

The House Ways & Means Committee Rural and Underserved Communities Health Task Force Request for Information– <https://waysandmeans.house.gov/rural-and-underserved-communities-health-task-force-request-information>

DUE: Friday, November 29th @ 5PM

INFORMATION REQUESTS (Limit each response to 250 words - Total submissions should not exceed 10 pages, 12 pt font):

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Boston Medical Center (BMC) is a private, not-for-profit academic medical center located in Boston, Massachusetts. As the largest safety-net provider and busiest trauma and emergency services center in New England, BMC's mission is to provide exceptional care, without exception to all patients. Our patient population has the highest public payer mix of any acute care hospital in Massachusetts at 77% – with over half of our patients receiving care funded through MassHealth (the state's combined program for Medicaid and the Children's Health Insurance Program) or free care (i.e. uninsured). Of our Medicare patients, who make up a quarter of our patients, 80% are dually eligible for Medicaid.

Our system has identified lack of stable and affordable housing as a key driver of high cost and a major strategic area for our system to address in order to positively impact patient and community health. Our internal analyses on the interplay of housing, substance use disorders (SUD), and medical comorbidities in the MassHealth Accountable Care Organization (ACO) patient population show that ***unstable housing is the most significant driver of annual total cost of care of any single factor***. In addition, our analyses show that 13% of patients in our Emergency Department and 25% of patients admitted to the hospital are homeless – indicating that lack of stable housing is one of the main upstream factors associated with our patients getting sick in the first place. In recognition of this, BMC has invested \$6.5 million over five years in affordable housing and related community-based programs.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Over the last twenty-five years, BMC has built a reputation as one of the most comprehensive and influential centers for addiction treatment in the country with over eighteen clinical programs for substance use disorders and many of the field's most prominent researchers. In 2017, we created the Grayken Center for Addiction with a generous donation from the Grayken family to advance our mission to serve as national leaders in the treatment of addiction and

export best practices for treatment and prevention throughout the field. Most recently, BMC was awarded \$89 million by the National Institute on Drug Abuse (NIDA) HEALing Communities Study to test expanded addiction treatment and prevention efforts in order to reduce overdose deaths by 40% over three years in selected communities statewide – including through increased access to Medication for Addiction Treatment (MAT) and naloxone, waiver training providers to prescribe MAT, and dissemination of our Office-Based Addiction Treatment (OBAT) model, which uses nurse care managers to integrate SUD treatment into primary care.

Despite the recent reduction in Massachusetts' opioid-related mortality rate, there remains much to be done in order to reach more vulnerable patients with opioid use disorder and effectively stop the epidemic. As the opioid crisis continues to evolve, which we see reflected in the shifting prevalence of different substances (increasingly fentanyl and methamphetamine) and growing disparity in overdose rates and connection to treatment among racial/ethnic minorities, public resources need to be flexible to enable a timely and appropriate response on the part of health systems.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

N/A

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where — a) patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? b) there is broader investment in primary care or public health? c) the cause is related to a lack of flexibility in health care delivery or payment?

N/A

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

BMC is a leader in accountable care for publicly insured patients. Through our health plan, BMC HealthNet Plan, BMC is managing the largest Medicaid ACO population in Massachusetts, with approximately 20% of the ~900,000 MassHealth ACO members enrolled in our ACOs across the state – in communities in Greater Boston, Southeastern MA (Brockton, Fall River and New Bedford), and Western MA (Holyoke and Springfield).

In order to support the capacity of our statewide ACO partner sites to treat the behavioral health needs of their patients, we recently launched a telepsychiatry program – starting with one site (Manet Community Health Center in Quincy), and growing to include four additional sites by

2020. The telepsychiatry program serves much the same function as our brick-and-mortar integrated behavioral health practice, relying on a team of behavioral health providers (including psychiatrists, psychiatry nurse practitioners, social workers, and psychologists) to support primary care providers in caring for patients – only in this case from a distance. Primary care providers are supported by psychiatry specialists through e-consult, while patients are able to meet with specialty psychiatry providers via video conferencing for short-term care and possible referral to community psychiatry when needed. Given the shortage of specialty behavioral health providers in these communities, the telepsychiatry program saves patients from making the trip to Boston (1-2 hours each way from most parts of the state) and in many instances creates access to behavioral health care where there previously was none.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

N/A

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Refer to answers to Questions 2 and 5.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

N/A

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

N/A

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

N/A