VERMONT
GREEN MOUNTAIN CARE BOARD

ACT 167 COMMUNITY ENGAGEMENT UPDATE

Hospital system transformation and community engagement process (2022 Acts and Resolves No. 167, Sec. 2)

Act 167 (2022) Sections 1 and 2

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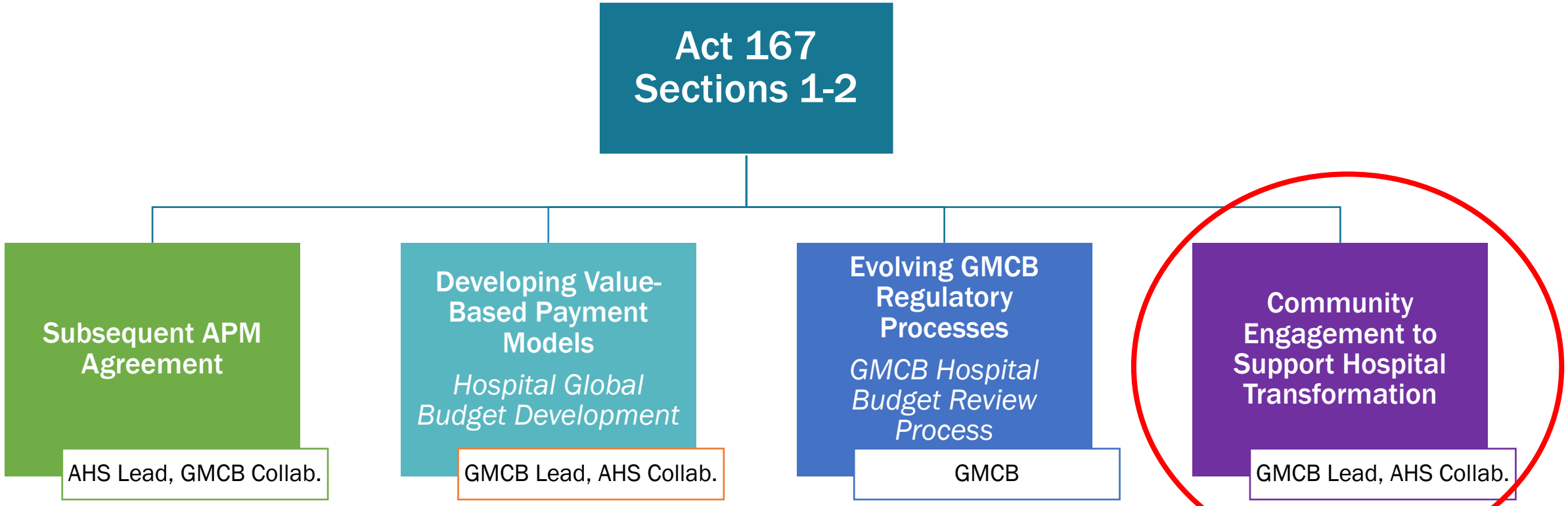

Link to legislation: https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT167/ACT167%20As%20Enacted.pdf
Link to GMCB Hospital Sustainability and Act 167 webpage: https://gmcboard.vermont.gov/hospitalsustainability

Oliver Wyman Expertise

- Clinician leader & facilitator
- Executive leadership in healthcare systems
- Rural hospitals
- Examining health disparity and overcoming health equity barriers (Southerlan)
- 3 years experience in VT with COVID data modeling and health services wait time report (Hamory)

Bruce H. Hamory, MD FACP

Partner & Chief Medical Officer, Healthcare & Life Sciences

- Helps providers, health systems and countries to redesign their delivery systems to improve value by improving quality and reducing costs
- Has worked with many groups to improve their operations, design appropriate physician compensation and institute new systems of care and management to improve performance
- Prior to joining Oliver Wyman, he was Executive Vice President, System Chief Medical Officer at Geisinger, and was previously Executive Director of Penn States' Hershey Medical Center and COO for the campus
- Has over 50 years of experience in health care practice, teaching, leadership, and redesign of systems for improvement

Elizabeth Southerlan

Managing Director, Healthcare & Life Sciences

- Has more than 15 years of experience partnering with healthcare provider systems to identify and deliver value from expansion opportunities
- Provides strategic guidance to healthcare leaders in a range of areas: corporate and operational strategy, organizational strategic design, health equity strategy and operationalization, product and service line design and launch, M&A strategy and execution, strategic transformation, contracting and renegotiation strategy, and operational performance improvement
- Earned a bachelor's degree in industrial engineering from The Pennsylvania State University and a master's degree in systems engineering and management from the Massachusetts Institute of Technology

Statewide Community Engagement: Progress and Timeline

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Engagement Plan Development
- August-October 2023

Round 1 Meetings: Community and Provider Listening Sessions
- October-November 2023

