

## **MEMORANDUM**

**To:** Public Interested in the HRAP

**From:** Department of Banking, Insurance, Securities and Health Care Administration

**Date:** June 22, 2009

**Re:** HRAP Recommendations

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Before each Recommendations section in the HRAP, the following language will be included:

As required by statute, we have included recommendations and implementation options. It is important to recognize that our implementation options are intended as possibilities. We recognize that not all of these options could be accomplished, that some of these options may conflict, and that resources may be unavailable to accomplish them. These implementation options should not be considered consensus options. We list these implementation options as ideas for further discussion only.

### Chapter Two – Ambulatory Care

**RECOMMENDATION 2.1.** Policymakers should examine ways to improve Vermont's primary care capacity to support wellness, prevention of disease and effective ambulatory management of chronic conditions.

*Implementation Option 2.1.1: The Blueprint, VPQHC and/or other interested stakeholder could continue to study the impact of the community care team model on efficiency, cost-effectiveness, and provider satisfaction in local primary care systems and practices.*

*Implementation Option 2.1.2: BISHCA could work with public and private payers to identify ways in which payment methodologies could be changed to encourage more efficient and effective primary care that is*

*measurable. This work should include early identification and effective interventions for high risk populations and individuals. This work should build be aligned and coordinated with the work of the Blueprint and the accountable care organization pilot project.*

*Implementation Option 2.1.3: The Legislature and private and public payers, including the federal Medicare program, could provide support for the continuation and possible expansion of the Blueprint medical home pilots as warranted by measurable evidence of success.*

*Implementation Option 2.1.4: Payers could examine reimbursement and evaluation models to support effective integration of clinical pharmacists in larger primary care practices to assist other clinicians with prescribing decisions and decrease avoidable complications of polypharmacy.*

*Implementation Option 2.1.5: The UVM College of Medicine or the Legislature, in collaboration with AHS, AHEC, Bi-State Primary Care Association, VDH, VAHHS, Department of Labor, Department of Education, OVHA, DAIL, VAHHA and others, could create an Office of Health Care Workforce Planning to objectively measure, assess, and prioritize healthcare workforce needs, including non-physicians, for the state as a whole, taking into account demographic trends, population health, opportunities for improved higher education, economic development, and efficient and effective distribution of workforce resources to support meeting population health needs and goals. Such office should be reasonably protected from entities with a vested interest in expanding certain capacities.*

*Implementation Option 2.1.6: VDH could collaborate with other organizations and agencies to expand its provider database to include more health care providers (including a more precise range of specialists, and midlevel providers, alternative medicine health care professionals) and collect data more regularly to support the monitoring of supply, and distribution of key workforce areas such as primary care. (2005 HRAP at page 228.)*

**RECOMMENDATION 2.2.** Policymakers should focus on ways in which to more fully integrate public health goals into health care systems.

*Implementation Option 2.2.1: VDH, BISHCA, OVHA and/or a combination thereof could systematically examine Vermont's health status across a variety of metrics and determine whether such status, where improvement is warranted, could be enhanced by more targeted access to certain health services and types of providers.*

*Implementation Option 2.2.2: BISHCA, VPQHC, VDH, OVHA, other interested stakeholders, and/or some combination thereof, could examine how to evaluate health care utilization and practice patterns in relation to health status indicators, social indicators, and outcome measures using the VHCURES and other health claims and utilization datasets. To the extent that care is not leading to improved health outcomes, stakeholders should examine ways to improve value received for health care dollars spent. Such work should build off of work done by BISHCA pursuant to utilization analysis mandated by An Act Relating to Containing Health Care Costs, Act 49 (2009 Session).*

*Implementation Option 2.2.3: OVHA and VDH could work together to establish formalized ways to align public health goals with Medicaid/VHAP benefits design.*

*Implementation Option 2.2.4: The UVM College of Medicine and state higher education programs for nursing and allied health sciences could examine ways in which to more fully integrate public health education into physician and other clinician training.*

*Implementation Option 2.2.5: BISHCA, AHS, UVM and other health organizations should continue efforts to collaborate to leverage and pool available health and population data resources to develop analytical models for a comprehensive evaluation of health risk and status, access to care, utilization, cost and health outcomes at sub-state levels to inform efforts to improve public and private health and delivery systems.*

