MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

May 19, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Welcome by HPC Chair Stuart Altman**
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- **Approval of Minutes from April 14, 2021 Meeting (VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **April 14, 2021** as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- **Executive Director's Report**
- Care Delivery Transformation
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

Recent HPC Publications

Hebrew SeniorLife Spotlight
December 2020

Features Hebrew SeniorLife and their expansion of the HPC-funded Right Care, Right Place, Right Time program to support all residents during the COVID-19 pandemic.

TCCI Program Brief
April 2021

High-level summary of the Targeted Cost Challenge Investments (TCCI) Program initiatives and results.

Sustaining Grant-Funded Initiatives Guide
January 2021

Sustainability guide based on experiences from Health Care Innovation Investment Program awardees that successfully sustained their programs beyond the HPC-funded period.

NAS Investment Program Brief
April 2021

High-level summary of the Neonatal Abstinence Syndrome (NAS) Investment Program initiatives and results.

COVID-19 Impact Study
April 2021

Study on the impact of the COVID-19 pandemic on the health care delivery system, including workforce, service delivery, and health care disparities.

OPP Annual Report
May 2021

Provides a comprehensive overview of activities of the Office of Patient Protection.

Upcoming HPC Publications

NAS Investment Program Evaluation Report

Detailed findings from the NAS Investment Program, including improvements in care, outcomes, and culture change.

Policy Brief: Performance Improvement Plans

Overview of successes and challenges in the process for monitoring and enforcing payer and provider performance relative to the benchmark.

Anti-Stigma Resource Guide

Practical tools and resources to address stigma in caring for families impacted by opioid use disorder based on lessons learned from awardees.

2020 Health Care Cost Trends Report

Presents annual overview of trends in health care spending and delivery in Massachusetts, evaluate progress in key areas, and make recommendations for strategies to increase quality and efficiency.

DataPoints: Avoidable Dental Care ED Use

This DataPoints issue will identify trends in avoidable dental emergency department use in Massachusetts between 2017 and 2019, with variation by race, age, income, region, and payer type.

Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact

Analysis and report evaluating the Commonwealth's entry into the Nurse Licensure Compact.

Health Equity Update

The HPC is committed to **embedding health equity concepts in all aspects of our work** and is applying all four of its core strategies to the goal of advancing health equity in the Commonwealth.

Health Equity Style and Practice Guide

HPC-specific use cases and resources will help us be intentional, respectful, and inclusive in our writing and our research.

Research and Market Oversight

HPC research and publications are incorporating race and other drivers to identify equity issues and will become a significant addition to market oversight responsibilities.

New Investment Programs

HPC investment programs are highlighting racial inequities in health care and outcomes, and identifying solutions to make a meaningful difference.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- **Care Delivery Transformation**
  - Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Investment Program
  - Investment Program Launch: Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) **(VOTE)**
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
  - **Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Investment Program**
  - Investment Program Launch: Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) **(VOTE)**
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

The NAS Investment Program

The Massachusetts Legislature directed the Health Policy Commission to implement an investment program to enhance and/or improve care for opioid exposed newborns (OENs) and for women with opioid use disorder (OUD) during and after pregnancy.

The HPC launched a $3 million **Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Investment Program** in 2016, awarding six hospitals funding to support new evidence-based interventions and emerging best practices to treat mothers and infants impacted by OUD.

Increasing non-pharmacologic interventions

Hospitals focused on promoting non-pharmacologic interventions such as rooming-in, skin-to-skin contact, use of mother's milk (breastfeeding and pumping of breastmilk), and sustained maternal presence at the infant's bedside, particularly after maternal discharge.

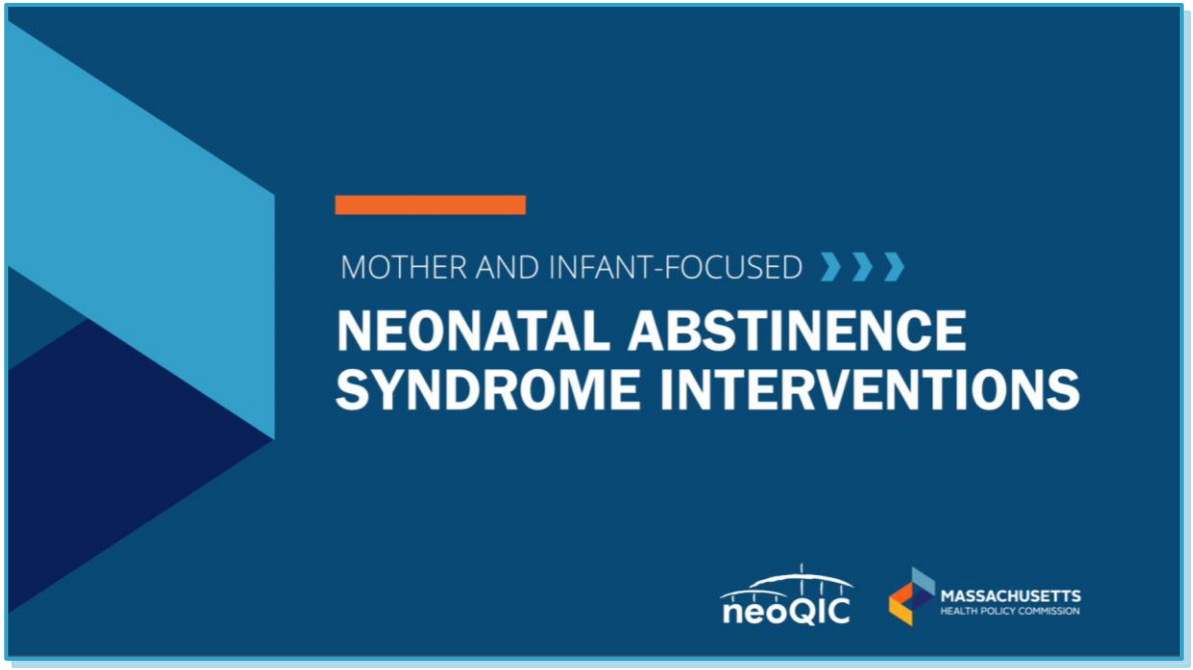
Optimizing NAS pharmacologic treatment

Hospitals standardized assessment and scoring of NAS symptoms and optimized protocols for pharmacologic treatment to ensure infants received appropriate dosing when medication was necessary. Some programs standardized their use of the Finnegan scoring tool, while others implemented the Eat, Sleep, Console (ESC) method.

Increasing access to services for mother and infant after discharge

Hospitals implemented NAS discharge care plans, and facilitated transitions to family support, peer counseling, early intervention services, pediatric primary care, and engagement with the Department of Children and Families.

Now Available: New video on the Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Investment Program



Interviews with providers from Beverly Hospital, highlighting the impact of non-pharmacologic interventions on mothers and infants impacted by opioid use disorder.

Available on the HPC's YouTube channel

HPC

NAS Investment Program Lessons Learned and Findings: Hospital Utilization

Pharmacologic Treatment

The percentage of term[1] OENs requiring pharmacologic treatment for NAS decreased from 68% to 48% to 35%, **an overall reduction of nearly 50%**.

Length of Stay

Average length of stay for term OENs decreased from 18 days to 12.1 days, **a nearly 33% decrease**.

Care in NICU or Special Care Nursery

The percent of term OENs requiring care in the NICU or special care nursery decreased from 56% to 39%, **a 30% decrease**.

HPC

[1]37+ weeks gestation

NAS Investment Program Lessons Learned and Findings: Non-Pharmacologic Interventions

Rooming In

Overall, **74% of term OENs were eligible for rooming-in**. **Among all term OENs eligible for rooming-in,** the number of infants rooming-in increased from 76% to 90% in mid-2017 and was sustained throughout, **a 18% increase**.

Mother's Milk

Overall, **63% of OENs were eligible to receive mother's milk**. **Among eligible OENs**, 65% were receiving mother's milk at the start of the NAS Investment Program, and this increased to nearly 80% in 2017, **a 23% increase**.

Skin-to-Skin Contact and Cuddling

From 2017 to 2019, **76-78% of term OENs received skin-to-skin contact** in the first day, and no sustained change was seen over the course of the NAS Investment Program.

Non-pharmacologic interventions resulted in lower rates of NICU or special care nursery care utilization and pharmacologic treatment.

HPC

NAS Investment Program Findings and Lessons Learned: Continuum of Care

- Many hospitals provided **wraparound services such as patient education, recovery support, and resource connections and referrals** that increased maternal engagement and support for women with OUD throughout the continuum of care.
- The HPC funded an outpatient initiative, **Moms-Do-Care,** at Beverly Hospital and Lowell General Hospital that expanded access to prenatal and postpartum care and medications for opioid use disorder (MOUD) for pregnant women with OUD.
- Multivariate models suggests that **women engaged in MOUD and comprehensive treatment have a greater ability and likelihood to engage in non-pharmacologic interventions** for the care of their newborn.

Sustainability

Culture Change and Policy Adoption

Awardees described that **one of the greatest achievements of the NAS Investment Program was the shift in attitudes and organizational culture** towards the care for families, mothers, and infants impacted by OUD.

This was accomplished through:

- Training
- Staffing
- Communication
- Patient centered approach

Resource Allocation and Protocol Adoption

All the **awardees planned to integrate the key features of their initiatives into standard workflows and operations** including:

- Rooming-in models
- Prioritizing non-pharmacologic interventions
- Breastfeeding guidelines
- Cuddler programs
- PRN or “as-needed” dosing
- Wraparound services
- Standardized scoring assessments

New Publications Promote Lessons Learned from the Mother and Infant-Focused Neonatal Abstinence Syndrome Investment Program

NAS IMPACT BRIEF *now available*

A snapshot of the NAS Investment Program, with data highlights and quotes from awardees.

NAS EVALUATION REPORT *now available*

Detailed findings from the NAS Investment Program, including improvements in care, outcomes, and culture change.

ANTI-STIGMA RESOURCE GUIDE

Coming soon!

Practical tools and resources to address stigma in caring for families impacted by opioid use disorder based on lessons learned from awardees.

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
  - Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Investment Program
  - **Investment Program Launch: Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) (VOTE)**
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

Statutory Mandate: Section 88 of Chapter 41 of the Acts of 2019

- The HPC, in consultation with the Department of Public Health and the Betsy Lehman Center, shall **implement a 2-year pilot program to reduce pregnancy-related deaths and improve pregnancy outcomes**.
- The commission shall select implementation sites through a competitive process in which applicants shall demonstrate:
    i. community need;
    ii. the capacity to address preventable causes of complications and death related to pregnancy and child birth;
    iii. the ability to facilitate care coordination among health care providers; and
    iv. a plan to formalize relationships between health care providers, including hospitals and community-based care providers.
- The commission shall collect data to gauge the success of the program in decreasing pregnancy-related deaths and track trends within the patient population, including, but not limited to, variance by age, race, and co-morbidities.

Inequities in Maternal Health Outcomes by Race

NATIONAL

Black birthing people in the United States are

3x – 4x

more likely to die from pregnancy-related causes than **White birthing people**.[1]

MASSACHUSETTS

Between 1998 and 2013, **Black non-Hispanic women** in Massachusetts had

2x

the rate of severe maternal morbidity, including blood transfusion, during delivery hospitalization[2] as **White non-Hispanic women**[3,4].

NEW ACTIVITIES

Growing attention on this issue has led to new activities at the state level, including the **Racial Inequities in Maternal Health Commission**, which aims to investigate and report on causes of and solutions to inequities.

1 Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765.

2 175 per 10,000 hospitalizations.

3 83 per 10,000 hospitalizations.

4 Massachusetts Department of Public Health. Massachusetts State Health Assessment. Boston, MA; October 2017.

HPC

Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Program Overview

The purpose of the BESIDE Investment Program is to address inequities in maternal health outcomes and improve the care and patient experience of Black birthing people by increasing access to and use of doula services.

Specifically, the BESIDE Investment Program aims to:

1. Increase the number of Black birthing people who are informed about the benefits of doula care and offered the opportunity to work with doulas, particularly doulas who are from the communities (e.g., geographic, cultural) of or share lived experience of inequities with Black birthing people.
2. Improve the prenatal, labor and delivery, and postpartum care of Black birthing people through the support of doulas.
3. Support the development of a culture of understanding and mutual respect between doulas and clinical and administrative staff within Massachusetts birthing hospitals and birth centers.
4. Embed principles of racial equity and cultural humility in the design and implementation of programs offering doula services.

BESIDE Program Structure

$500,000

The HPC will commit $500,000 to the BESIDE Investment Program.

3 Months

Awardees will take part in a 3-month Planning Period.

2 Awards

The HPC will award funding of up to $250,000 to up to 2 eligible entities (i.e., birthing hospitals and birth centers).

21 Months

Awardees will take part in a 21-month Implementation Period.

HPC

BESIDE Program Principles and Activities

Secure a Doula Workforce

Applicants may secure doula services by hiring doulas who reflect the target population directly or by contracting with a doula organization.

Enhance or Establishing Doula Services

Applicants may establish new doula services programs or enhance existing doula services programs.

Offer Doula Services Throughout Pregnancy and Beyond

Applicants must offer doula services from the start of the prenatal period until at least six weeks postpartum, including offering a minimum of six total doula visits with at least one visit during the prenatal period and one during the postpartum period.

Embed Principles of Racial Equity and Cultural Humility

Applicants must demonstrate an existing commitment to racial equity and ensure the values, priorities, and needs of Black birthing people in the applicant's community are reflected in the program design.

Support an Organizational Culture of Mutual Respect

Applicants must support the development of a culture of understanding and mutual respect between doulas and clinical and administrative staff.

