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:

Organizational Impacts

Wellforce implemented emergency strategies to more effectively serve our communities under the rapidly changing landscape of the COVID-19 pandemic. Like other providers, Wellforce had to make the difficult decision to reschedule elective procedures and limit the scope of our clinical offerings given the staffing and resource challenges we were facing. The strategic decision to stop elective procedures and surgeries across our system enabled us to redeploy clinical staff to prioritize care for the surging needs of COVID-19 patients.

As COVID-19 cases surged across the Northeast, Wellforce cared for more than 100 critically ill patients in the intensive care units and more than 200 patients on our medical/surgical units on any given day. These clinical and operational challenges burdened all levels of our health care system.

Frontline clinicians experienced the greatest impact during the surge of COVID-19 cases. At the onset of the pandemic, many unknown factors about the transmission and variable course of the virus contributed to the strain felt by our frontline clinicians. Prior to the development of treatment protocols, clinicians faced changing rules and policies daily as more information about the virus became known. Not only did our clinicians have to make the difficult choice for themselves and their families relating to risk exposure, but they also had to overcome the challenges relating to the appropriate use of PPE and rigorous required health screenings prior to attending in-person shifts.

Clinicians also had to serve as counselors and connection points for family members of sick patients during their isolation, especially challenging for critical care staff attending to intubated patients in the intensive care units. Many workers were isolated from their families and friends to continue to serve the community and ensure that their families were safe. For others, isolation from their families was not an option. The undue burden of arranging childcare due to school and daycare closures was felt across our workforce, particularly by our female frontline employees.

In addition to clinicians and frontline workers, non-clinical staff and leaders throughout the health system also experienced similar challenges. Many were redeployed and had to stretch their skills and time beyond the typical call of duty into different operational roles. Many

staff were directed to work from home to restrict the spread of COVID-19 and to reduce the burden on scarce yet essential PPE supplies.

As we emerged over the summer from the worst effects of the pandemic, Wellforce has worked to create a hybrid workplace model for non-patient facing employees whereby workers may perform some of their shifts onsite and some of their shifts remotely. Despite obvious public health benefits of a hybrid/remote work environment, our employees experienced many challenges during this transition as well. Supply chain issues have made it difficult for many to readily access IT equipment and these issues were compounded with interrupted internet and childcare resources, furthering exacerbating the burden felt by our workforce.

Recruitment and Retention

Wellforce continues to promote a robust and diverse recruitment strategy. Wellforce is focused on hiring external diverse talent as well as developing and promoting our internal workforce making available pipeline programs for our diverse staff. We are constantly assessing the shifting market dynamics, including regular compensation and benefits analyses, to ensure we remain competitive. We continue to face salary pressures across our system, driven in part by increased competition for licensed and experienced staff, augmented by a significant increase in travelling clinicians. We have recently implemented the Wellforce Recruitment and Referral Program to assist in attracting highly-qualified medical staff.

We have several retention strategies across the system including rounding on staff and recognition and multi-disciplinary teams working together to enhance quality and safety outcomes for our patients. We are addressing wellness and resiliency in a variety of ways across the system including providing our leaders with training/resources, meeting free Fridays, establishing boundaries before and after work for staff to “get off the grid”, and leveraging our Spiritual Care teams and our Employee Assistance Program. We continue to leverage a strong communication strategy to ensure our employees understand how their individual roles support Wellforce’s mission via regular email messages and virtual Town Halls.

Telehealth

COVID-19 forced a rapid transformation of health care delivery. To meet the needs of patients and comply with pandemic safety measures, Wellforce helped mobilize platforms for system-wide telehealth services, which dramatically increased the number of remote patient visits in many of our practices.

Telehealth allowed Wellforce clinicians to continue to serve patients during the COVID-19 pandemic. Using telehealth, clinicians have been able to monitor non-critically ill COVID-19 positive patients, follow up on patients with chronic disease without risking a visit to the hospital or clinic, and have provided care to many patients in the safety and comfort of their own homes.