*Implementation Option 2.2.6: VDH, the Department of Agriculture, DAIL, and/or other interested stakeholders could continue to facilitate the expansion of locally produced fresh whole foods in hospitals, nursing homes, home delivered meals, other health care facilities, nutritional support programs and local school systems.*

*Implementation Option 2.2.7: VDH could examine ways in which to formally integrate the evidence based recommendations of the CDC Community Preventive Services Guide into existing health promotion programs across a variety of platforms, including public and private initiatives aimed at improving population health. (2005 State Health Plan page 40.)*

*Implementation Option 2.2.8: VDH, VCHIP, the Vermont Department of Education and other stakeholders could continue to build on work to expand and improve school-based health programs that include health education and counseling addressing the six preventable risk behaviors that are often established in early childhood as identified by the Centers*

*for Disease Control (tobacco use, unhealthy eating, inadequate physical activity, alcohol and other drug use, unsafe sexual behaviors, and behaviors that result in violence and unintentional injuries). (2005 HRAP at page xiv; 2005 Vermont State Health Plan.)*

*Implementation Option 2.2.9: VDH, BISHCA, VPQHC, and/or the Vermont State Dental Society could measure the percentage of Vermonters with a dental medical home and recommend measures which could be taken to increase those percentages for children, adults, and the elderly.*

**RECOMMENDATION 2.3.** Policymakers should determine ways to leverage mid-level primary care providers to improve primary care capacity, enhance population health, and maximize individual care quality.

*Implementation Option 2.3.1: The Vermont Legislature could examine ways in which education, at all levels, could be used to encourage individuals to stay in Vermont and practice medicine in underserved areas.*

*Implementation Option 2.3.2: AHEC, Department of Labor, Vermont State Colleges, Department of Education, VAHHS, VMS and/or other interested stakeholders could continue to develop ways in which to reach out to Vermont middle school and high school students, as well as recent high school graduates and adults contemplating a second career, to encourage careers in nursing and other primary care mid-level positions.*

*Implementation Option 2.3.3: The Vermont Legislature could implement the recommendations of the Taskforce on Advance Practice Registered Nurses as Primary Care Providers Final Report. (2008 Legislative Report.)*

*Implementation Option 2.3.4: VDH, UVM, AHEC, Bi-State Primary Care Association, and other stakeholders with an interest in the mid-level practitioner workforce could collaborate to identify needs for and to support development of mid-level specialty certification programs relevant to the delivery of primary care targeting medically underserved areas and populations including but not limited to mental health, substance abuse, and gerontology.*

**RECOMMENDATION 2.4.** Policymakers should facilitate meaningful access to disease prevention and health promotion strategies that have been proven effective.

*Implementation Option 2.4.1: The Vermont Legislature could examine ways in which incentives could be used to encourage workplace and other*

*community based wellness and health promotion programs, with a focus on public health goals, such as obesity prevention.*

*Implementation Option 2.4.2: VDH could continue its work to assist communities and towns to incorporate wellness and health promotion strategies into infrastructure planning and investment.*

*Implementation Option 2.4.3: Legislators and the Commission on Health Care Reform could examine ways in which to formally integrate shared decision making tools into Vermont health care provider practices. Such examination should build off the demonstration project proposal authorized in the 2009 legislative session and should address necessary malpractice protections which may need to be a part of any meaningful shared decision making program.*

**RECOMMENDATION 2.5.** Vermont's health care delivery system should move toward more integrated multidisciplinary approaches, enhancing the connections between health care providers and community resources, such as schools and community groups.

*Implementation Option 2.5.1: VAHHS, VMS, VPQHC and/or other interested stakeholders could determine ways in which to increase provider engagement in concepts such as accountable care organizations and the Blueprint that seek to improve care integration and quality, while reducing intensity of utilization.*

*Implementation Option 2.5.2: VAHHS and VMS could work with their members to determine ways in which health care providers perceive barriers to integration, including barriers to integration with community and school health based initiatives. Based on these perceptions, VAHHS and VMS could work to eliminate such barriers.*

### Chapter Three – Hospital Services

**RECOMMENDATION 3.1.** Policymakers should understand Vermont's overall health care cost and outpatient utilization trends.