Anticipated BESIDE Program Timeline

MAY/JUNE

- Issue RFP following Board approval: **May 20**
- Begin to collect and track questions, release FAQs
- RFP information session: **June 8**

JULY/AUGUST

- Final day for questions: **July 2**
- Proposals due: **July 20**
- Review proposals and select awardees

SEPTEMBER

- Announce awardees: **September 15**
- Begin contracting

NOVEMBER

- Program launch

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Birth Equity and Support through the Inclusion of Doula Expertise

MOTION: That the Commission hereby approves the proposal for an investment program to support Massachusetts birthing hospitals and birth centers to offer doula services to improve the care and patient experience of Black birthing people during and after pregnancy, and authorizes the Executive Director to issue a Request for Proposals (RFP) to solicit competitive proposals according to the framework described in the documents presented and pursuant to section 88 and 1450-1200 of chapter 41 of the Acts of 2019.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- **Market Oversight and Transparency**
  - 2020 Cost Trends Report: Income and Affordability Findings
  - Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact **(VOTE)**
  - Material Change Notices
  - 2021 Performance Improvement Plan Process
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
  - **2020 Cost Trends Report: Income and Affordability Findings**
  - Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact **(VOTE)**
  - Material Change Notices
  - 2021 Performance Improvement Plan Process
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

Building on prior research, the HPC examined differences in health care spending patterns by income.

BACKGROUND

- Both a 2016 report from the Massachusetts Attorney General's Office and analysis underlying MassHealth ACO risk adjustment found lower health spending incurred by Massachusetts residents with lower income.
- The implications of this lower spending are unclear.

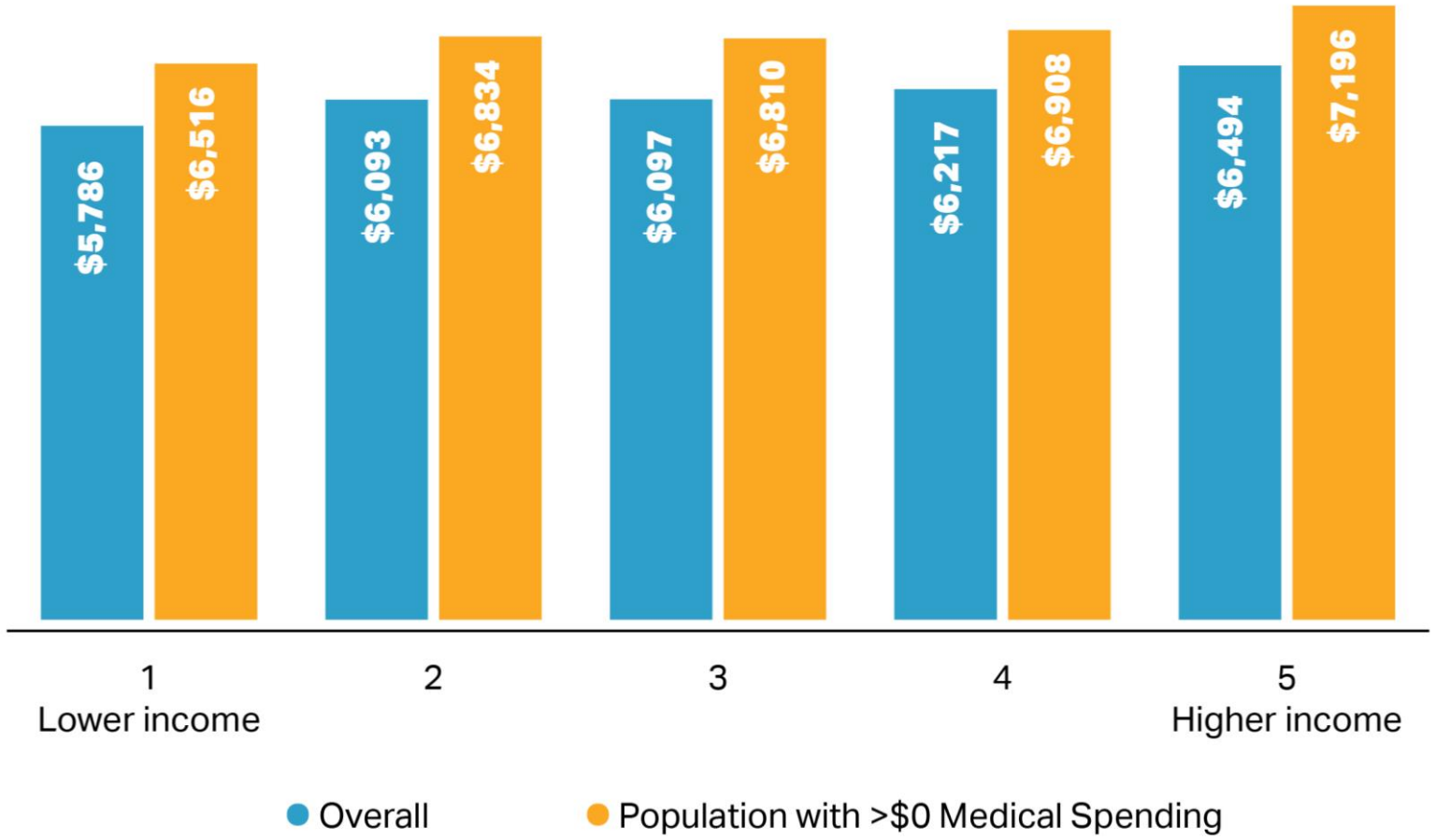
RESEARCH GOALS

- Use the **MA APCD** to explore spending patterns by income in more detail, particularly to gain an understanding of possible differences in category of spending.
- Investigate **CHIA's Massachusetts Health Insurance Survey (MHIS)** to understand possible drivers of these utilization patterns among commercially-insured residents with lower income and higher income.
    - The analysis also drew upon a special Recontact Survey, created and fielded by the HPC and CHIA in 2019 as part of the MHIS, focusing on individuals who had potentially avoidable ED visits

Commonwealth of Massachusetts Office of the Attorney General Examination of Health Care Cost Trends and Cost Drivers, Oct 13, 2016
Arlene Ash., et al. "Social determinants of health in managed care payment formulas." JAMA internal medicine 177.10 (2017): 1424-1430
Sherman, Bruce W., et al. "Health care use and spending patterns vary by wage level in employer-sponsored plans." Health Affairs 36.2 (2017): 250-257.

Commercially-insured adults in the lowest income communities had 11% less health care spending than those from the highest income communities.

Total annual spending incurred by residents by income quintile of their zip code, 2018

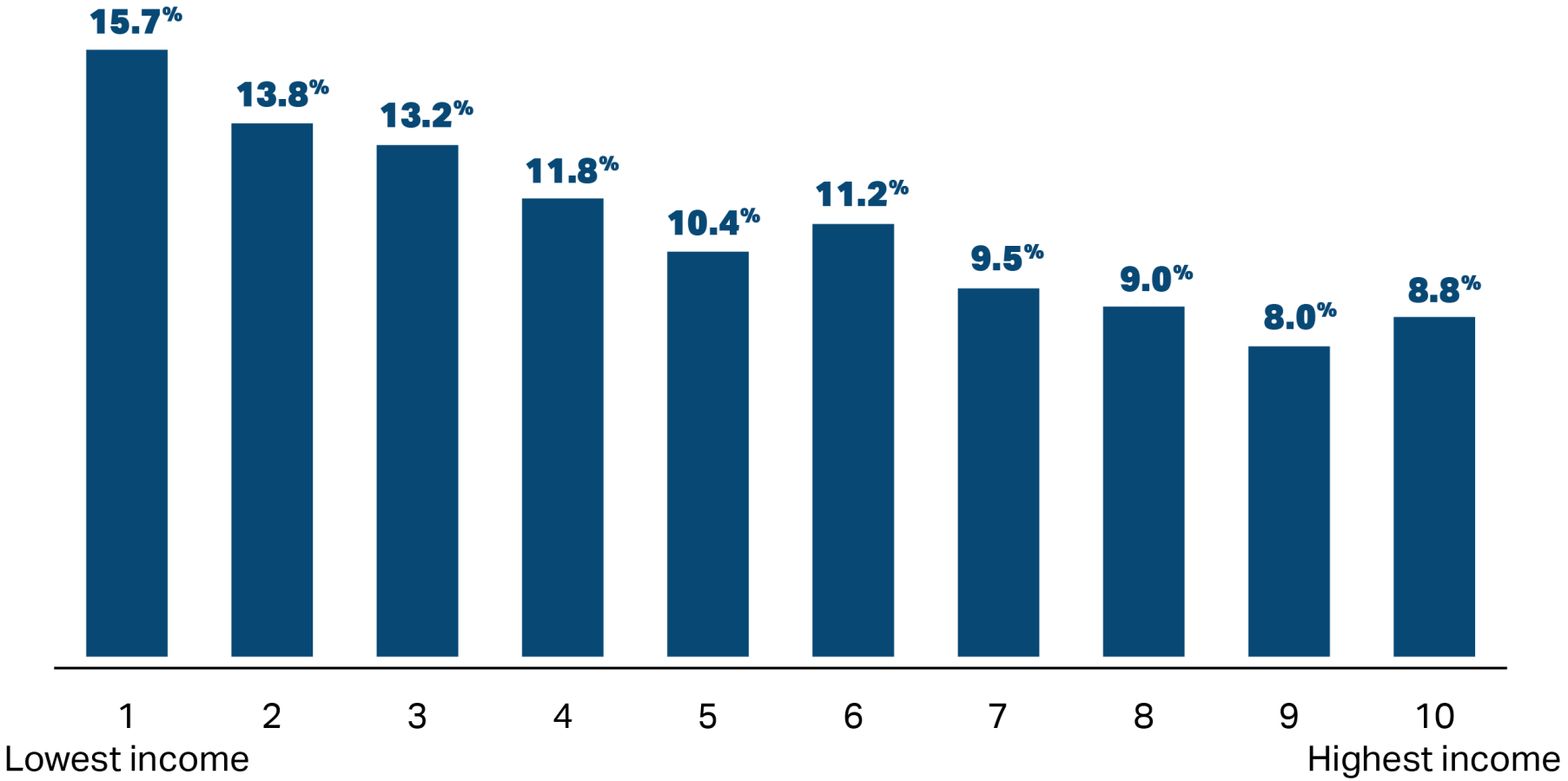


Notes: Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64, with continuous coverage throughout 2018 and no unobserved carved-out benefits. Grey bars represent the overall population (N=801,198), while dark blue bars reflect the population with any observed medical spending in 2017, excluding individuals without zero spending (N=717,104). Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

Adults with lower income are more likely to have zero medical spending, contributing to overall spending differences.

Percent of adult commercial members without any medical spending by income decile, 2018

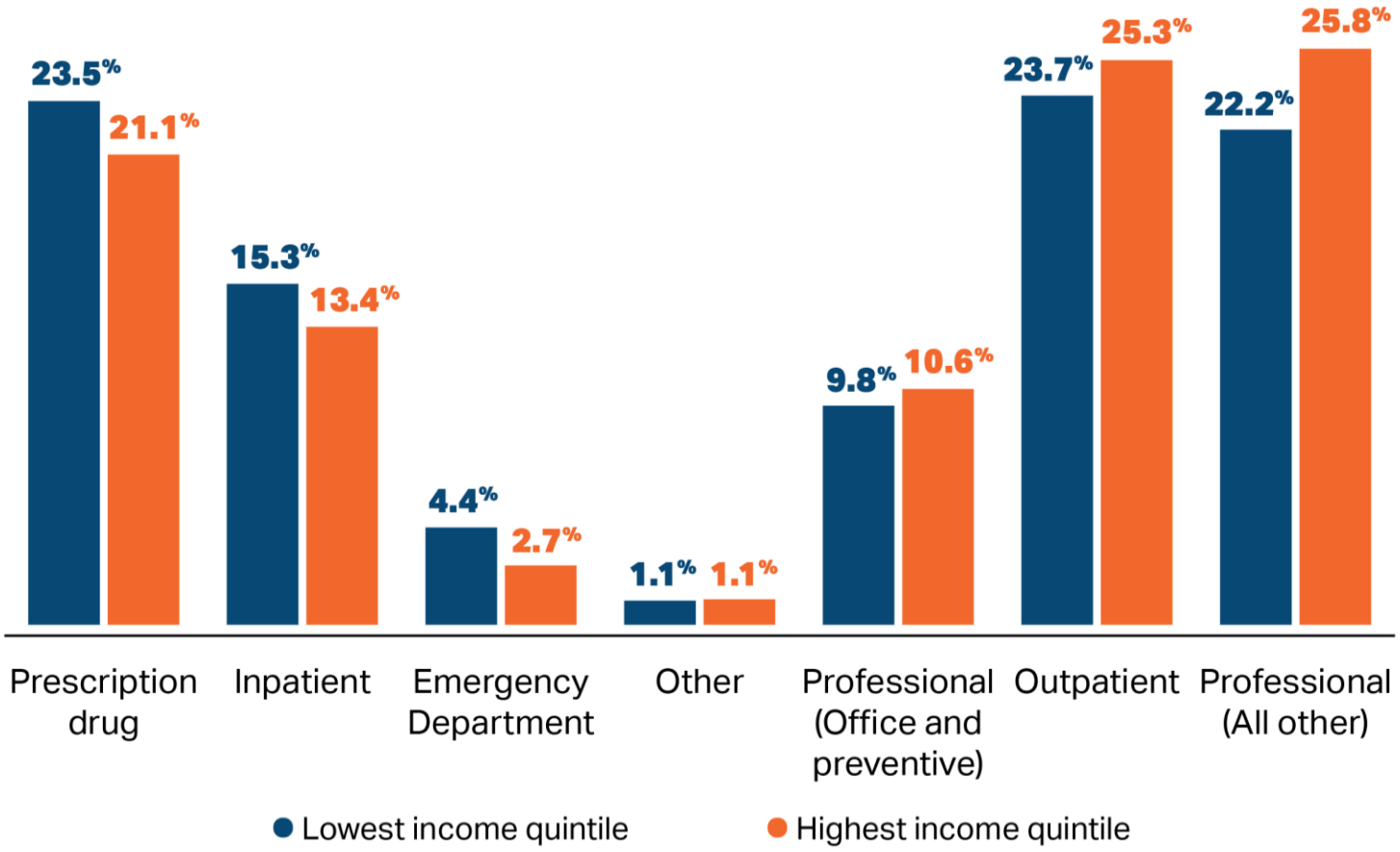


Notes: Prescription drug spending is excluded from this analysis. Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64 with full coverage in 2018. Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

Those in the lowest income quintile had more inpatient, ED, and prescription drug spending, but less professional and outpatient spending.