As a result of the operational changes and the mobilization around telehealth, access and patient satisfaction has improved. We have been strongly supportive of the continuation of telehealth beyond the public health emergency, while helping to ensure that reimbursement across all payers remains at a level that will support the infrastructure needed to continue to provide these services.

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 system has had to face the unfortunate decision to occasionally delay or refuse transfers due to capacity constraints and over the past few months we have seen an increase in admissions across the Wellforce system. This increase has been driven mostly by non-COVID illnesses, including heart disease, stroke, cancer, complications of diabetes and behavioral health problems.

In response to the long-lasting and socioeconomic consequences facing Boston, compounded by the COVID-19 pandemic, Tufts Medical Center launched grant programs to community-based organizations serving Chinatown, Dorchester, South End, and South Boston, in July 2021. The grant initiative, which featured pledged support of $700K, is designed to address the financial stress intensified by the pandemic and combat pre-existing wealth gaps in the Boston communities. The grants support community-based organizations and their programs to improve residents' economic well-being. This includes a new workforce development program to train participants how to navigate and utilize Epic databases. The grant program also empowered students and clients at the Asian American Civic Association (AACA) to learn new skills that will enable them to start new careers at major hospital systems and insurance companies. Immigrants and economically disadvantaged individuals from across Boston neighborhoods and beyond will get specialized training, wraparound support services, and direct placement into significantly higher paying jobs.

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 pandemic created immense challenges for health systems across the country that will take years to overcome, but there were innovations undertaken throughout COVID-19 that could help improve health care delivery going forward. One innovation that we hope can persist is the alignment of policies across health insurance plans. While this was limited to things such as telehealth flexibilities, we do believe there is an ongoing benefit to streamlining unwarranted differences in the clinical and payment rules across payers. Disparate rules create challenges for health systems in planning future services and deploying system resources.

The increased use of alternative care sites such as home care and telehealth during the pandemic created a more flexible care delivery model as well. In addition to a substantial uptick in the use of telehealth services, we launched a Mobile Integrated Health pilot project in March 2020 with the goal of providing immediate access to urgent treatment (onsite or remotely) to patients that may otherwise use the Emergency Department (ED), which resulted in an increase in the provision of care outside of Lowell General Hospital. The visits treated concerns such as dehydration, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure exacerbation, fall evaluations and wound care. More than 800 visits were performed in the first year of operation. Our analysis demonstrated that the program avoided more than 400 ED encounters and more than 100 inpatient admissions with considerable savings. The purpose of this project was to provide ongoing treatment to our patients during the pandemic without regard to reimbursement impact. While we see it as a success, we did this without consideration for our health system finances, but it was the right thing to do for our patients.

We believe health systems should have the flexibility to manage the treatment of patients in lower-cost settings, but these efforts are often frustrated by the need to have multiple clinical and financial conversations with each health plan in order to be reimbursed. That process is often an obstacle to innovation and the delivery of fair and equitable health care. We believe in accountability for total health expenditures and quality and that there should be greater flexibility to redesign care within our system. For example, payers often remove the ability for health systems to administer pharmaceuticals to their patients when the clinical provision of care shifts away from the hospital setting to the home despite a health system's management of the patient's ongoing treatment. The health system loses a degree of control in their patient's treatment so payers can increase the scale of business they manage with national, for-profit pharmacy benefit managers in contracts that lack clarity with respect to financial terms or incentives. Ultimately, these practices adversely impact low income and communities of color the most, preventing innovative and accessible healthcare that could more easily address preventable diseases and other social determinants of health. It has been challenging to hold health systems accountable for the provision of high quality and efficiently delivered care while they are excluded from providing the full continuum of services they offer.

The availability to tap into additional workforce populations will allow the Commonwealth to adapt more quickly to meet the challenges of an evolving health delivery landscape. Wellforce strongly supports the mutual recognition model enabled by the Nurse Licensure Compact. The Compact not only allows registered nurses and licensed practical/vocational nurses to hold one multi-state license to practice, but also grants nurses the privilege to practice in other Compact member states. By joining the Compact, Massachusetts would increase access to experienced nurses and improve the Commonwealth's response to an evolving healthcare delivery landscape that has been strained by recent public health emergencies.