Current Stage →

Data Synthesis and Analysis
- December-March 2024

Round 2 Meetings: Communication and Discussion of Options/Recommendations
- Spring 2024

Statewide Community Engagement: Numbers To Date

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1800+
Participants
Across all stakeholder types and meetings[1]

~52
Participants
On average per community meeting, including state-wide meetings

100+
Organizations
Contacted

93+
Public Comments
Received

Meeting Type	# of Meetings	Estimated # of Attendees[1]
Stakeholder meetings on engagement plan	16	91[2]
Hospital Leadership and Boards	28	235
Diverse Populations	13	96
State Partners	12	18
Community Leaders	3	6
Community Meetings *(public HSA level)*	18	931
Provider Meetings *(public HSA level)*	14	460
Provider interviews and sessions	15	128

1: The number of attendees provided is an estimate based on all available attendance reports, but could potentially be higher;
2: The 91 participants are excluded from the 1.8K total as they are accounted for in the other meeting types

OliverWyman

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act 167: Community Engagement to support hospital transformation

Update to the Green Mountain Care Board

January 17, 2023

Bruce H. Hamory, MD and Elizabeth Southerlan

AGENDA

- Goals of Act 167 (of 2022) Community Engagement and the Project
- Work Completed to Date
- Preliminary Findings from Interviews and Listening Sessions
- Work in Progress
- Final Phase of Work

GOALS OF ACT 167
COMMUNITY ENGAGEMENT TO SUPPORT HOSPITAL TRANSFOR

- **Develop and conduct a process that is:**
  - Data-informed,
  - Patient-focused,
  - Community-inclusive
- **Outputs from the process are to help hospitals:**
  - Reduce inefficiencies
  - Lower costs (*constrain cost growth*)
  - Improve population health outcomes
  - Reduce health inequities
  - Increase access to essential services

ACCESS TO ESSENTIAL HEALTH SERVICES
PRIMARY CARE

"My physician retired and it has taken me 18 months to find another one." – Community Participant
"No one is taking new patients. There is a one year waiting list for new patients." – 2nd Community Participant

- Shortage of Primary and Specialty Physicians
  - Aging group of practitioners
  - "Burnout" and "Moral Injury" from perceived inability to help patients
- Shortage of Advanced Practice Clinicians (Nurse Practitioners, Physician Assistants, Doctors of Nursing Practice with Clinical Certification)
  - No instate training programs for APRNs or PAs
  - Lengthy training for DNPs to Clinical Certification
  - Shortage of instructors and sites for student clinical rotations
- Administrative complexity reduces clinical availability for patients and increases costs
  - "I spend at least 2 hours a day on the phone for precertification and prior authorization" – Practicing Physician
  - "Our office has 4 support staff for each clinician" – Practicing Physician
- Difficulty recruiting medical professionals of all kinds to Vermont
  - Lack of housing- especially affordable housing
  - Lack of child care
  - Poor support for elderly relatives
  - Low pay scales relative to national benchmarks

ACCESS TO ESSENTIAL HEALTH SERVICES PSYCHIATRIC AND SUBSTANCE USE TREATMENT

“Psych referrals are controversial (e.g. difficult to obtain). I switched diagnoses and they still didn’t have resources for PTSD.” – Patient
“ER is not the place for mental healthcare, and people give up if you go to ER and the docs aren’t trained for MH. “ – Mental Health Advocate

- Shortage of Psychiatrists and Mental Health Professionals
  - Leaving state for better paying jobs
  - Onerous requirements to obtain a license for mental health professionals
- Shortage of Inpatient Mental Health beds for acute and chronic needs
  - “ There are 194 beds for adults and 23 bed for kids (will go up after including 12 new beds in a hospital attached to SVMC)… prior to the pandemic, this would have met the needs but not anymore” – State Official
- Shortage of Intensive Outpatient treatment and daycare services
- Lack of group housing for appropriate patients
- Difficulty in finding appropriate transport for suicidal patients
- Lack of appropriate facilities in ED for suicidal and other psychiatric patients

ACCESS TO ESSENTIAL HEALTH SERVICES
EMERGENCY AND OBSERVATION SERVICES

“Many patients that are labelled “avoidable” actually must be seen. They come from SNFs, police, social services, etc. and have nowhere else to go.” – ED Director

- Recent estimate that up to 30% of ED visits were “Potentially Preventable” by good primary care or community based Mental Health services
- EDs are often crowded and holding patients who need to be transferred to another hospital for care
  - One hospital reported a need to use 8 beds in their ED to board inpatients awaiting transfer (among several others).
  - Another hospital reported opening 12 ED beds and having 8 of those occupied by boarders within 4 weeks.
- Observation beds are also commonly used to “board” patients awaiting transfer
- There are routinely delays in finding an inpatient bed and an EMS service to take the patient
- Specialty Coverage for ED patients in smaller hospitals is difficult
  - Telehealth is helpful, but expensive and poorly reimbursed.

