic we have had an ongoing effort to evaluate scope of practice for our nurses, in particular which kinds of practices can safely be transitioned from ICU to floor care. This will continue.

- Greater collaboration as a system in different groups has brought greater coordination across campuses. Examples include the labs across the campuses, infection control, employee health, HR, communications to name a few.
- Data and analytics were key in our response. We have leveraged geospacial mapping and tableau reporting during the pandemic and hopefully this has helped to socialize data driven approaches across the organization which will set the stage for greater use in other topics.
- Creation of the citywide COVID Equity Task Force co-chaired by UMass Memorial Health and the City of Worcester Department of Health and Human Services to collaborate and coordinate outreach, testing and vaccines will continue past COVID-19 to respond to the systemic health disparities of the community.

In the midst of the pandemic, there was a nation-wide collective call for racial justice and an end to systemic racism following the murder of George Floyd. UMass Memorial Health has joined in this collective call by taking action to address racial disparities in our health care industry, particularly to address the impact in our region. Here are some examples of the actions we've taken as a system during the last year:

- We formed a Health Equity Steering Committee to assess and guide our internal health equity and anti-racism work. The committee was charged with making recommendations for improving the equity in the care we provide and making UMass Memorial Health a more inclusive workplace.

- Joining forces with the City of Worcester, we created a COVID-19 Equity Task Force to address the racial disparities we were seeing as COVID-19 spread throughout the city. Most recently we announced a $1 million donation to the City of Worcester to help establish the Worcester Health Equity Fund. Through a signed health equity services agreement, UMass Memorial Health is providing the funding to support City of Worcester initiatives aimed at improving health equity and reducing health disparities among its residents.

- Our caregivers at Marlborough Hospital worked with community partners such as the City of Marlborough, the Town of Hudson and faith-based organizations to provide COVID-19 vaccines for underserved populations. HealthAlliance-Clinton Hospital caregivers did similar anti-racism work through their collaboration with the Community Health Network of North Central Massachusetts.

- Our two public Health Equity Open Forums started a dialogue between UMass Memorial and the community about racial disparities in our region and how we can partner with local advocates and organizations to address COVID-19 vaccine equity.

- We developed internally a $1 million Seed Fund program to fund ideas for promoting equity in our health care delivery and fostering a more equitable and inclusive workplace culture.

- As part of our Anchor Mission this past year we hired 21 people from the most vulnerable neighborhoods of Worcester. We have set a goal of 30 for this coming year. We have invested over $3 million in six projects across central Massachusetts. One project establishes an innovative "tiny home" village for the chronically homeless, whereby individuals can have their autonomy while also building community connections and support. Another project creates an arts and affordable housing community in Fitchburg, right across from the art museum, where immigrants and others can nurture and display their artistic talents because art helps to revitalize communities. And we have pledged to triple our purchases from minority and women-owned businesses over the next five years.

- Our newly launched Office of Diversity, Equity, Inclusion and Belonging under the strategic direction of our Chief Diversity, Equity and Inclusion Officer is setting the direction of our work in this area in collaboration with all other operational and clinical areas within the System. Having a robust strategy will enable us to make the improvements necessary to become a more inclusive organization for our caregivers and a more welcoming place for our patients and families. In addition, UMass Memorial has hired an Associate Chief Quality Officer for Health Equity to ensure equitable clinical care across the system and to help address racial and ethnic health-related disparities in the communities we serve.

Below are some more specific examples of the kind of work UMass Memorial did during the pandemic to address health equity issues. UMass Memorial intends to continue these types of transformational initiatives long after the pandemic ends.

Care for the Homeless and Other Vulnerable Populations: COVID-19 in a lot of ways fractured our normal health systems. The overall health infrastructure wasn't really designed for the magnitude and gravity of what we were engaged in. Despite the initial turmoil of it all, something unusual was happening at UMass Memorial's field hospital, located at the DCU Center in downtown Worcester. In addition to being the first field hospital in the state, the site was also unique in that its staff prioritized the needs of some of Worcester's most vulnerable individuals — COVID-19 patients experiencing homelessness. To address the needs of this particular population, UMass Memorial embarked on a community partnership to respond to people's need for shelter and to protect public health. During its first period of operation, the field hospital was partitioned to create two fully functioning areas: one for COVID-19 positive patients who required an inpatient level of care and the other for COVID-19 positive individuals who required a supportive shelter environment even though they didn't require hospital treatment. Throughout Worcester, EMS employees conducted COVID-19 testing for individuals experiencing homelessness, transported patients who tested positive for COVID-19 to shelters, and even helped staff the field hospital when patient volume went up.

Meeting Psychiatric Needs During a Pandemic: In UMass Memorial Health's Psychiatric Treatment and Recovery Center (PTRC), a secure 26-bed unit in Worcester, treatment involves direct interaction with psychiatrists, nurses, occupational therapists and social workers — as well as with patient peers who are going through similar experiences. PTRC team members were concerned that the transfer of PTRC patients who tested positive for COVID-19 to medical units severely limited those therapeutically significant personal connections for their patients.