Percent of health care spending by category for commercially-insured adults in the lowest and highest income quintiles, 2018



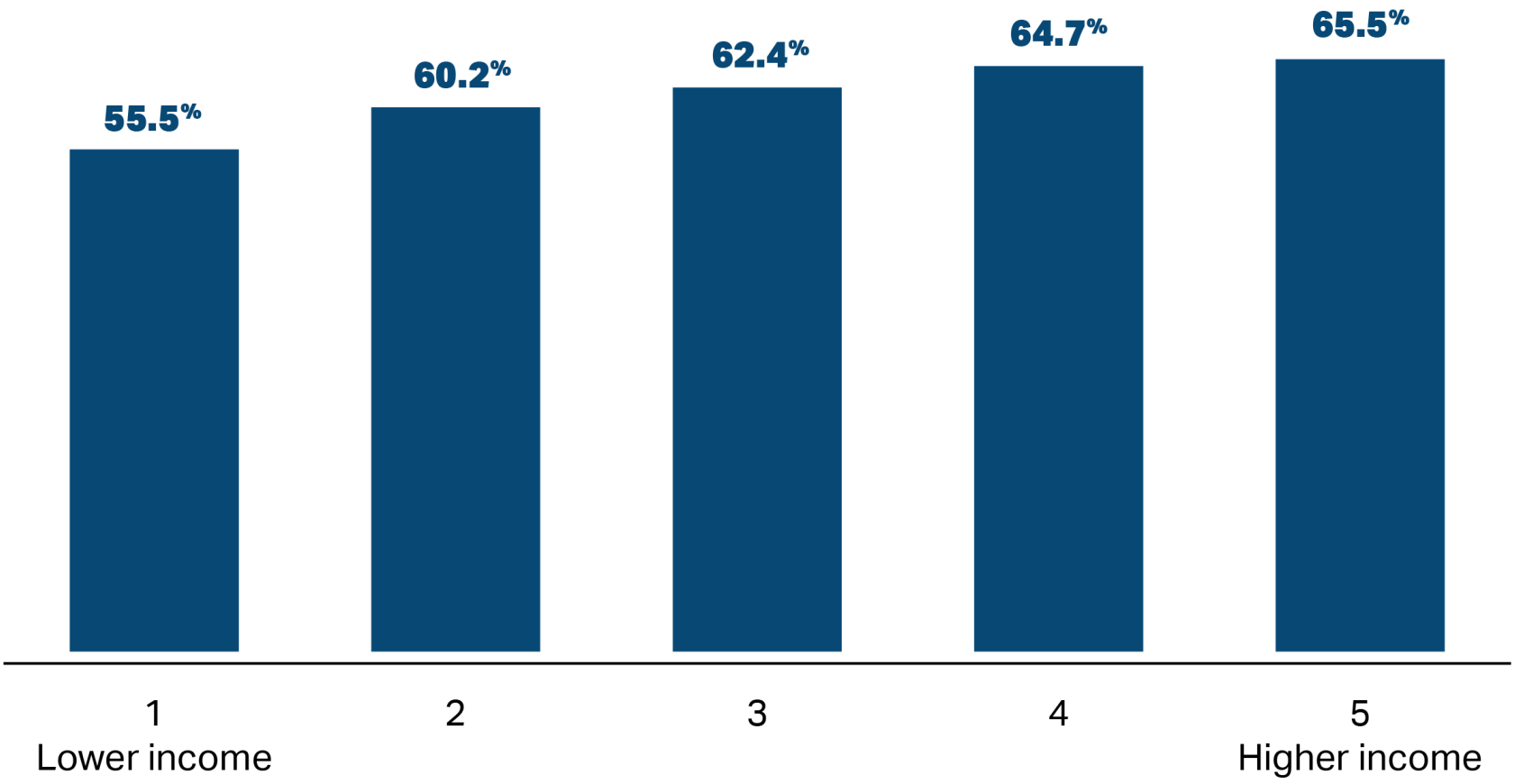
A robust, affordable, accessible health care system should be associated with less potentially avoidable ED and inpatient care, and greater use of professional and preventive care.

Notes: Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64, with full coverage in 2018 and any observed medical spending. Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

Those living in higher income communities were 18% more likely to have a preventive care visit.

Percent of commercially-insured adults with at least 1 preventive visit by income quintile, 2018

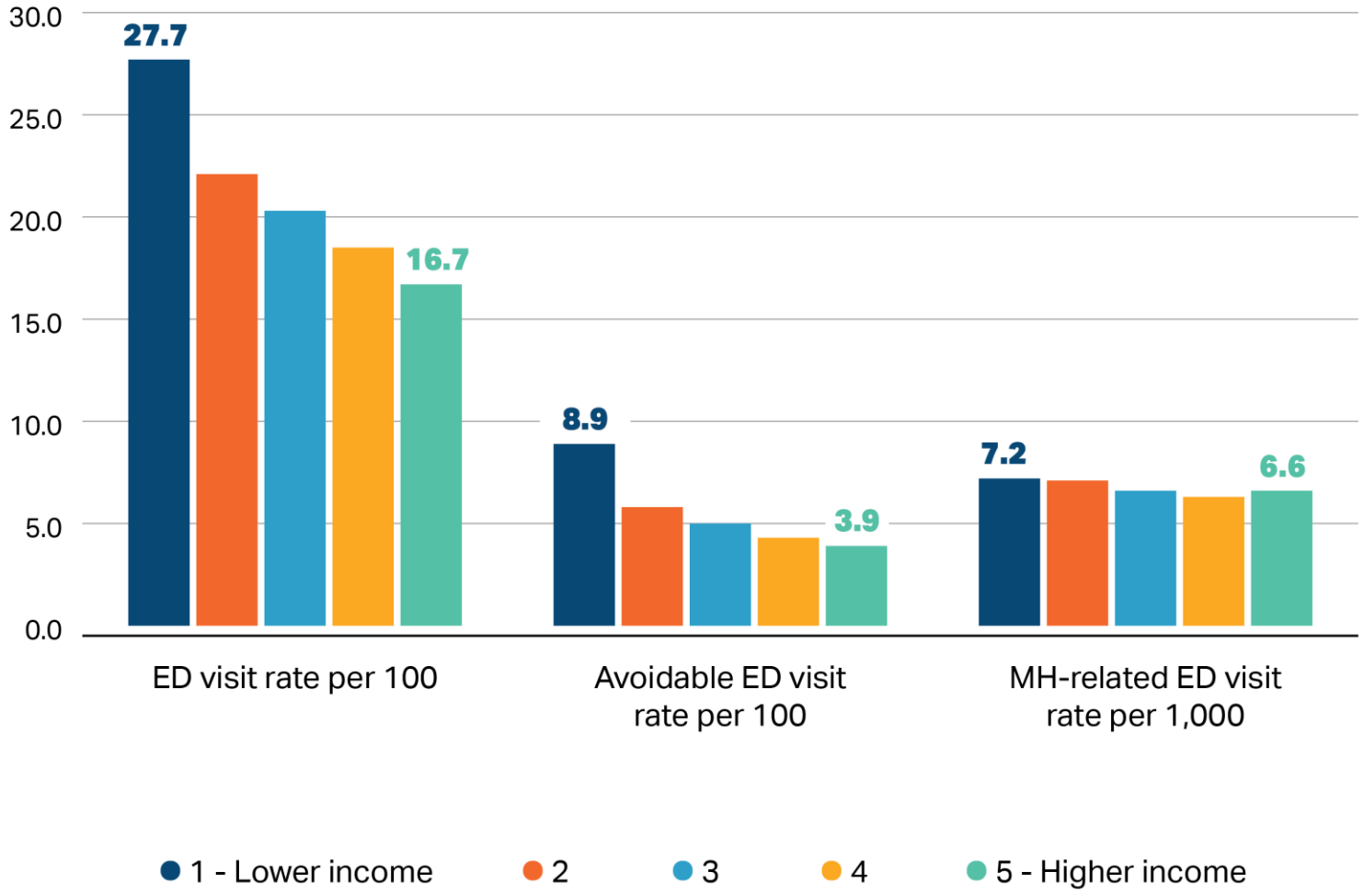


Notes: Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64, with full coverage in 2018 and any observed medical spending. Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

Those in the lowest income quintile had 1.7 times more ED visits and 2.3 times more avoidable ED visits than those in the highest-income quintile.

Emergency department visit rates per indicated number of members by income quintile, 2018

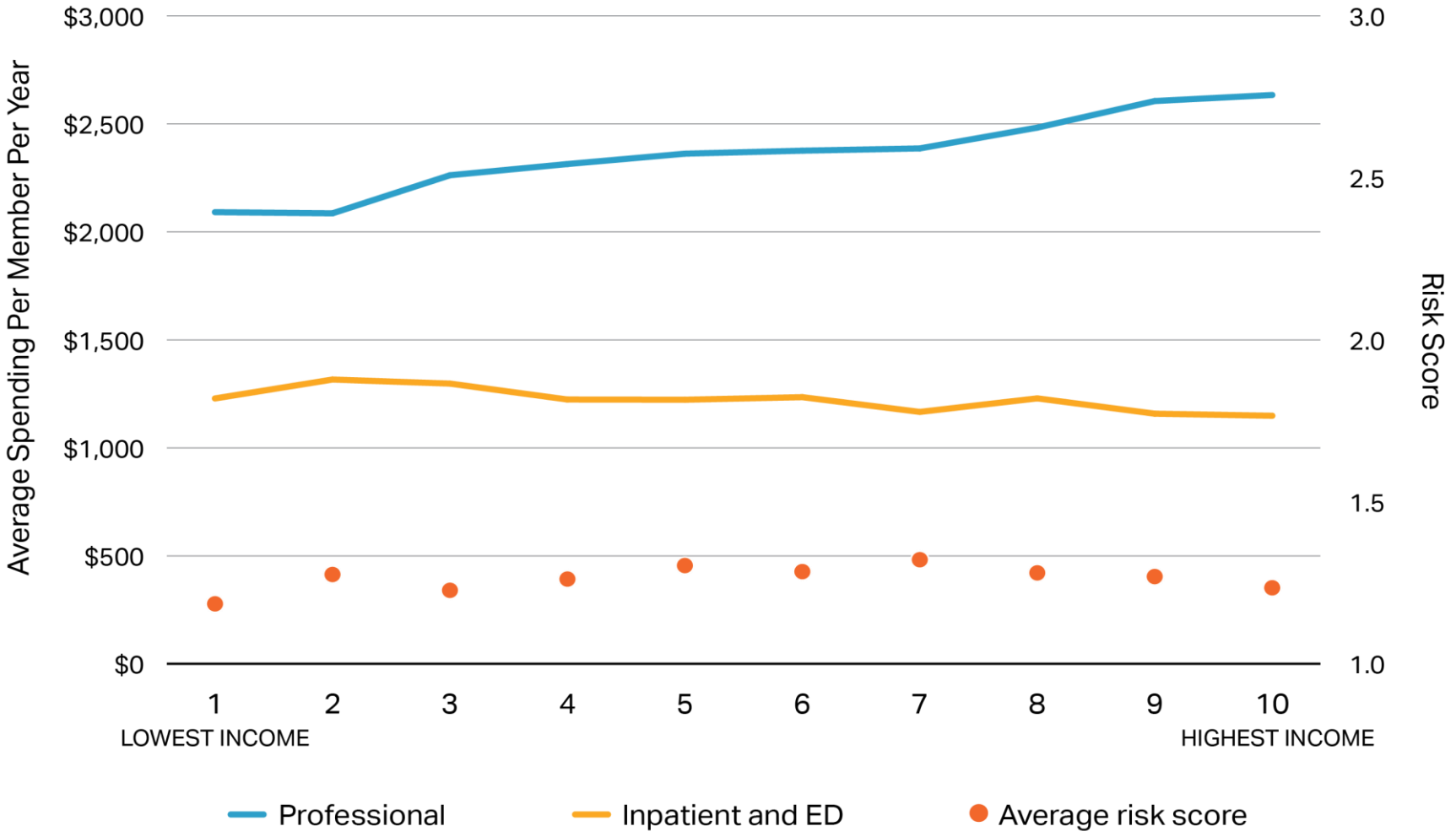


Notes: Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64, with full coverage in 2018 and any observed medical spending. Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

As community income increases, professional spending increases and combined inpatient and ED spending decreases.