*Implementation Option 3.1.1: BISHCA could prepare an analysis of Vermont's inpatient and outpatient utilization rates and report this information in its annual expenditure analysis.*

*Implementation Option 3.1.2: BISHCA could analyze Vermont's health care expenditures over time and examine why Vermont's expenditures are*

*rising faster than the national average, compare costs to state and regional peers, and identify options and consequences for reducing cost increases.*

*Implementation Option 3.1.3: BISHCA could identify those areas with high variation and commence quality improvement collaboration groups with VPQHC, VAHHS, VMS and others to recommend actions to address the variation. This work should build off of the study mandated by Act 49 (2009 Session).*

*Implementation Option 3.1.4: BISHCA could analyze datasets, including VHCURES, to assess outpatient utilization data and compare to national benchmarks to determine whether such utilization appears to indicate inappropriate utilization.*

**RECOMMENDATION 3.2.** Policymakers should examine the policy considerations that should be addressed given the current regulatory and organizational structures of health care providers.

*Implementation Option 3.2.1: BISHCA, in consultation with VDH, OVHA, VAHHS, VMS, VPQHC and/or other interested stakeholder could work to establish appropriate hospital service access standards. These standards could then be incorporated into the certificate of need process and other appropriate regulatory processes.*

*Implementation Option 3.2.2: BISHCA could evaluate the pros and cons of the Vermont hospitals operating as a regulated system rather than as individual regulated entities. Considerations to be addressed should include cost and quality implications, access to services, local circumstances and anti-trust issues. Such analysis should also address the potential impact of eliminating competition on efficiency and innovation.*

*Implementation Option 3.2.3: UVM, VPQHC and/or VAHHS could build models to determine the potential financial impact on Vermont's existing hospitals if there were an increase in ambulatory surgical centers or specialty hospitals.*

*Implementation Option 3.2.4: BISHCA, with VAHHS, could examine ways in which current regulatory frameworks may or may not support other health care allocation and delivery goals.*

*Implementation Option 3.2.5: BISHCA and VDH, in collaboration with other agencies and health care organizations, could identify and adopt common hospital service area definitions to facilitate data collection and improved analysis that recognizes migration into and out of Vermont for*

*services. The effort should include recommendations for a schedule of updates depending on the dynamic nature of the services.*

**RECOMMENDATION 3.3.** Policymakers should continue to implement regulatory and programmatic strategies to enhance further integration between and among hospitals and their communities.

*Implementation Option 3.3.1: VDH, VAHHS, VPQHC, other stakeholder and/or a combination thereof could continue to identify specific ways in which patients and their families can more thoroughly take advantage of end of life choices for care, through standardization of information regarding choices, health care provider education, coordination with community health care facilities and hospice providers, public variability reporting and other measures deemed to allow patients the most informed and dignified end of life care possible.*

*Implementation Option 3.3.2: BISHCA and OVHA could continue to work with payers to examine ways in which public and private insurance coverage benefit design for hospice, pain management and palliative care could be refined to support high quality, patient centered end of life care.*

*Implementation Option 3.3.3: VPQHC or other entity could report on a comprehensive inventory and analysis of reporting requirements applicable to hospitals and other health care providers and identify redundancies and potential efficiencies through such strategies such as standardizing data element definitions and consolidating data collection.*

*Implementation Option 3.3.4: VAHHS, VMS and VDH could work together to create a trauma registry to monitor the quality and timeliness of trauma care; determine if formally organized trauma care registry is needed in the state; and, if so, guide development and implementation of that system. (2005 State Health Plan page 60; 2005 HRAP at page 62.)*

*Implementation Option 3.3.5: VDH, DMH and other interested stakeholders could establish an efficient and cost effective program for providing standardized training to first responders to address psychiatric and substance abuse emergencies. Such training should be developed with a data component so that effectiveness can be measured and assessed.*

**RECOMMENDATION 3.4.** Policymakers should examine methods, such as comparative effectiveness research, to analyze new medical technology and services and assess the impact such technology may have on Vermont's health care quality and cost.

