Rural Health Services Task Force

Approved Meeting Notes
November 21, 2019

Members Present:

Robin Lunge, Member, GMCB
John Olson, Chief, State Office of Rural Health & Primary Care, VT Dept. of Health
Mike Fisher, Office of the Health Care Advocate
Devon Green, VP of Government Relations, VAHHS (designee for Steve Gordon, President and CEO, Brattleboro Memorial Hospital and Dan Bennett, President and CEO, Gifford Medical Center)
Dr. Rick Barnett, Licensed Psychologist-Doctorate, Licensed Alcohol/Drug Counselor
Jill Olson, Executive Director, VNAs of Vermont
Laura Pelosi, Vermont Health Care Association
Dr. Melissa Volansky, MD, Stowe Family Practice, Executive Medical Director, CHSLV

Members by Phone:

Kate Burkholder, LADC, Treatment Associates, Inc

Absent Members: Ena Backus, Director of Health Care Reform, Agency of Human Services; Dan Bennett, Present & CEO, Gifford Medical Center; Steve Gordon, President & CEO, Brattleboro Memorial Hospital; Dr. Paul Parker, Richmond Pediatric & Adolescent Medicine; Tony Morgan, Executive Director, The Rutland Free Clinic

Public Present and by Phone:

Rep. Woodman Page; Rep. Marcia Martel; Senator Joe Benning; Senator Jane Kitchel; Rep. Scott Campbell; Rep. Lucy Rogers; Kevin Mullin, chair, GMCB, Tom Pelham, member, GMCB; Jennifer Kaulius, Government and Community Relations, UVMMC; Thifeen Deen, Office of Rep. Peter Welch; Lucie Garand, Downs Rachlin Martin PLLC; Frank Knoll, North Country Hospital Board; Steve Genereaux, MD, Little Rivers; Andre Bissonette, North Country Hospital; Care Demnow; Shawn Tester, NVRH; Luca Fernandez, VDH; Margaret Robinson, DMH; Leah Pearl, CRNA, Vermont Association of Nurse Anesthetists; Jennifer Wooland, VDH; Kevin Wiberg, Vermont Community Foundation; Kelly Dougherty, VDH; Lori Perry, GMCB

I. Introductions

Task Force Chair Robin Lunge opened the meeting with introductions. Given the objective of encouraging public participation/discussion on rural health care issues, the Task Force did not vote on the November 5th meeting minutes and instead moved directly into an overview of the Task Force's charge and work.

II. Break out groups

Groups formed based on the Task Forces' three priority topics: Workforce, Care Coordination and Financial Sustainability. Groups discussed each topic for approximately 30 minutes. The groups recorded their work on flip chart paper (a copy of the notes is attached) and reported out to the group at large.

III. Next Steps

The Task Force's next meeting is scheduled for December 5th in Montpelier.

Rural Health Services Task Force
November 21st Meeting
Break Out Groups

Care Coordination

Benefits of Care Coordination

- Avoid duplication of services, wasted resources
- Better patient outcomes

Barriers to Care Coordination

- Uninsured/poorly insured never come to care
- Competition: money follows the patients
- Siloed by region/discipline
- Fee for service doesn't acknowledge all the enabling services that are needed
- Communication: patients can't find resources; providers can't find information on other care encounters
- Decentralized/fragmented health care facilities

Opportunities for Care Coordination Expansion

- Payment reform expands telehealth and telemonitoring, ability to assess outside traditional office visit
- Community/Statewide networks: peer-based services for chronic diseases (AA for diabetes); Rural Health Networks, Blueprint for Health; Department of Health; OneCare VT
- VITL for information sharing

Workforce

- All provider groups: nursing, nurse educators, interstate compact license
- Education pipeline: k-12 (science, math, tech); loan repayment; tax incentives; clinical preceptorship
- Foreign Born, refugees and licensure
- Non-licensed entry level health workers
- Telehealth- broadband
- Cross-competency
    - Integrated primary/mental health
    - Private/public partnerships

Financial Sustainability

- Medicaid
    - All providers
    - Payer mix
    - Slow rate of growth in rates
    - Budget neutrality and General Fund
    - Caseload Growth
    - Choices for Care is insolvent, ERC
    - Hospitals are not the only ones with operating losses
    - Special Obligations: most providers are obligated by mission and regulation to serve all (exceptions for some physician and dental)

- Minimal duplication of services
- Inconsistency on major policy issues year-to-year- 340B, etc.
- Hospital revenue depends on service, docs
- Hospital Revenue Caps
    - Uncompensated care likely to rise
    - Workforce scarcity drives costs- wage pressure
    - Slow enrollment into long term care
    - Medicaid if not only "regular Medicaid"
    - Discharge challenges: no bed, not qualified or facility but not ok at home, tertiary care is full
    - Often minimally reimbursed because of coding issues
    - NH has a per diem for MH with no bed
- Mental Health/Substance Use
    - Higher levels of acuity at all levels of care
    - Look at reports and plans
        - DAIL- Aging Report
        - Older Vermonters Plan
        - HRAP
        - VDH
- Telemedicine and Other
    - Trust and rapport not as easy when remote, ortho must be hands on
    - Everyone working to top of license
    - Good by remote
        - Diagnostics
        - Vitals for people with multiple chronic conditions
        - Specialist consult
    - Regulations require some types of services
    - Some services important to attract families (birthing center, etc.)
    - Key local providers
        - Hospital
        - Hospice
        - Home health
        - Dental
        - Pharmacy
        - Mental Health/substance use disorder
    - More facilitated MD visits for people at home (Chittenden County pilot)
    - Other rural pilots
    - Impact of social isolation