Average Inpatient/ED and Professional spending PMPY by income decile, 2018



Notes: Results are reported according to community income level linked to zip code tabulation area. Population includes commercially-insured adults age 18-64, with full coverage in 2018 and any observed medical spending. Results are adjusted for differences in age, sex, and risk score. The risk score information herein contained has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2018

Differences in health care spending patterns by income are suggestive of underlying access and affordability inequities.

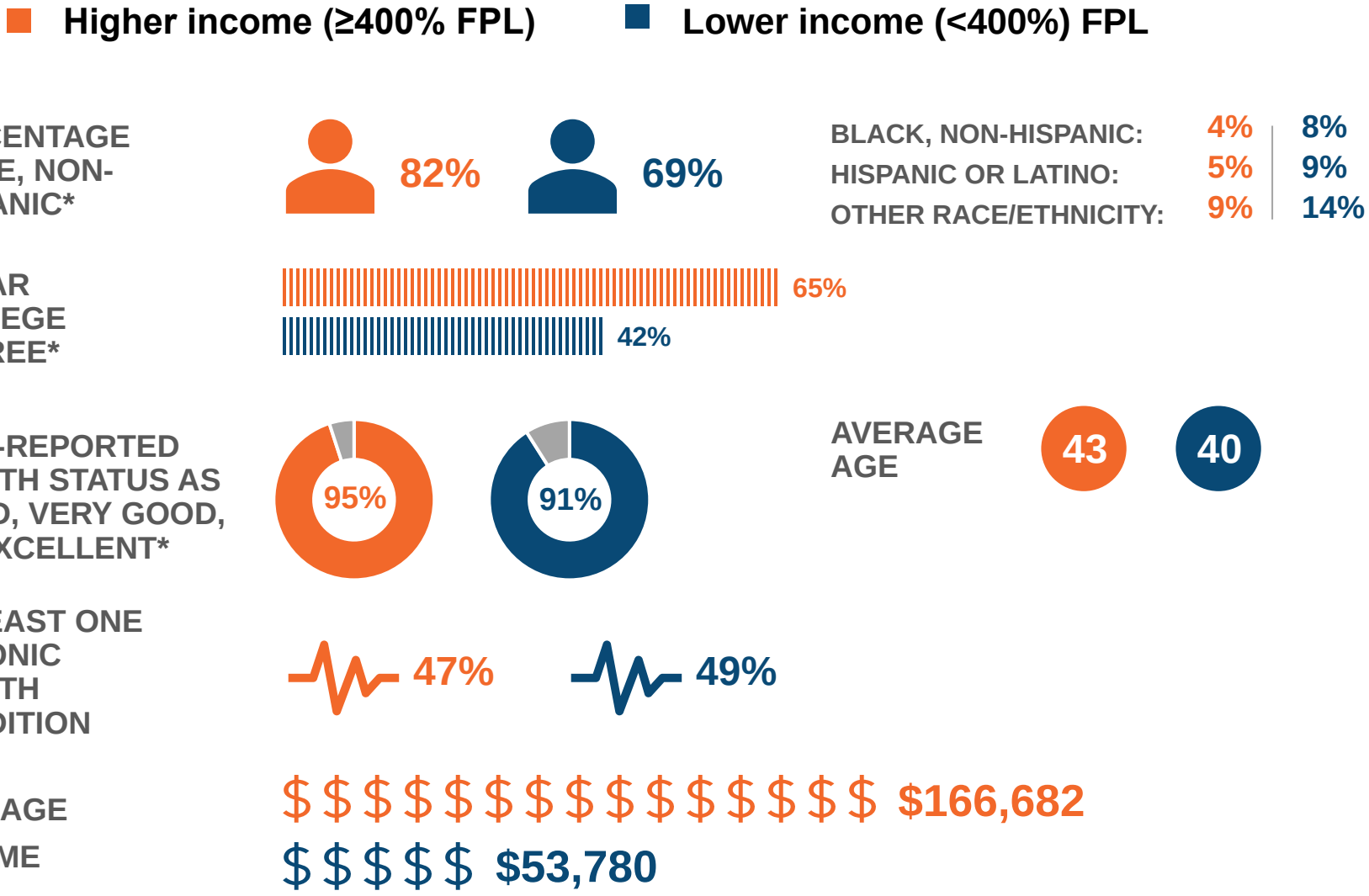
- Residents in lower income areas have **fewer health care expenditures** yet typically **pay the same or more in premiums.**
  - Employees in low-wage firms contributed $288 more per year for single coverage and $1,572 more per year for family coverage than employees in other firms.
  - Total premiums (employer + employee) were the same.
- The different patterns of health care spending by community income suggest residents with lower income may be less likely to make use of effective, routine care that can prevent longer-term hospital and ED visits.
- The HPC sought insight into the underlying reasons behind these patterns using lower and higher income commercially-insured households' responses to questions concerning **access, affordability and avoidance of care** from the Massachusetts Health Insurance Survey (MHIS) and a special HPC/CHIA follow-on survey.

Notes: Data sources are the CHIA 2019 MHIS Survey and the 2019 MHIS Recontact Survey

Source: Center for Health Information and Analysis: "The Benefits Divide: Workers at Lower-Wage Firms and Employer-Sponsored Insurance in Massachusetts" Aug 2017

Center for Health Information and Analysis "An Inside look: Unexpected Medical Bills are a Challenge for Many", "An inside look: Problems paying Family Medical Bills are a Burden for Some", "Affordability Issues are More Common in High Deductible Health Plans", 2021, "2019 Massachusetts Health Insurance Survey," see https://www.chiamass.gov/massachusetts-health-insurance-survey/

Adults in lower income households were more likely to be people of color and to have less education, but report similar health status.



Notes: 400% Federal Poverty Level (FPL) is $103,000 for a family of 4 in Massachusetts. Results are weighted to produce state-level estimates. * indicates significance at P<0.05 level.

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults in lower and higher income households were similarly likely to report having a usual source of care and a recent doctor's appointment.

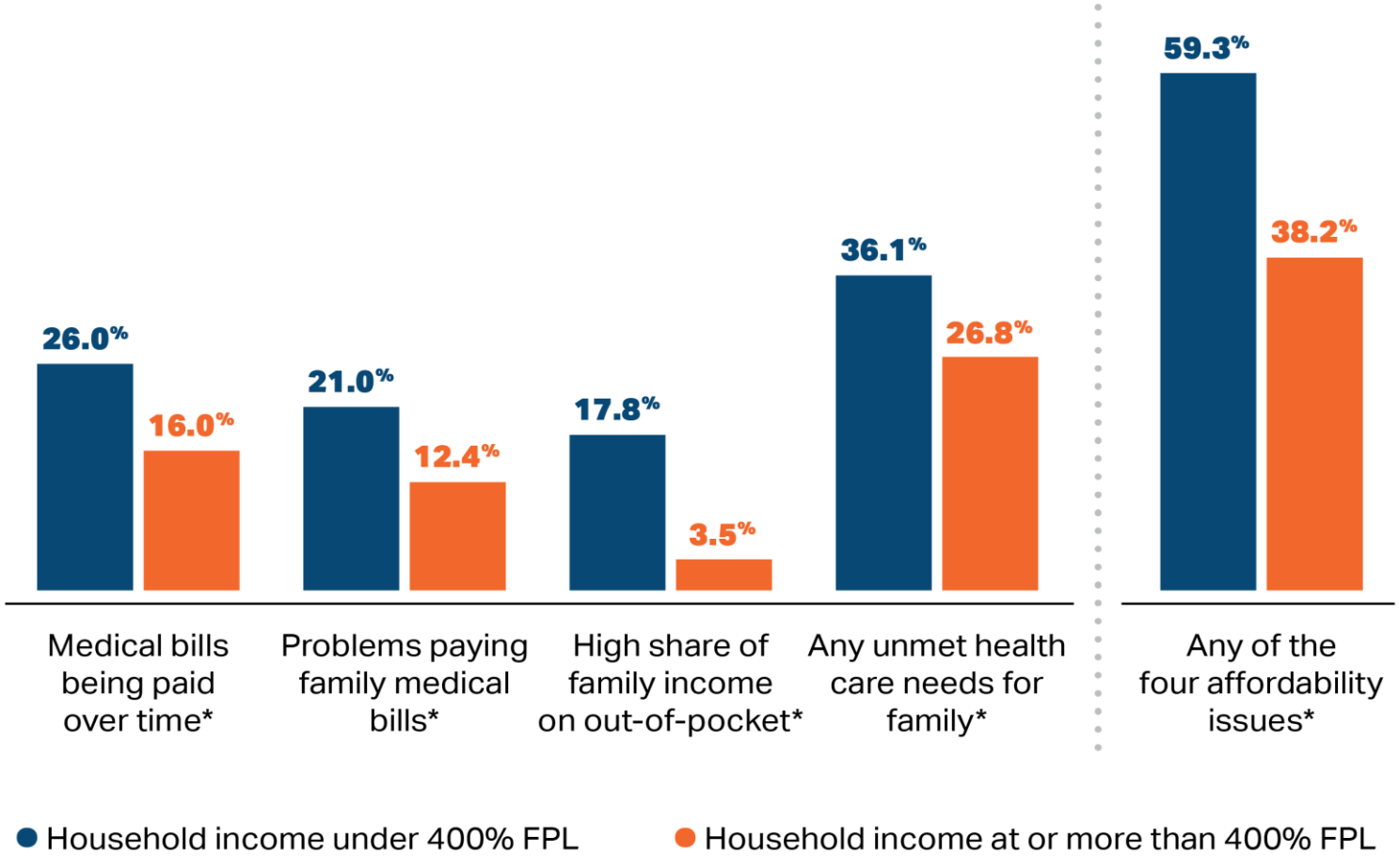
There are relatively minor differences in access to doctor or preventive care associated with income. Households with lower income and higher income were similarly likely to report having (respectively):

- A usual source of care (91% vs. 94%)
- A doctor's office or community health clinic as a usual source of care (87% vs. 88%)
- An appointment with a doctor or specialist in the past 12 months (87% vs. 91%)
- An appointment for preventive care in the past 12 months (76% vs. 80%)
- Been able to get an appointment at a doctor's office or clinic as soon as one was thought needed (80% vs. 80%)

Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019.
Question text: "Is there a place where you usually go when you are sick or when you need advice about your health?" "What kind of place is it?" "In the past 12 months, how many times did you visit a general doctor who treats a variety of illnesses?" "In the past 12 months, did you visit a specialist?" "Was this visit to a general doctor, nurse practitioner, physician's assistant or midwife for a check-up, physical examination, or for other preventive care?" "Has this happened to you in the past 12 months? [You were unable to get an appointment at a doctor's office or clinic as soon as you thought one was needed]"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income were more likely to experience affordability issues than those with higher incomes.

Percent of commercially-insured adults who experienced affordability issues by household income status, 2019

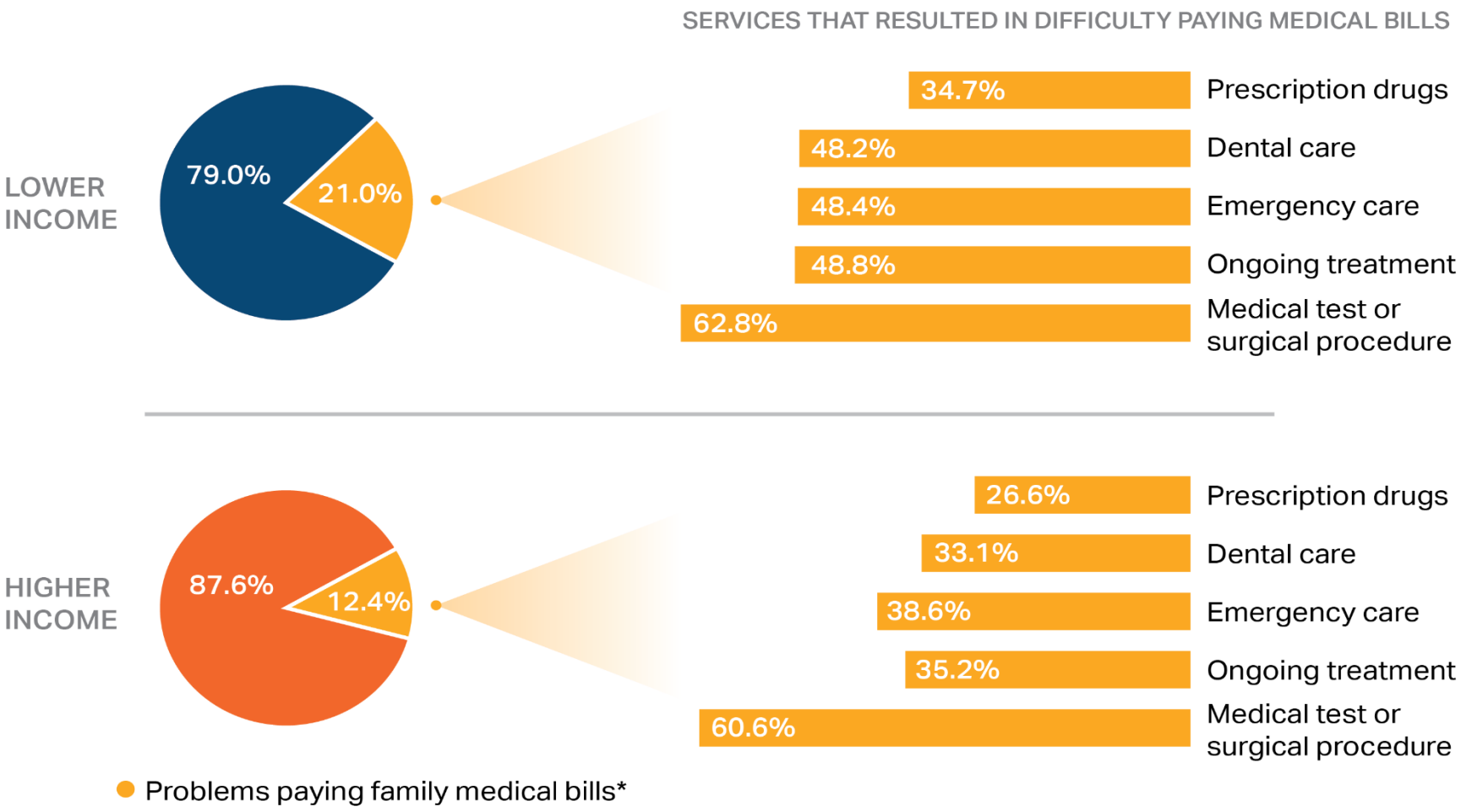


Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.
Question text: “Do you currently have any medical bills that are being paid over time?” “In the past 12 months, did you have any problems paying or were you unable to pay any medical bills?” “Was the "out of pocket" spending for health care in the past 12 months for you and your family less than [5% or 10% of income] or [5% or 10% of income] or more?” “Did any of your immediate family members go without health care that they needed because of costs at any time in the past 12 months?”
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

HPC

Medical tests and surgical procedures were the most common services that resulted in problems paying medical bills.