ACCESS TO ESSENTIAL HEALTH SERVICES
PRENATAL CARE

- There were no mentions of inadequate prenatal care.
- Data from State Vital Records support the statement that prenatal care is generally available and utilized.
- Prenatal / maternal care data for diverse groups is difficult to access because of the low numbers; however, we heard anecdotally that like the rest of the US, Black women in Vermont are more likely to experience preterm birth and have higher infant mortality rates than white women.
- It was also stated that some rural areas in Vermont have limited access to specialized maternal healthcare services, such as neonatal intensive care units (NICUs). This can be a challenge for families who need these services, and transferring to NICUs is done without much consideration for how far those units are from the mother / family caring for the infant.

ACCESS TO ESSENTIAL HEALTH SERVICES TRANSPORTATION

“Transportation is an issue- 17% of local patients don’t have a car.” – Local care provider
“Ambulance service is critically important, and there is {sic} not enough ambulances to go around which increases wait times.” – Community member

- Personal transportation to and from care is often lacking
  - Lack of a vehicle
  - Inability to afford the gas for distant visits
- Public transportation may not be available when needed
  - Busses and shared rides only available during business hours
  - Bus routes may not connect with longer distance transportation
  - No transportation options to get people home from an ED visit if transported there by EMS
- Availability of EMS transportation for intra-hospital transfers is sporadic
  - One hospital reported having to call 31 EMS services to find transportation
  - One EMS service reported spending hours at an ED waiting to take a patient in because the ED was full
- Patients often need to travel long distances for specialty care
  - One person reported spending $5,000 and travelling 8,000 roundtrip miles to obtain needed care for a spouse.

ACCESS TO ESSENTIAL HEALTH SERVICES
DIAGNOSTIC SERVICES

“There’s a 6-month wait time for a colonoscopy locally.” – Physician

- Specialized diagnostic equipment is sometimes not available in small hospitals
  - Population served is too small to support the service
  - Some hospitals are sharing specialists and equipment
- Access to specialty services and tests at the referral centers is poor for non-emergent issues
- Timely access to interventional Cardiology is a problem
  - STEMI patients have been sent out of state for emergent care
  - Patients with unstable angina have had waits of 3+ days for evaluation
- Problems common to all hospitals and communities:
  - Lack of enough specialists to oversee and interpret tests
  - Shortage of technicians to perform tests (PFTs, Neurologic testing, MRI/CT, etc.)
  - Precertification for testing/treatment is difficult

ACCESS TO ESSENTIAL HEALTH SERVICES
HOME CARE

“It is worth noting that the limited access to community based/home-based service options does impact the amount of time that individuals may remain hospitalized .” – Community Member

- Home Health Agencies have had to reduce services because of lack of staff and poor reimbursement.

ACCESS TO ESSENTIAL HEALTH SERVICES DENTISTRY

“Many doors are slammed because dental providers won’t accept Medicaid. “ – Community member

- Access to Dentists is a statewide problem
- It is especially severe for children and those on Medicaid (despite recent increase in reimbursement)
- Lack of preventive dental care results in:
  - Emergency Department visits for dental complications
  - Need for general anaesthesia for children requiring major dental procedures that could be prevented

ACCESS TO ESSENTIAL HEALTH SERVICES
ROBUST REFERRAL STRUCTURE

"I can't find specialists for my patients now." – Primary Care Physician

- The current referral system for all services is functioning very poorly.
  - There are shortages of virtually all specialists at both UVMMC and Dartmouth-Hitchcock as well as in rural areas. This results in long wait times for routine services. Emergent needs are usually met, though there are issues as noted above.
- Recruitment of all medical professionals, including specialists, at both UVMMC and Dartmouth is being hampered by shortages of housing and other services as noted above.
- Communication between hospitals and from specialists to primary care providers is poor.
  - VITL, the state Health Information Exchange, is still under development and does not deliver accurate medication lists or lists of current active diagnoses.
  - Hospitals and providers are on many different EMRs and depend on a functional HIE to connect.
  - Getting and making sense of specialists' consultation note and recommendations is often difficult and time consuming.
  - OneCare is not considered to be timely in providing the information needed to provide care to patients.
- A complicating issue is that specialists are finding it difficult to refer patients back to their primary care provider.
  - The result is that specialty clinic capacity is filled with stable patients and there is little room to see new patients in a timely manner.