The pandemic also provided a great opportunity to strengthen partnerships with our communities to improve COVID-19 vaccination equity. Since the City of Boston announced

its vaccine equity initiative grantees, Tufts Medical Center's Office of Community Health Improvement Programs has met with community-based organizations to discuss existing needs in the community to increase vaccine acceptance and health equity. We received a grant and issued sub-contract grants for three community-based organizations (Chinese Progressive Association, Boston Chinatown Neighborhood Center, and Asian Community Development Corporation), to conduct in-depth, one-on-one grassroots outreach and education with interpreter services. In collaboration with multicultural clinical experts Wellforce jointly developed a plan that helped close the gap of access to the Asian population in Boston. This model of health equity collaboratives where health systems and community share resources and accountability to address health disparities must continue 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.**

We have developed a Diversity and Health Equity dashboard at Tufts Medical Center to analyze patient outcome data based on demographics, race and ethnicity. We are in the process of working with our quality and safety function to integrate this data as part of their work to continue to improve and also include the data of all our hospitals towards prioritization of health disparity efforts. This dashboard has already been used to support improvement projects and was used to stratify the outcomes of patients with COVID-19.

Wellforce is currently working to transition its entire digital healthcare ecosystem to a cloud-based platform hosted on Amazon Web Services (AWS) with the goal of integrating an agile and scalable digital ecosystem that combines the Epic electronic health record, hundreds of applications, databases, and more. This platform will allow for easier data extraction, analytics, and care coordination. Wellforce hopes to be fully operational with its whole digital ecosystem operational on the platform by spring 2022

Identifying and acting on healthcare disparities in our area requires maintaining accurate patient-reported data about the populations that Wellforce serves. The new Epic platform design principles is a way to deliver culturally competent care enabled by technology. It allows Wellforce to include and streamline data elements and categories to gather more nuance on patients' racial, ethnic, and language (REAL) data, as well as information on sexual orientation and gender identity, disability, and social determinants of health. Including the integration of Cultural and Linguistic Services in a patient's appointment will improve patient access and satisfaction of the patient experience. The new MyChart APP will allow patients to update their profile including cultural needs and the use of a "CHAT BOT' to communicate in different languages.

Another component of our data collection and dissemination initiative includes health equity education. Our Center for Diversity, Equity, and Inclusion (DEI) has hired a full-time System Director for DEI education and research to develop innovative learning opportunities toward our goal of providing an unmatched care experience. We are also hiring a community benefits and health equity leader to build internal capacity to serve our increasingly diverse populations. These key resources will leverage our increased capacity to meet regional community needs and provide more equitable care.

Historically, Wellforce had the challenge of collecting data across a newly formed system comprised of a large academic medical center in Boston and two community hospitals in Lowell and Melrose. Wellforce recognized the importance of creating a common process and policies to improve the data collection to support health equity across our system.

Moreover, to address the barriers of data collection across the state, our Center for DEI joined the Massachusetts Tax Payers Foundation working group, comprised of subject matter experts who are familiar with available data, ongoing efforts on equity, metrics to measure progress, and federal and state requirements used to quantify racial and ethnic disparities. The goal of the working group is to improve and expand the data available to measure changes in racial and ethnic inequalities in Massachusetts. The work seeks to: (1) identify metrics and data sources to measure disparities in wealth, income, education, health care, and criminal justice, (2) conduct research and discussions with experts to reach a consensus of which metrics best measure changes in racial and ethnic disparities, (3) determine what data are unavailable, and (4) recommend how best to collect and/or augment the data for future analyses.

Overall, improving data collection will help health systems across the Commonwealth invest and develop in a health equity and data strategy. These strategies will help us improve patient care delivery and reduce health disparities. Funding to support this work should be made available across the state and should be collaborative with expert organizations, health systems and academia to share best practices.

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**	368	360*
	Q2	306	360*
	Q3	337	360*
	Q4	341	360*
CY2020	**Q1**	384	395*
	Q2	197	370*
	Q3	254	397*
	Q4	321	416*
CY2021	**Q1**	455	402*
	Q2	476	395*
	TOTAL:	**3,439**	**3,815***

Total based on daily average