Percent of commercially-insured adults with problems paying family medical bills and services that resulted in difficulty paying medical bills by household income, 2019



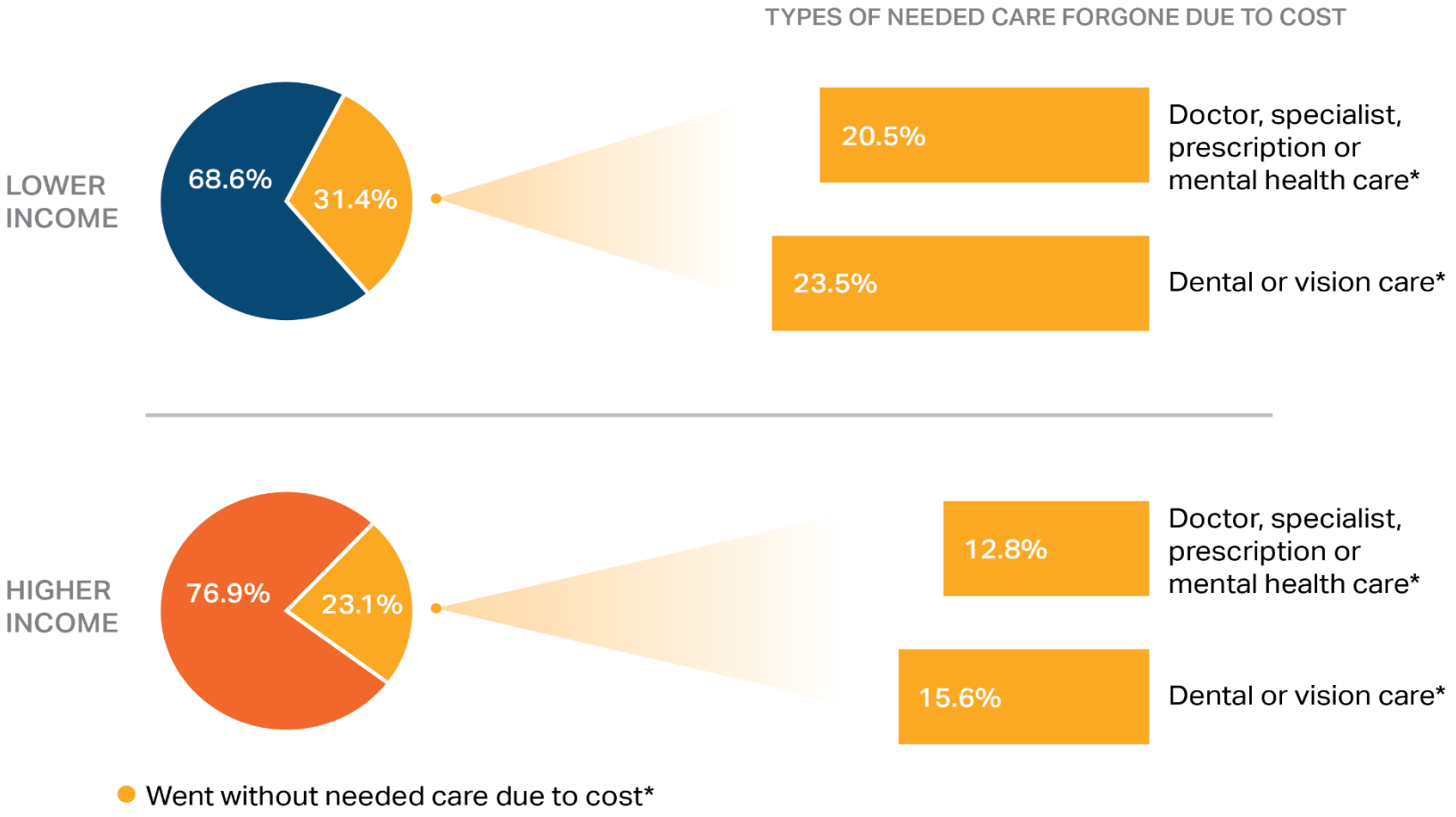
Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level

Question text: "In the past 12 months, did you have any problems paying or were you unable to pay any medical bills?" "What types of medical services led to those medical bills?"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income were much more likely to go without needed health care or prescription drugs because of cost.

Percent of commercially-insured adults who went without needed care because of cost and types of needed care forgone by household income, 2019

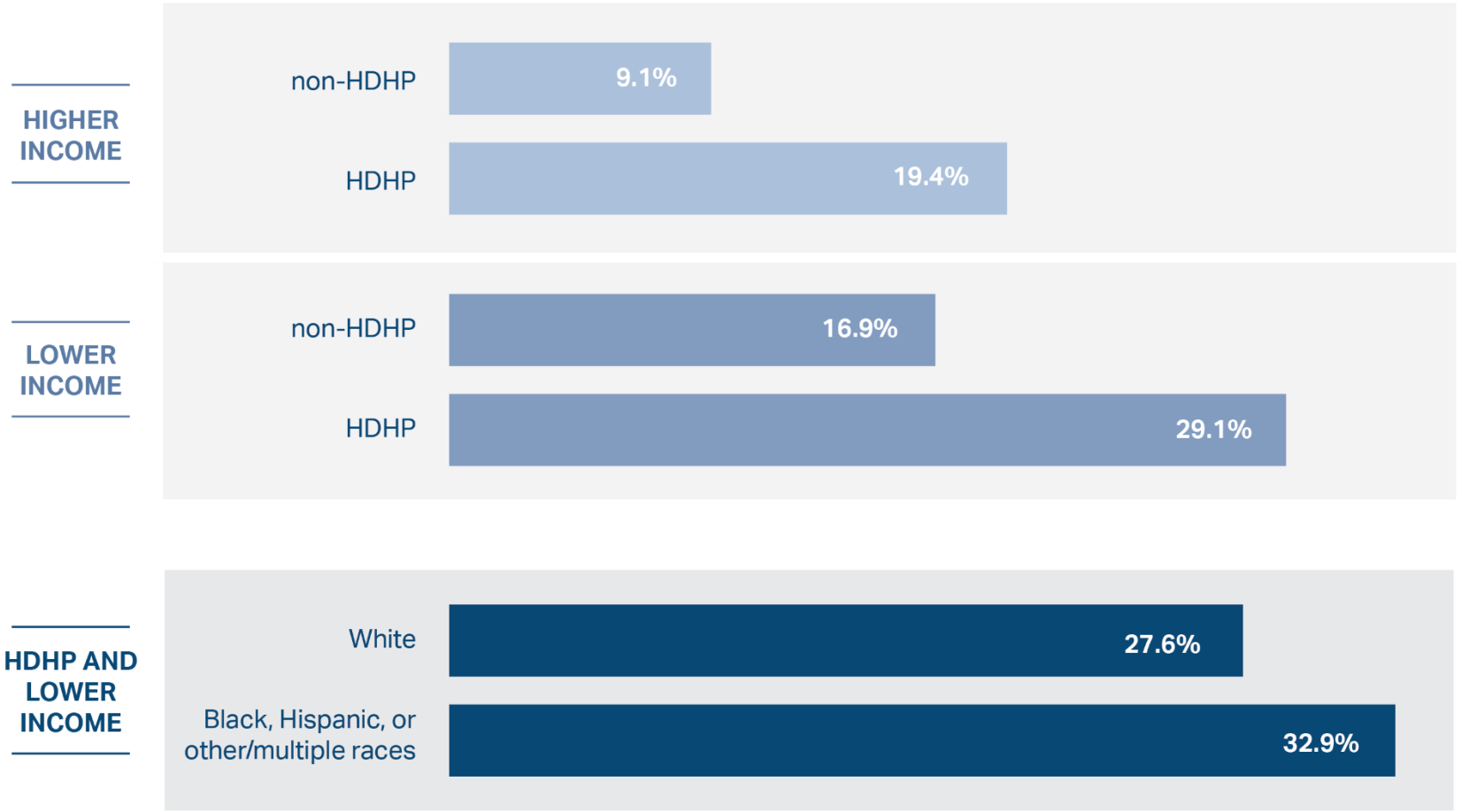


Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.
Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "…not fill a prescription for medicine needed for you", "… not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed", "not get dental care that you needed", "not get vision care that you needed"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with high deductible plans were also twice as likely to go without needed health care or prescription drugs because of cost.

Percent of commercially-insured Massachusetts adults who said they went without needed doctor care, specialist care, mental health care or prescription drugs, 2019

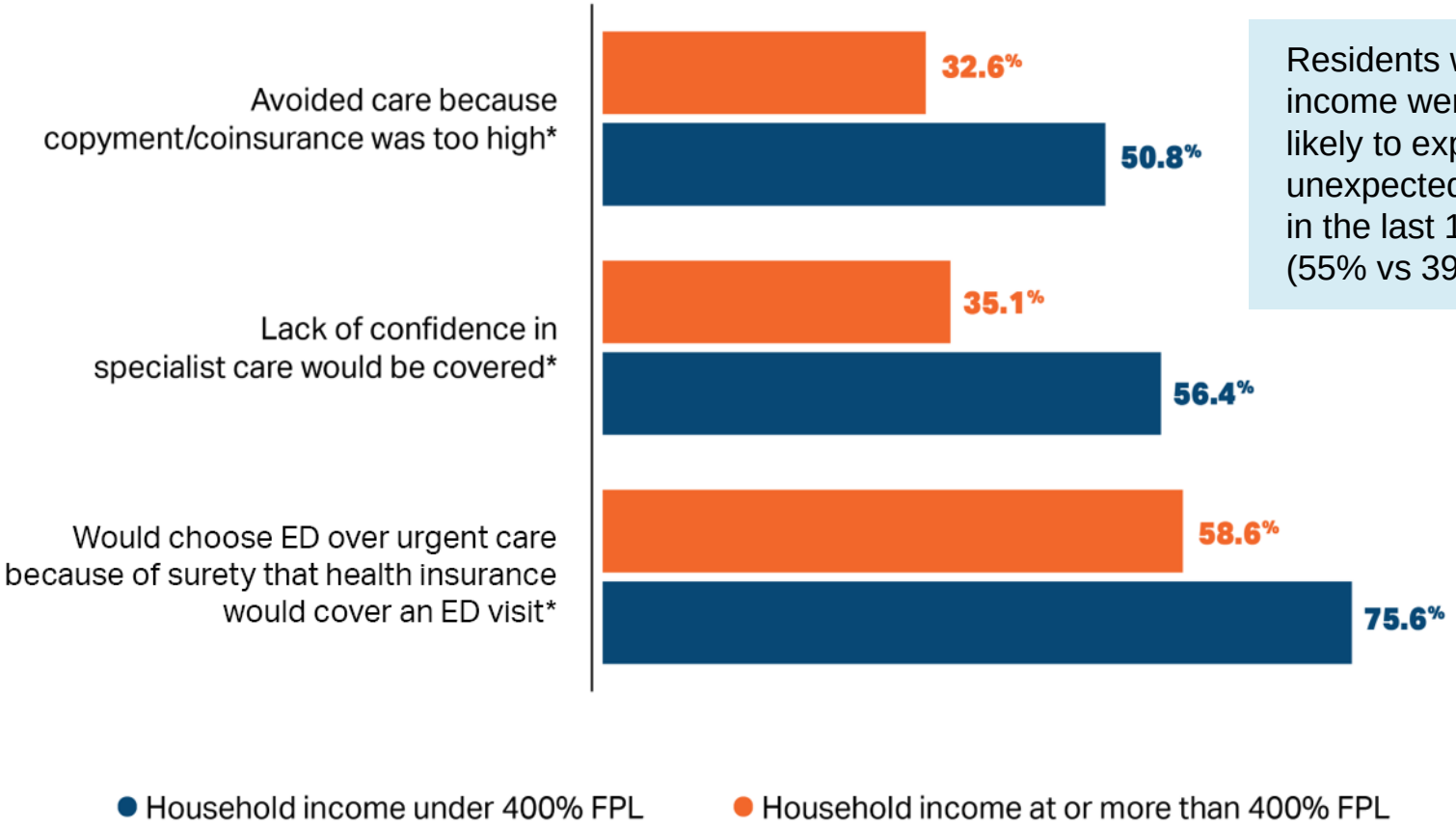


Notes: 'Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Question text: “Because of cost, did you go without needed ___ care”, where the categories for types of care included those noted above as well as vision care, dental care, medical equipment, or care from an NP, PA or CNM.