*Implementation Option 3.4.1: The Legislature could establish a policy body to examine new health care technologies to establish their efficacy and subsequent distribution.*

*Implementation Option 3.4.2: BISHCA and VDH, working with the UVM College of Medicine, could identify sources of objective information about the effectiveness of new technology and services and determine how most effectively to communicate the availability and reliability of these resources to providers and payers. VDH and BISHCA could consider regulatory or other mechanisms to encourage adherence to using most effective technology and services and not using that which is ineffective, including using the certificate of need, hospital budget and public reporting programs.*

*Implementation Option 3.4.3: BISHCA, OVHA and payers could consider ways in which to utilize payment methodologies to encourage the use of the most effective technology and discourage the use of that which has not been shown to be effective.*

**RECOMMENDATION 3.5.** Policymakers should embrace population based analysis as a means of assessing health care needs and planning future health care services capacity.

*Implementation Option 3.5.1: BISHCA and VAHHS could continue work on quality measures reporting, with a focus on both enhancing the usefulness of such information for consumers and in encouraging overall quality improvement by hospital systems.*

*Implementation Option 3.5.2: The UVM College of Medicine could continue its efforts to translate clinical research into private and public health through its translational center, with some focus for how such work could be utilized in Vermont's health care delivery and allocation systems.*

*Implementation Option 3.5.3: VDH could continue using population based analysis to more fully inform decisions about investments in public health.*

*Implementation Option 3.5.4: BISHCA could continue using population based and variation analysis by directly and clearly incorporating such analysis into certificate of need decisions.*

*Implementation Option 3.5.5: OVHA could continue using population based analysis and variation analysis to inform its benefit package design.*

*Implementation Option 3.5.6: BISHCA, VDH, DMH, VAHHS and VPQHC could work with hospitals that have higher than the state average of*

*ambulatory sensitive admissions and determine what resources, including non-hospital based community programs, could reduce the number of such admissions. (2005 HRAP at page 123.)*

#### Chapter Four – Mental Health and Substance Abuse Services

**RECOMMENDATION 4.1:** Policymakers should ensure that, consistent with the Futures Plan, Vermont continues to focus its mental health and substance abuse resources at the outpatient, residential recovery and community levels.

*Implementation Option 4.1.1: As plans for funding a Vermont State Hospital move forward, stakeholders could consider ways to leverage expenditures in the community health system to potentially decrease the need for more intensive services*

*Implementation Option 4.1.2: DMH, DCF and other AHS Departments, could continue working with representatives of DOE and local school systems to establish the most efficient way to reach children that are at risk of mental health and substance abuse challenges, focusing on cost effective strategies which reduce future need and improve quality of life.*

*Implementation Option 4.1.3: DMH could continue to evaluate costs and outcomes of residential recovery and other programs and replicate successful strategies.*

*Implementation Option 4.1.4: DMH could implement the recommendations included in the 2007 Follow-up Study on the Financial Sustainability of the Vermont Designated Agency Provider System for Mental Health, Developmental Disability and Substance Abuse Services, including streamlining data collection and billing requirements for community mental health services.*

*Implementation Option 4.1.5: DMH, the community mental health centers, mental health and substance abuse providers, and/or other interested stakeholders could continue to develop additional community based suicide prevention programs based on the National Strategy for Suicide Prevention and The Vermont Suicide Prevention Platform. (2005 HRAP at page 216.)*

**RECOMMENDATION 4.2:** Policymakers should review and study barriers to psychiatric capacity in emergency rooms settings, for elders, and for children and adolescents.

*Implementation Option 4.2.1: DMH could study whether there are systemic changes which could improve access to mental health and substance abuse care, such as encouraging hospitals and other facilities to work together to recruit providers in geographic areas or specialties with shortages, developing provider retention strategies, providing resources to allow primary care practices to address mental health more extensively within their scope of practice, and facilitating telemedicine consultations..*

*Implementation Option 4.2.2: DMH and BISHCA, in consultation with providers, the UVM Medical School and payers, could study ways in which telemedicine could be used to leverage resources and facilitate access.*

*Implementation Option 4.2.3: DMH, VDH, BISHCA, VPQHC, VMS, and/or other interested stakeholders could survey psychiatrists and hospitals to identify the greatest barriers to emergency care coverage and make recommendations to eliminate those barriers.*

**RECOMMENDATION 4.3:** Policymakers must continue to emphasize the vital importance of integrating mental health and substances abuse services with other health services.