COST OF HEALTHCARE IN VERMONT

“People can’t afford health insurance so they don’t get it. “ – Community Member

- Universally considered to be “too high”
- High Healthcare costs thought to be due to:
  - High hospital costs
  - Poor access to early treatment resulting in patients seen with more advanced and severe (costly) illnesses
  - Repetition of tests, especially high end imaging
  - “For Profit Motive” for both hospitals and insurance companies
- Hospital costs driven by:
  - Staffing costs
    - Increased costs of employees (all kinds)
    - Use of “Travellers” to fill vacancies in Nursing and Technicians
    - Use of “Locum Tenens” by hospitals to staff certain physician vacancies
  - Increased costs of drugs and supplies
  - Loss of 340B funding reduces income

DIVERSE POPULATIONS AND HEALTH EQUITY

We conducted ~30 targeted interviews with community members identifying or representing Vermonters from the following populations:

- BIPOC
- Immigrant / Refugee
- Migrant farm workers
- Disabled
- Neurodiverse
- LGBTQIA+
- Older Vermonters
- Low Socio-Economic status (food, transportation, housing needs)
- Veterans
- Incarcerated

Common themes were shared across all groups that Vermont needs to address to provide equitable care to the majority of its populations:

1. **Gaps in culturally competent care**
   - Inequity among the rural and economically disadvantaged is most common (largest number of people)
   - Translation / interpretation resources not easily accessible to patients or hospital staff – this pertains to all hospital communications (e.g., bills, phone trees, in-person care)
   - Access to care for Neurodivergent people is limited, with mental health treated like physical health (looking for immediate fix like a broken bone), especially in the ED
   - Little appreciation for cultural differences (e.g., Afghan and Muslim women should be seen by women physicians)
   - There is a lack of sensitivity and willingness to deal with Gender Identity (e.g., housing requests)
2. **Gaps in culturally competent and psychologically safe working environment**
   - Policies for zero tolerance for hate toward workforce are not known (e.g., no signs in hospitals re: patient code of conduct)
   - Public records of racial equity discussions / decisions include critiquing of POC leaders' tone (e.g., ability to have discussions "in a manner that is non-abrasive and non-confrontational")
3. **Lack of coordination with care givers and community services**
   - Patients with needs that are best served outside the hospital are driving up ED utilization (e.g., Mental health, substance abuse, SDoH, LTC needs)
   - Admin resources required for patients in community health care/nurse programs to access Medicaid or additional resources to cover costs is too complex and burdensome

"All VT clients go to Dartmouth for HIV care." – Clinician

"An ED doctor told me to stop using the ED like a hotel." – Patient with Mental Health needs

"Everyone in VT has a snowplow." – Hospital Exec

"Patients should find and pay for their own interpretation services." – Hospital Exec

"We don't have any diversity in Vermont so it's not an issue for us." – Hospital Exec

"I drive out of state for all my healthcare. I was advised to do so by another POC as soon as I moved here." – Patient of Color

CONDITIONS NECESSARY FOR SUCCEEDING WITH VBP POPULATION

- Tight **alignment of financial incentives** among all participants.
- **Sharing of accurate and timely clinical information and financial performance** with all participants
- **Adequate resources for primary care, mental health and preventive services** in the community
- **Availability of referrals to specialists and needed diagnostic tests**
- **Availability of appropriate levels of care other than acute inpatient beds (**inpatient and outpatient mental health services, extended care facilities)
- Ability of Tertiary and other referral facilities to accept patient transfers for needed care
- Availability of appropriate transportation for patients between facilities

ACT 167 COMMUNITY ENGAGEMENT TO SUPPORT HOSPITAL TRANS
CURRENT STATUS

- 1 December, 2023 - 30 April, 2024 (approx.)

- Awaiting availability and validation of 2022 hospital discharge data.
- We will use only 2021 and 2022 VHCURES and hospital discharge data to look at current problems and the future.
- Another consulting group is analyzing VHCURES data to quantitate:
  - The numbers of dual eligible individuals in each HSA
  - The total volumes (inpatient and outpatient) of certain surgical procedures at each hospital
  - Volumes of “potentially avoidable” ED visits, hospital admissions, and the diagnoses associated
  - Estimate any current shortfalls in care
  - Calculate number of patients leaving Vermont for care that could be given in Vermont
  - Project future needs for primary care and hospital services
- OW is summarizing the information and data collected to date to begin formulating hypotheses.
- OW will conduct visits to each hospital to meet administrators and examine facilities.

- After the above and based on the data and comments collected to date, potential solutions to achieve the stated goals will be formulated.
- These solutions will be tested to predict their effect on community access to care, hospital finances and sustainability and to improve equity.

ACT 167 COMMUNITY ENGAGEMENT TO SUPPORT HOSPITAL TRANS
FINAL PHASE

- 1 May, 2024 - 30 June, 2024 (approx.)

- In person public community meetings will be held in each Hospital Service Area to discuss the potential solutions.
- In person meetings with the hospital teams and Boards will be held to discuss the potential solutions.
- Following the hospital and community meetings the potential solutions will be re-examined and then presented in a report to the Green Mountain Care Board.