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income avoided care because of copays/coinsurance and lack of confidence that needed care would be covered.

Percent of commercially-insured adults who avoided needed care because of cost or lacked confidence in coverage, by household income status, 2019



Residents with lower income were more likely to experience an unexpected medical bill in the last 12 months (55% vs 39%).

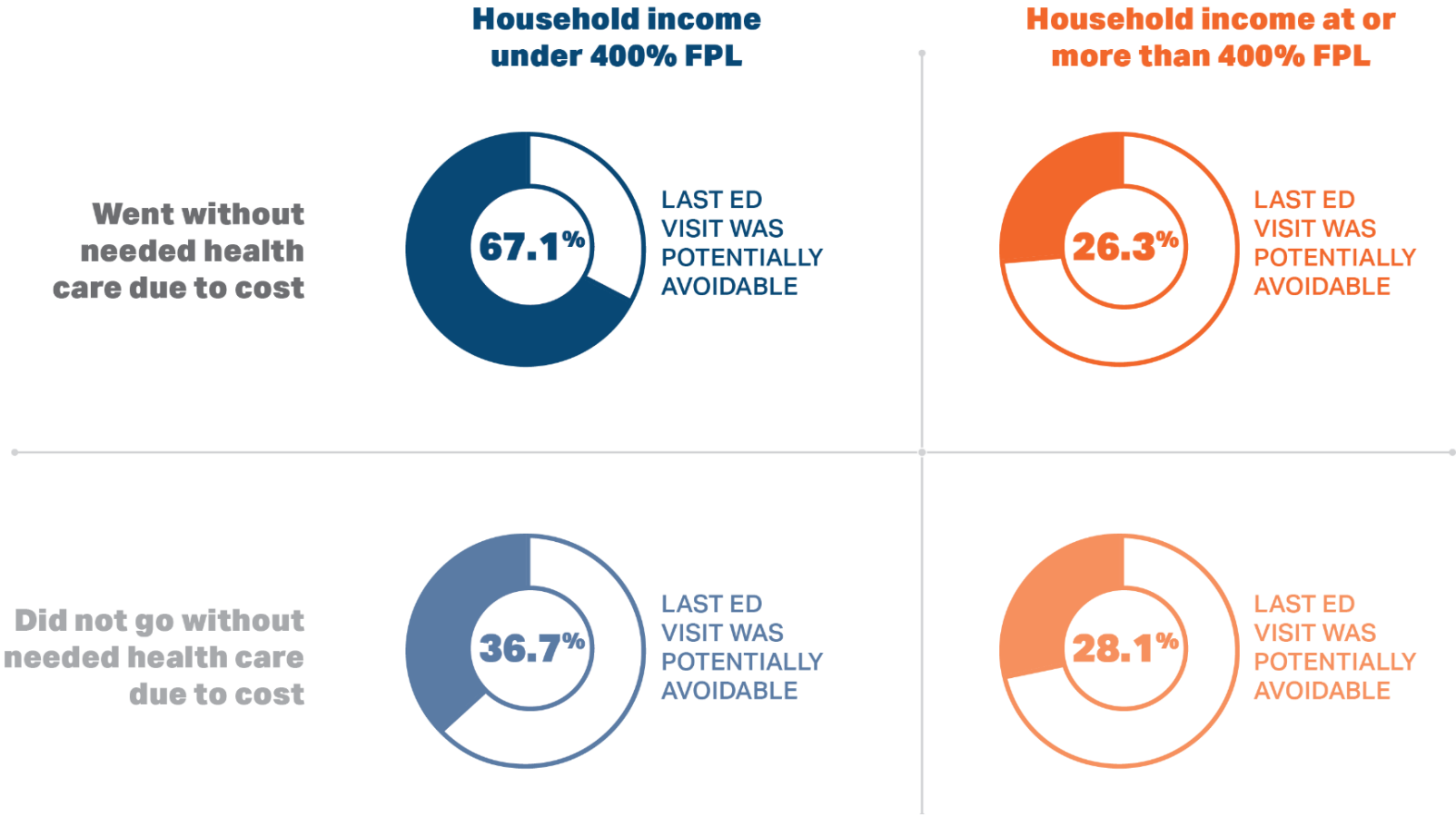
Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.
Question text: "Would any of these be important reasons for you to choose a hospital emergency room over an urgent care center or retail clinic?" "The last time you went without needed care because of cost was it because of any of the following?" "How confident are you that you know whether or not the following would be covered by your health insurance plan if it was needed?" "In the past 12 months, have you or any of your immediate family members received a medical bill where the health insurance plan paid much less than expected, or did not pay anything at all?"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey and 2019 MHIS Recontact Survey

HPC

Those who have lower income and went without needed care due to cost were twice as likely to have had a potentially avoidable ED visit.

Percent of commercially-insured adults whose last ED visit was potentially avoidable, by household income and unmet health care needs due to cost, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Needed health care includes doctor, specialist, prescription drug, and mental health care. Clockwise from upper left quadrant, estimated number of Massachusetts residents whose last ED visit was potentially avoidable: 32,210/48,031, 18,421/70,097, 89,246/317,376, and 57,464/156,749. Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "…not fill a prescription for medicine needed for you", "… not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed". "The last time you went to a hospital emergency room, was it for a condition that you thought could have been treated by a regular doctor if he or she had been available?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Key Findings

- Commercially-insured MA residents living in lower income areas were more likely to **have zero health care spending**. Those in the lowest income areas **had more spending for inpatient, ED, and prescription drugs** than adults living in higher income areas, but **less spending on professional and outpatient care**.
- **These patterns are likely influenced by individuals with lower income avoiding care due to concerns about cost.**
- Residents with lower income were much **more likely to experience any affordability issue (e.g., medical bills and unmet health care needs)**. For those who experienced problems paying family medical bills, **medical tests and surgical procedures** were the most common source of those bills.
- Residents with lower income were much more likely to **go without needed care and prescription drugs** because of cost, and those with high deductible health plans were even more likely to do so.
- Residents with lower income report that a key factor in going without care was that **cost-sharing was unaffordable**. Adults with lower income were also more likely to report having **uncertainty that care would be covered**, which can affect the choice to seek needed care and even lead to choosing higher cost settings of care (e.g., the ED over urgent care).
- Those who have lower income and went without needed care due to cost were twice as likely to have had a **potentially avoidable ED visit**.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
  - 2020 Cost Trends Report: Income and Affordability Findings
  - **Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact (VOTE)**
  - Material Change Notices
  - 2021 Performance Improvement Plan Process
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

Report Evaluating Entry into the Nurse Licensure Compact

The state's FY21 budget requires the HPC, in consultation with the Board of Registration in Nursing ("BORN"), to conduct an analysis and issue a report evaluating the Commonwealth's entry into the Nurse Licensure Compact ("NLC" or "Compact").

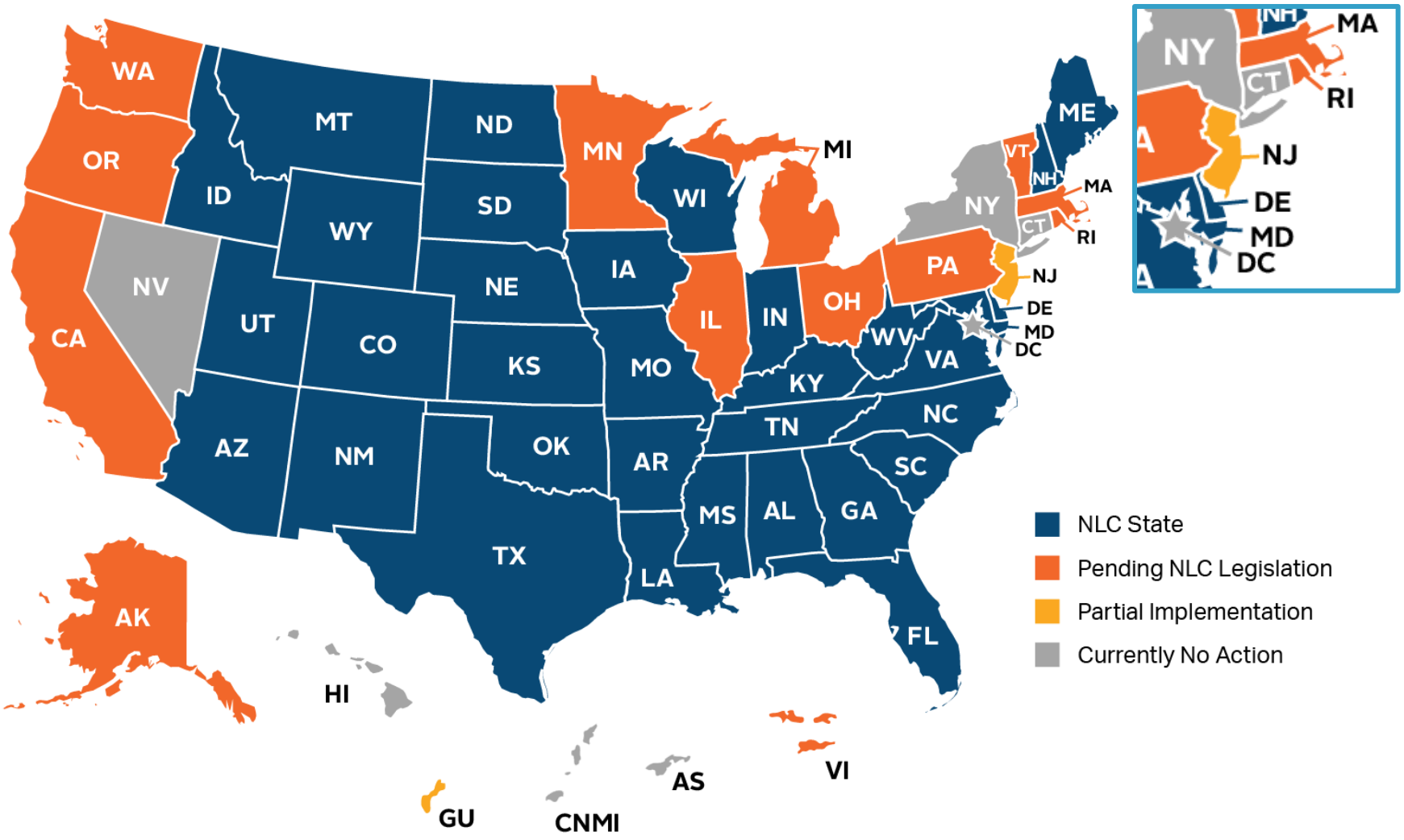
- The NLC is an **interstate compact** that allows eligible **registered nurses** ("RNs") and **licensed practical nurses** ("LPNs") (together, "nurses") to hold a **multi-state license** to practice in their home state and all other Compact states
- Among other requirements, the study includes:
  - An analysis of whether entry into the NLC would increase the Commonwealth's emergency and pandemic preparedness;
  - An analysis of other states' entry into the NLC and any impact on quality of care resulting from entry;
  - An analysis of the ability of RNs and LPNs in the Commonwealth to provide follow-up care across state lines, including via telehealth; and
  - Recommendations regarding the Commonwealth's entry into the NLC
- The HPC must file the report with the legislature no later than **June 15, 2021**

Report Development Process Overview

The HPC's multi-faceted approach in developing the report included:

- Consulting with BORN
- Reviewing available literature
- Consulting with experts
- Analyzing nurse and labor market data
- Researching key stakeholder perspectives
- Engaging with National Council of State Boards of Nursing ("NCSBN") and other states

NLC Membership Status



National Council of State Boards of Nursing, https://www.ncsbn.org/nurse-licensure-compact.htm (as of May 14, 2021).

NLC Background: Key Points

Developed by the NCSBN, the Compact was first implemented in 2000 and revised in 2015, which resulted in the enhanced NLC ("eNLC").

A nurse practicing with a multi-state license is accountable for compliance with the state practice laws of each state in which they practice.

The Compact is governed by the Interstate Commission of Nurse Licensure Compact Administrators, the quasi-governmental, joint public agency of the party states.

To join the Compact, a state must enact the model legislation. The Compact may be amended by enactment of all party states, and a party state may withdraw from the Compact by enacting legislation to repeal the Compact.

To obtain a Compact license, a nurse must: (1) be a legal resident of a Compact state; (2) satisfy the licensure criteria required by the local board of nursing in that state; and (3) meet the Compact's Uniform Licensure Requirements.

The eNLC requires multi-state licensure applicants to satisfy 11 Uniform Licensure Requirements (ULRs), including a state and federal fingerprint-supported criminal background check.

A Compact license allows nurses to practice (in person or via telehealth) in any Compact state without obtaining additional state-specific licenses.

There is an annual membership fee for party states of $6,000.

HPC

Analysis: Nursing Workforce Characteristics and Vacancy Rates

KEY FINDINGS

While Massachusetts has a higher rate of RNs per capita than the U.S. overall, data suggest that the RN labor market in Massachusetts may experience slower growth and tighten in the coming years.

- The Massachusetts RN workforce is older, and the age differences are even greater for acute and critical care RNs; growth in nursing graduates is slower than other areas of the country.

- Hospitals reported that vacancy rates varied by specialty and geographic region (e.g., highest RN vacancy rates in emergency departments), and open RN positions in adult critical care and emergency department were among those that took the longest time to fill.

Analysis: Emergency and Pandemic Preparedness

KEY FINDINGS

Joining the Compact would facilitate the Commonwealth's emergency preparedness, enabling the Massachusetts health care delivery system to react more dynamically to unforeseen and sudden changes in nursing needs, during pandemics and other emergencies.