*Implementation Option 4.3.1: VMS, VAHHS, VDH and DMH could further explore barriers to integration and ways in which further integration could be facilitated.*

*Implementation Option 4.3.2: Stakeholders could evaluate the costs and outcomes of integration strategies implemented by the community care team pilots funded by payors and the Blueprint. If the pilots prove successful, the integration strategies could be replicated.*

*Implementation Option 4.3.3: The Blueprint could continue to work toward ensuring that patient registries are created that are available and expandable to mental health and substance abuse providers.*

*Implementation Option 4.3.4: DMH, mental health and substance abuse providers, and patient advocates could collaborate to develop and implement tools to assist individuals and families in informed decision making that explain choices about programs and providers, so that individuals and families may fully participate in planning and evaluating treatment and support services in light of their own preferences. (2005 State Health Plan at page 91.)*

*Implementation Option 4.3.5: VDH, VMS, VAHHS, ADAP, DMH and/or other interested stakeholders could continue to identify ways in which*

*primary care practitioners can have ready access to evidence based education and resources about how to address alcoholism and other substance abuse issues. Such education should include a comprehensive description of resources available, as well as screening, prevention and patient support tools.*

**RECOMMENDATION 4.4:** Policymakers should determine ways to improve care delivery models, funding models and administration at community mental health centers and other care settings.

*Implementation Option 4.4.1: VDH, providers, patient advocates and other interested stakeholders could continue to explore ways to collaboratively institute more evidence based care practices, as discussed in the 2009 Draft Report on Clinical Services Service Design. (See also the 2005 State Health Plan at page 98.)*

*Implementation Option 4.4.3: BISHCA could evaluate barriers to private insurer coverage of outpatient consultations between psychiatrists and primary care physicians (without a face to face meeting), telemedicine, inpatient psychiatrist nurse practitioner consultations for medical/surgical patients, and other innovative efforts intended to increase access to mental health and substance abuse treatment, and the impacts of such barriers on overall costs to the health care system.*

## Chapter Five – Long Term Care Services

**RECOMMENDATION 5.1:** Policymakers should continue to grow and enhance home and community based options for long term care to keep pace with changing demographics.

*Implementation Option 5.1.1: OVHA, DAIL and other interested stakeholders could identify payment reform mechanisms and other regulatory tools which could facilitate the increased reliance on community based care.*

*Implementation Option 5.1.2: The Legislature could examine ways in which greater respite care support could expand capacity of the health care system with relatively little expense. (2005 State Health Plan at page 84.)*

*Implementation Option 5.1.3: BISHCA, VDH, DAIL and/or the Blueprint could examine ways in which to enhance and improve home and community based health promotion and disease prevention programs for older Vermonters and people with disabilities.*

**RECOMMENDATION 5.2:** Policymakers should examine whether current regulatory structures, both through BISHCA's certificate of need program and DAIL's compliance programs, are sufficient to address issues associated with nursing home complex corporate ownership structures.

*Implementation Option 5.2.1: BISHCA, in collaboration with DAIL, could develop a proposal to improve the regulatory framework for enhanced authority over complex corporate ownership of nursing homes.*

**RECOMMENDATION 5.3:** Policymakers should examine creative ways to enhance the availability of a high quality direct care workforce through wage and benefit improvements and better recruitment and retention strategies.

*Implementation Option 5.3.1: DAIL, DMH and other interested stakeholders could examine the greatest needs of the direct care workforce and identify specific barriers to career satisfaction that don't involve increased resources.*

*Implementation Option 5.3.2: VAHHA, DAIL and/or other interested stakeholders could identify ways in which workforce retention could be enhanced, focusing on strategies other than additional compensation, such as enhancing career satisfaction and quality of life.*

**RECOMMENDATION 5.4:** Policymakers should implement strategies to strengthen Vermont's nursing facilities through advancement of culture change models that are more home-like, the development of special care units, and the promotion of quality of care while providing incentives for home based care.

*Implementation Option 5.4.1: DAIL could continue to examine ways in which its payment structure could be modified in order to encourage nursing homes, and other providers, to provide higher quality care that builds on Vermont's policy goals.*

*Implementation Option 5.4.2: DAIL, OVHA, health care service providers, community groups, long term care insurance carriers, other stakeholders and/or a combination of these entities could develop and encourage the use of standardized informed decision making tools to assist people to make long term care decisions which support their needs, values and preferences. (2005 Vermont State Health Plan at page 81.)*