We were unable to provide optimal mental health care to COVID-positive inpatient psychiatric patients while they were in isolation on the medical floors, and we could not bring them back to the secure unit where there were COVID-negative patients. The solution was to make PTRC into a COVID-only unit in early April 2020. The transformation drew on operational and clinical resources throughout the UMass Memorial system. Everything needed to be rethought — infection control, nutrition, laundry, environmental services, information technology, security, pharmacy, employee health and much more. Even the HVAC system needed to be altered to provide the negative pressure necessary to prevent air inside the unit from blowing into the hallway, which had to be kept free of the coronavirus.

With just days to complete these complicated, interconnected changes, UMass Memorial was able to convert PTRC into a place that could effectively serve patients coping with a COVID-19 diagnosis on top of the challenges of significant mental illness.

Closing the Racial Gap in Numbers of Well-Child Visits

UMass Memorial Health is committed to taking a systemic and data-driven approach to the elimination of health disparities. In the autumn of 2020, a multidisciplinary team of physicians, data analysts, clinic management, and staff from the Office of Clinical Integration and the Office of Quality and Patient Safety reviewed a range of health metrics to identify health equity gaps and found a significant disparity in well-child visit rates when comparing white patients and Black and Latino patients.

During the year leading up to October 2020, which was used as a baseline, only 58% of Black patients and 64% of Latino patients had their annual well-child visit, compared with 72% of white patients. With clear evidence of a health equity gap, we set a goal of increasing the numbers of well-child visits to at least 64% for Black patients and 69% for Hispanic patients.

UMass Memorial developed multifaceted interventions, including targeted and proactive scheduling and outreach which proved to be effective methods of reducing cancellations and no-shows and getting many more children to well child visits. As of August 2021, teams in pediatrics and family medicine had conducted well-child visits with 69.2% of our pediatric Black patients and 72.9% of our pediatric Latino patients, far exceeding the initial goals. While rates of well child visits for all patients increased, the initiative also narrowed the overall disparity between white, Latino and Black children. Efforts are ongoing to identify and mitigate additional barriers to well-child visits for Black and Latino children with the goal of continuing to close the racial disparity gap and increase overall rates of well-child visits.

In 2022, UMass Memorial will initiate a new effort to close racial disparities in rates of osteoporosis screening and treatment.

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.

At the start of the Covid-10 pandemic, we undertook a systemwide cleanup of our race and ethnicity data. At the time of our conversion to the Epic electronic medical record in 2018 we brought over demographic data from our legacy system including race and ethnicity; however, the data was old and in categories that did not align with current standard classifications. In order to "clean up" the data we did a systematic deletion of any "unknown" entries and forced the fields to be required information upon registration in order to get the most current and accurate race and ethnicity for our patients as they presented for care in the coming months. This effort has resulted in over 50,000 records being updated. We are part of a Press Ganey health equity collaborative and when they compare our level of race and ethnicity statistics to other healthcare systems, ours ranks among the best.

We currently collect race, ethnicity, and language as part of our demographic collection for all patients that present to our organization. This information can be collected via our scheduling and check in workflows. Patients also have the ability to update these fields through our Patient Portal (myChart). Patients also can provide sexual orientation and gender identity information (sex assigned at birth, gender identity and legal sex) through our Patient portal and this data may also be requested during the clinical rooming process or by the provider. We provide education to all new schedulers, front desk and registration staff on why we collect this data, and the importance of accurate data collection.

We have put an emphasis on collecting SDOH from our primary care patients this past year. We have been focusing on optimizing the process for time-challenged caregivers where SDOH screening will become a simple and routine vital sign check like taking a patient's pulse and blood pressure. Currently, we have screening happening in 75% of our primary care practices at varying levels.

We leverage our CommunityHELP/Aunt Bertha platform for the following:

•Resource listings –via zip code, needs category, 104 languages

•Curated favorites lists | saved favorites –claimed, local resources/need by area and saving your personal favorites

•Send e-referrals to outreach to community benefit organization to link our patient with needed resources (warm handoff)

•GOAL: A preferred partners network supporting closed loop, bi-directional communications through CommunityHELP that tracks caregiver outreach & CBO referral receipt and follow-up

Some barriers we have faced or still face:

1. Accuracy of data collection, patients are often reluctant to share due to stereotype concerns and how the data might be used. Also, there is often a misunderstanding of the classifications for race/ethnicity – training of all current staff was held in mid – 2020 and updates were made to our training documentation and new hire training classes

2. Collection of data in high volume quick turnaround areas (COVID Testing and Vaccination areas) – we provided paper demographic collection forms for patients to fill out prior to appointments or collection. Stressed the importance of adequate data collection to end users. Added race, ethnicity, and language to paper COVID lab orders.

3. SOGI data collection and SDOH screening are not yet standard across the system and the data is incomplete.

4. Collection of the data is difficult in the highly stressed and busy primary care locations. Patients are booked in 10-15-minute visits and there is much to address in that timeframe.

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**	11	85
	Q2	14	86
	Q3	21	112
	Q4	8	107
CY2020	**Q1**	12	93
	Q2	11	64
	Q3	18	136
	Q4	21	101
CY2021	**Q1**	24	104
	Q2	21	145
	TOTAL:	161	1033

1. UNDERTSTANDING 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:
Click or tap here to enter text.

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):
Click or tap here to enter text.

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):

Click or tap here to enter text.

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.
Click or tap here to enter text.

AGO QUESTION

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	Q2		
	Q3		
	Q4		
CY2021	**Q1**		
	Q2		
	TOTAL:		