- Massachusetts faced significant challenges meeting the demand for nurses during COVID-19, most notably regarding ICU RNs, and data suggest Massachusetts hospital employers had greater difficulty than comparator states.

- The Compact would enhance the ability of Massachusetts to more readily address staffing needs, particularly for the nurse specialties most sought during pandemics, natural disasters, or other crises.

Analyses: Other States' Entry into the NLC; Nurse Perspectives on NLC

KEY FINDINGS: OTHER STATES' ENTRY

Compact membership has increased following adoption of the revised eNLC, and participating jurisdictions (now 35) report benefits to state boards of nursing, employers and nurses.

- Research on the impact of the Compact has not identified negative effects of joining the Compact.

- Other states have acknowledged that the Compact can reduce administrative barriers to licensure of qualified nurses, enhancing member state ability to address short-term nursing needs.

KEY FINDINGS: NURSE PERSPECTIVES

The Compact offers potential benefits to individual nurses, and there is evidence from other states that nurses recognize such benefits.

HPC

Analysis: Temporary Licenses Issued During COVID-19 & BORN Authority Under the NLC

KEY FINDINGS

Under the Compact, BORN would retain its authority over nursing practice and education in Massachusetts, including in determining all requirements for licensure in the Commonwealth, and in licensure enforcement.

- BORN's experience processing thousands of temporary licenses during the COVID-19 response was administratively burdensome, but BORN has not identified any issues with the quality of the nurses practicing in Massachusetts with temporary licenses (and fewer than 1% of the temporary licenses issued since March 31, 2020 have had a complaint taken against them).

- The Compact ULRs would strengthen BORN's licensure application process, bringing it in line with the highest regulatory standards for licensed health care professionals, and participation would improve BORN's ability to communicate in a timely manner with other states regarding nurse licensure and enforcement activities.

Analysis: Telehealth, Cross-Border Care & Nursing Education

KEY FINDINGS

The COVID-19 pandemic highlighted the importance of and potential for telehealth and demonstrated the need to remove barriers to cross-state practice in order to strengthen the ability of the health care system to adapt care delivery modes and respond to needs more flexibly in a post-COVID-19 world.

- The Compact supports the delivery of telehealth nursing practice across the health care continuum and across state lines, with potential positive impacts on costs and quality of care.

- Compact membership may also help address the significant concerns regarding the supply of nurse educators, providing an investment in the future of nursing education.

Analyses: Anticipated Impact on Health Care Cost, Quality & Access; Estimated Fiscal Impact

KEY FINDINGS: ANTICIPATED IMPACT

There is no evidence that joining the Compact would have a negative effect on quality of nursing care in the Commonwealth and the ability to fill short-term staffing needs and facilitate telehealth could yield positive effects for health care access, quality, and cost.

KEY FINDINGS: FISCAL IMPACT

The Compact is estimated to have only a modest fiscal impact and will not impede BORN's ability to continue its mission.

- BORN would continue to receive licensure fees from nurses licensed in Massachusetts, except for some revenue collected from nurses residing in other Compact states who currently pay for licensure by reciprocity in Massachusetts.

Conclusion and Recommendation

The Key Findings reflect **multiple benefits for the Commonwealth** in joining the Compact, namely:

1. Benefits for the oversight of nursing practice in Massachusetts, as well as benefits for health care employers and individual nurses
2. Enhanced ability of the Massachusetts health care system to prepare for pandemics, emergencies, and other staffing needs
3. Greater facilitation of telehealth and other care delivery transformations in the future

In conclusion, the Health Policy Commission **recommends** that the Massachusetts state legislature enact legislation enabling Massachusetts to join the 35 other jurisdictions, including neighboring states New Hampshire and Maine, that successfully operate under the Compact.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Report on Analyses and Recommendations Evaluating the Commonwealth's Entry into the Nurse Licensure Compact

MOTION: That, pursuant to Section 96 of Chapter 227 of the Acts of 2020, the Commission hereby authorizes the issuance of the report and filing with the Massachusetts state legislature, as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
  - 2020 Cost Trends Report: Income and Affordability Findings
  - Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact **(VOTE)**
  - **Material Change Notices**
  - 2021 Performance Improvement Plan Process
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	29	23%
Physician group merger, acquisition, or network affiliation	26	21%
Acute hospital merger, acquisition, or network affiliation	24	19%
Clinical affiliation	24	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	16	13%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

Notices Currently Under Review

- A proposal by **Collaborative Care Holdings** (CCH), a subsidiary of UnitedHealth Group's OptumCare business, to acquire the non-clinical assets of **Atrius Health** (Atrius). Atrius is the largest physician-led provider organization in the Commonwealth with approximately 1000 employed clinicians and 30 medical practice locations across Massachusetts. CCH, through OptumCare, provides a variety of services and data analytics to over 53,000 physicians nationwide, including Reliant Medical Group in Massachusetts.

RECEIVED SINCE 4/14

- A proposal by **Wellforce** to reorganize its existing contracting entities, New England Quality Care Alliance, Lowell General Physician Hospital Organization, and their affiliated ACOs form a new clinically integrated network (CIN), to be initially named Wellforce CIN.

- A proposed clinical affiliation between **Boston Children's Hospital** (Children's) and **Cape Cod Hospital** (CCH) under which Children's and its affiliated physician foundations would provide 24/7 in-house professional medical services, clinical oversight, medical leadership, and certain wrap around services to CCH's pediatric program.

Elected Not to Proceed

- A proposed joint venture between **Shields Health Care Group** and **Heywood Healthcare**, an independent healthcare system serving north central Massachusetts and southern New Hampshire, to own and operate a DPH-licensed clinic for the provision of PET/CT and MRI services to Heywood patients.

- A proposal by **Ophthalmic Consultants of Boston**, a sub-specialty ophthalmic practice of 35 ophthalmologists with 10 practice sites throughout Eastern Massachusetts, to acquire **Eye Health Services**, a sub-specialty ophthalmic practice of 20 ophthalmologists with nine practice sites, also throughout Eastern Massachusetts.

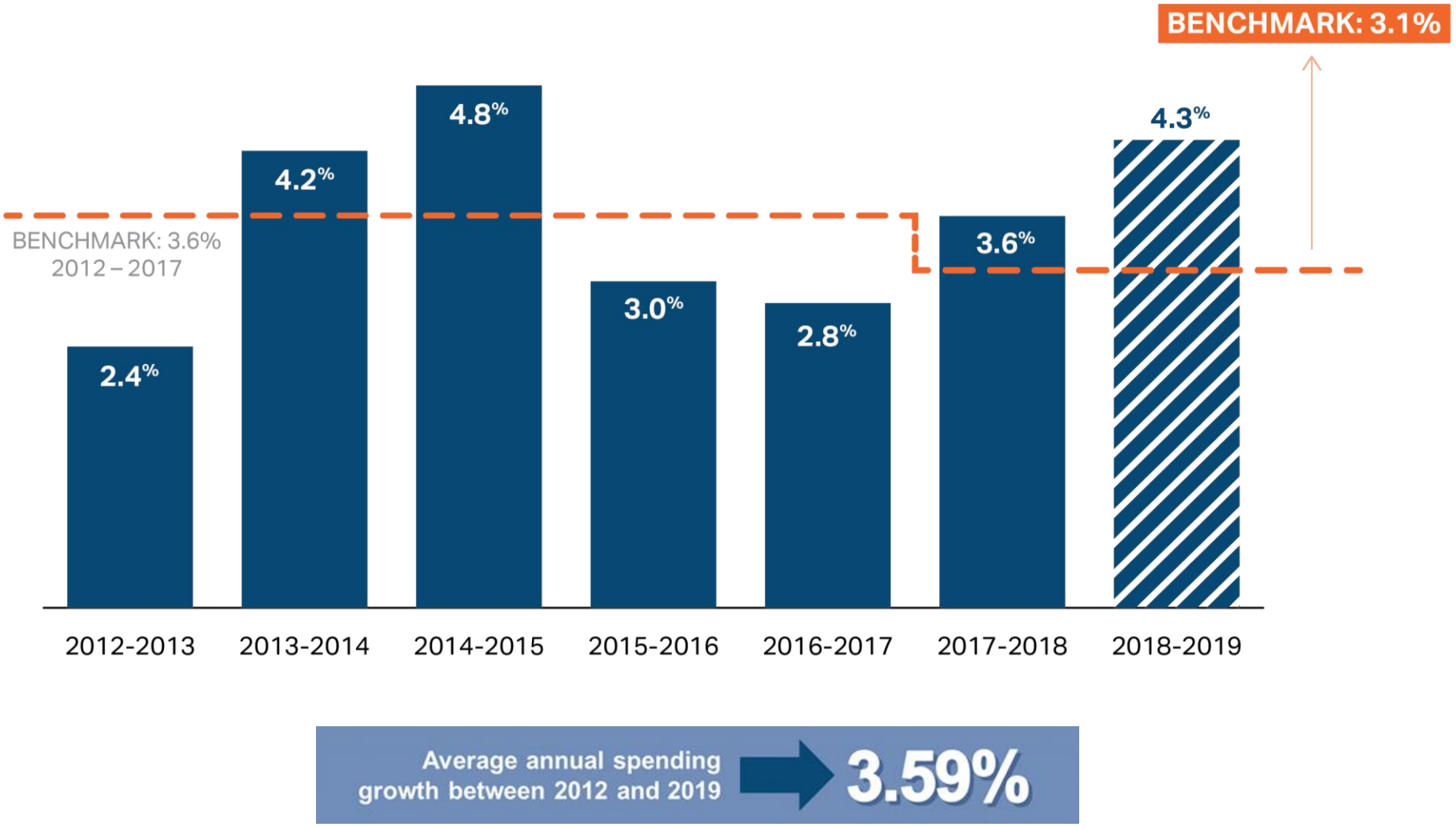
MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
  - 2020 Cost Trends Report: Income and Affordability Findings
  - Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact **(VOTE)**
  - Material Change Notices
  - **2021 Performance Improvement Plan Process**
- Schedule of Next Meeting **(July 14, 2021)**
- Executive Session **(VOTE)**

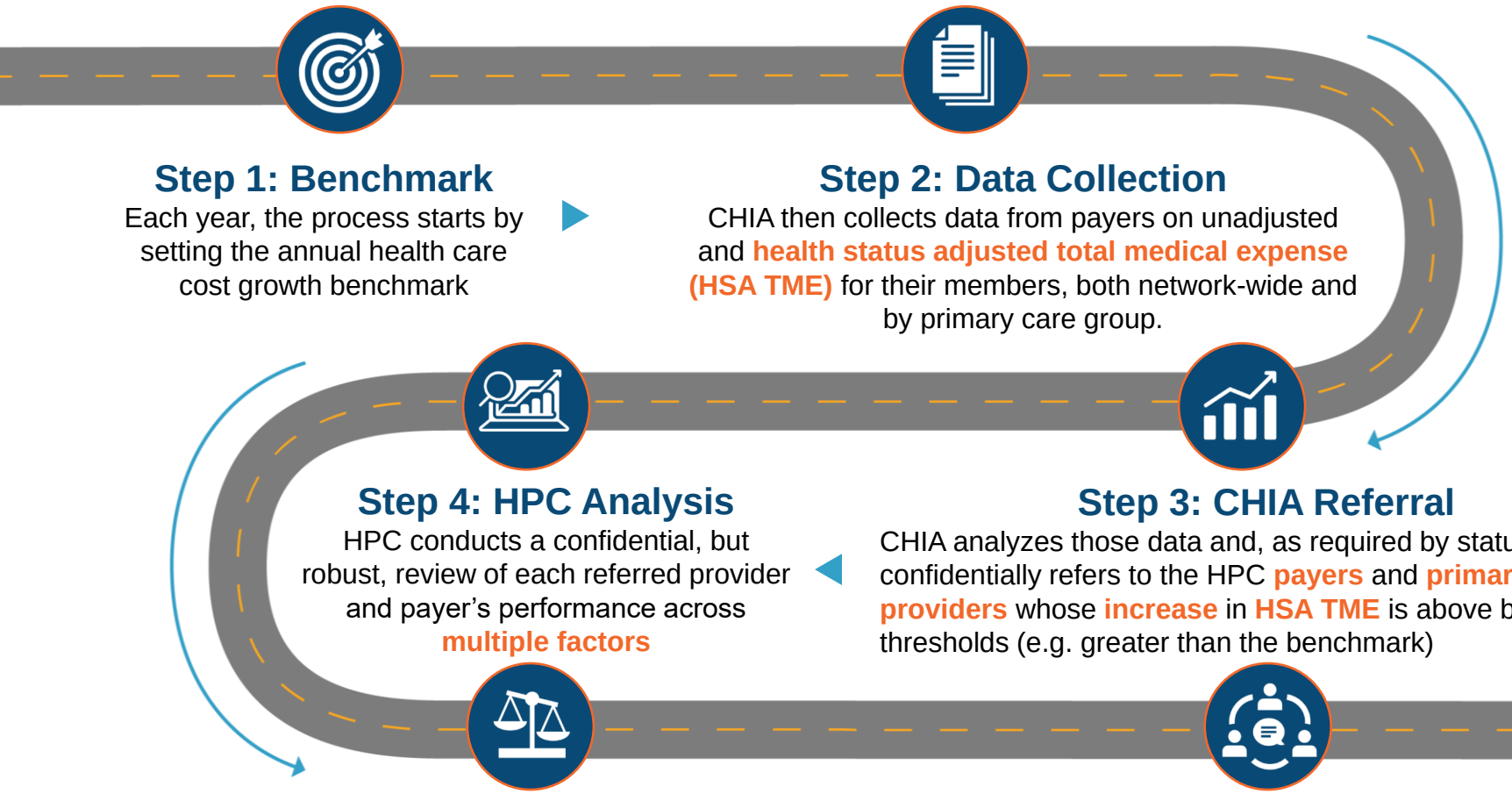
Accountability for the Health Care Cost Growth Benchmark: An Overview

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012-2019



Notes: 2018-2019 spending growth is preliminary.
Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2020.

Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers** whose **increase** in **HSA TME** is above bright line thresholds (e.g. greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to than $500,000 can be assessed as a last resort in certain circumstances.

HPC

Accountability for the Health Care Cost Growth Benchmark: CHIA Referral

CHIA is required to refer providers and payers to the HPC based on an **increase** in **health-status adjusted total medical expense (HSA TME)**.

- Total medical expense (TME) is a measure of **all medical spending** (rx, hospital, physician office visits, etc.) **for a group of patients**. Provider TME reflects all spending by the provider's *primary care patients*, regardless of where the spending occurred.
- Health status adjusted (HSA) means that the spending figures are then **adjusted** based on demographic information and health conditions in patients' medical records **to reflect the health status** of the population.
- HSA TME exists only for **payers** and **primary care providers**. It does not exist for other provider types (e.g. hospitals)
- CHIA has created **two bright line thresholds** for referral to the HPC:
  1) HSA TME growth ≥ the benchmark; OR
  2) HSA TME growth ≥ 85% of the benchmark if the payer or provider is large (≥ 2% of statewide member months) and has either high unadjusted growth (≥ the benchmark) or, for providers, a high baseline level of spending (≥ the 75th percentile).

  But unadjusted spending growth or a high spending level alone cannot trigger referral.

Accountability for the Health Care Cost Growth Benchmark: HPC Review

HPC then conducts a confidential, but robust multi-factored review of each referred entity, in consultation with its Commissioners

1 Initial Review of All Referred Entities

Examples of Factors Examined

- Performance across all books of business, including those not referred by CHIA
  - HSA TME
  - Unadjusted TME
  - Risk score

  } level, growth, comparison to peers
- Entity size and market share
- Relative Price
- Previous appearance on CHIA's list
- Factors outside of entities' control

↓

2 Board Deliberation and Vote to Follow Up with Some Entities

→

3 Meet with Follow Up Entities and Gather More Data

Examples of Data Requested

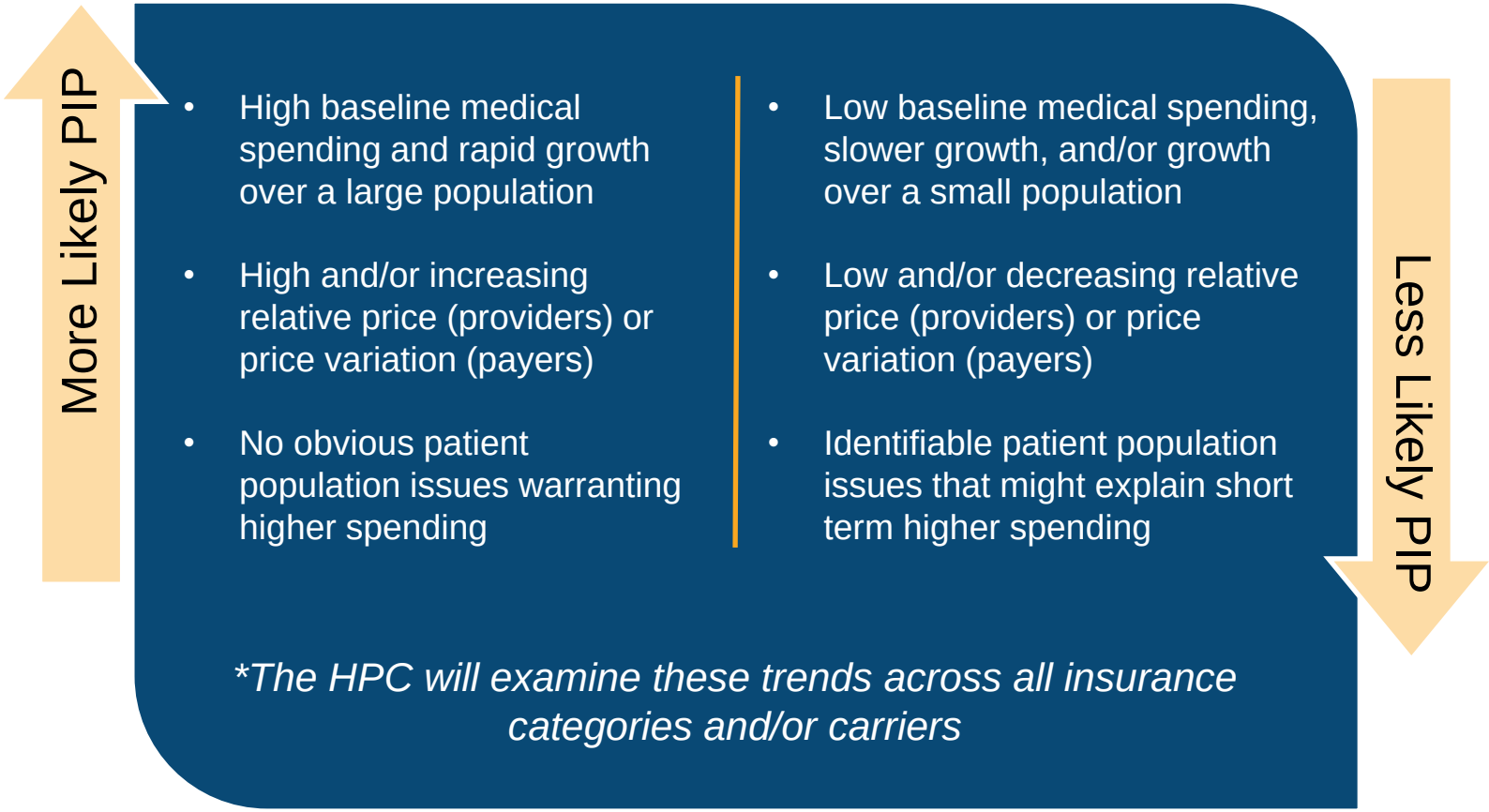
- Entity's explanation for spending growth
- Impact of care delivery and other strategies to control spending
- Historical payer rate increases
- Role of pharmaceutical spending
- Patient population and referral patterns

↓

4 Board Deliberation and Vote Whether to Require PIP

HPC

Payer and Provider Example Analysis



Reflecting on Five Years of Accountability Under the PIPs Process

In the five years since the PIP process began, no entity has yet been required to complete a PIP. While there are some limitations to the referral process, the process to date has had some key successes.

Importance of the multifactor review process

HPC's in-depth review of individual payer and provider performance across multiple factors and metrics and over time can help distinguish between factors that are more **within a payer or provider's control** (e.g. prices) and those that are **unexpected or outside of their control** (e.g. enrollment changes, new high cost drugs, COVID).

Providing greater insight into payer and provider performance

Payers and providers have **appreciated the greater insight** into their own performance.

Working with the HPC to address spending trends

Some entities have also expressed **willingness to work with HPC** on an ongoing basis to address spending trends, even without a public PIP.

2020 and 2021 PIPs Reviews; Updated PIPs Timeline

- Last year, the HPC had been following up with a number of payer and providers based on their 2016-2017 performance. However, those **reviews were paused** in order to allow payers and providers to focus on responding to COVID. The **Board will determine the next steps** in the HPC's review process in Executive Session.

- The HPC now also has information about 2017-2018 and 2018-2019 performance and will be following up with entities in the coming months.

- CHIA has also **updated the timelines** for data collection and PIP referrals going forward, meaning that the lag will be reduced between the performance year and CHIA and HPC's review of that performance by approximately 6 months.

MASSACHUSETTS
HEALTH POLICY COMMISSION

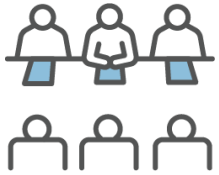
AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting (VOTE)
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
- **Schedule of Next Meeting (July 14, 2021)**
- Executive Session **(VOTE)**

Upcoming 2021 Meetings and Contact Information

BOARD MEETINGS

July 14
September 15
November 17



COMMITTEE MEETINGS

June 2
October 6
December 15

SPECIAL EVENTS

ADVISORY COUNCIL
September 29
December 8

Mass.gov/HPC

@Mass_HPC

HPC-info@mass.gov

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from April 14, 2021 Meeting (VOTE)
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
- Schedule of Next Meeting **(July 14, 2021)**
- **Executive Session (VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Enter into Executive Session

MOTION: That, having first convened in open session at its May 19, 2021 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, M.G.L. c. 6D, § 2A, and M.G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX

NAS Investment Program Awardees

HPC Funding for Inpatient Care

- Baystate Medical Center (12 months): $249,778
- Boston Medical Center (12 months): $248,976
- UMass Memorial Medical Center (12 months): $249,992
- Lawrence General Hospital (12 months with no-cost extension): $250,000

HPC Funding for Inpatient Care and Moms-Do-Care Wraparound Service[1]

- Beverly Hospital (24 months): $1,000,000
- Lowell General Hospital (24 months): $999,032

Awardees received technical assistance offered by the HPC via its clinical advisor, the **Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC)**.

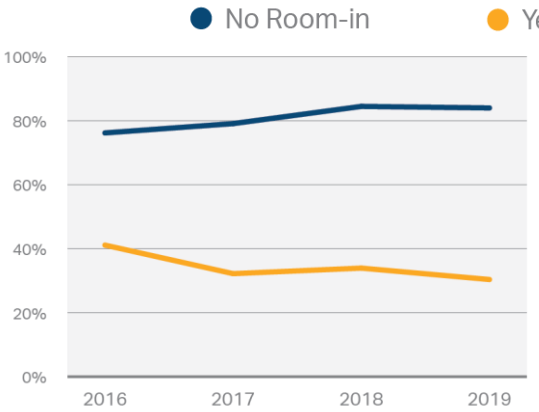
[1] Approximately 15% of Beverly Hospital and Lowell General Hospital's awards were allocated to technical assistance from NeoQIC and Massachusetts Department of Public Health

NAS Investment Program Findings and Lessons Learned: Impact of Non-Pharmacologic Interventions on Hospital Utilization

Subgroup and multivariate analyses were completed to better understand the impact of non-pharmacologic interventions on hospital utilization.

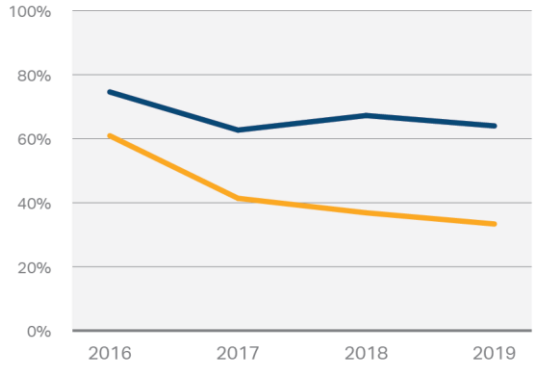
Lower rates of NICU or special care nursery care and pharmacologic treatment were seen among OENs that roomed in. Similar patterns were seen for length of stay, with **median hospital length of stay for term OENs being lower for infants who roomed in** compared to those who did not.

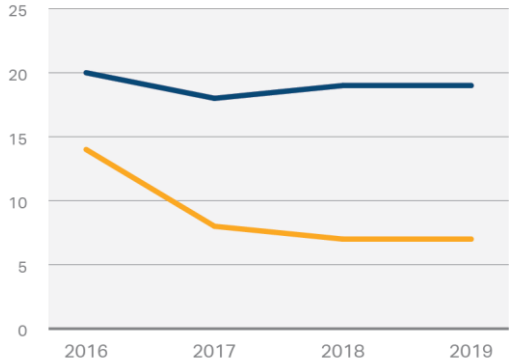
Similar trends were seen with use of mother's milk and skin-to-skin contact.



Term OENs requiring care in NICU/SCN by receipt rooming-in

Term OENs requiring pharmacologic treatment for NAS by receipt of rooming-in





Median hospital LOS (days) for term OENs by receipt of rooming-in

HPC

Measurement and Evaluation

1. Characteristics of enrolled Black birthing people
2. Total number of Black birthing people offered doula services
3. Total number of Black birthing people enrolled
4. Duration of enrollment of Black birthing people in the Program
5. Number of doula visits conducted during the Period of Performance
6. Prenatal and postpartum clinical visit attendance rate
7. Provider and staff experience
8. Doula experience
9. Patient experience

Selection Criteria

APPLICANT: Alignment of the applicant's patient population with the target population

RACIAL EQUITY COMMITMENT:

- Demonstrated organizational commitment to addressing racial equity
- Understanding of the values, priorities, and needs of the target population
- Approach to ensuring a framework of cultural humility and racial equity

PROPOSED PROGRAM:

- Approach to raising awareness of the program and its benefits
- Feasibility of the approach to securing the doula workforce
- Alignment of the program with the requirements for the scope and duration of doula services
- Strength of the approach to providing a system for communication and care coordination
- Approach to ensuring a respectful and productive working environment

MEASUREMENT AND DATA COLLECTION: Clarity and adequacy of proposed activities

BUDGET: Appropriateness and efficiency of the budget to achieve activities and goals

SUSTAINABILITY AND SCALABILITY:

- Presence of a plan to capture the results of the program to support considerations of long-term sustainability
- Feasibility of approach to scaling a successful program