Rural Health Services Task Force

ACT 26 OF 2019

REPORT AND RECOMMENDATIONS

JANUARY 7, 2020

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Introduction: The Task Force

Act 26 of 2019 Legislative requirements:

1. Inventory of current system of rural health delivery in Vermont, including the role of rural hospitals in the health care continuum
2. Consider how to ensure sustainability of rural health care system, including identifying the major financial, administrative, and workforce barriers
3. Identify ways to overcome any existing barriers to the sustainability of the rural health care system, including prospective ideas for the future of access to health care services in rural Vermont across the health care continuum
4. Identify ways to encourage and improve care coordination among institutional and community service providers
5. Consider potential consequences of the failure of one or more rural hospitals in Vermont

Introduction: The Task Force

Membership

Robin Lunge, J.D., MHCDS, Board Member, GMCB- Task Force Chair
Ena Backus, Director of Health Care Reform, Agency of Human Services
Dr. Rick Barnett, Licensed Psychologist-Doctorate, Licensed Alcohol/Drug Counselor
Dan Bennett, Present & CEO, Gifford Medical Center
Kate Burkholder, LADC, Treatment Associates, Inc
Dillon Burns, Director, Mental Health Services of Vermont Care Partners
Michael Fisher, Chief Health Care Advocate, Office of the Health Care Advocate
Steve Gordon, President & CEO, Brattleboro Memorial Hospital
Jill Olson, Executive Director, VNAs of Vermont
John Olson, M.Ed., Chief, State Office of Rural Health & Primary Care, VT Dept. of Health
Tony Morgan, Executive Director, The Rutland Free Clinic; **Steve Maier**, Executive Director, VT Coalition of Clinics for the Uninsured
Dr. Paul Parker, Richmond Pediatric & Adolescent Medicine
Laura Pelosi, Policy and Regulatory Affairs, Vermont Health Care Association
Dr. Melissa Volansky, MD, Stowe Family Practice, Executive Medical Director, CHSLV

Meetings

10 meetings from June – January, including one public forum in St Johnsbury and one workforce meeting in Brattleboro

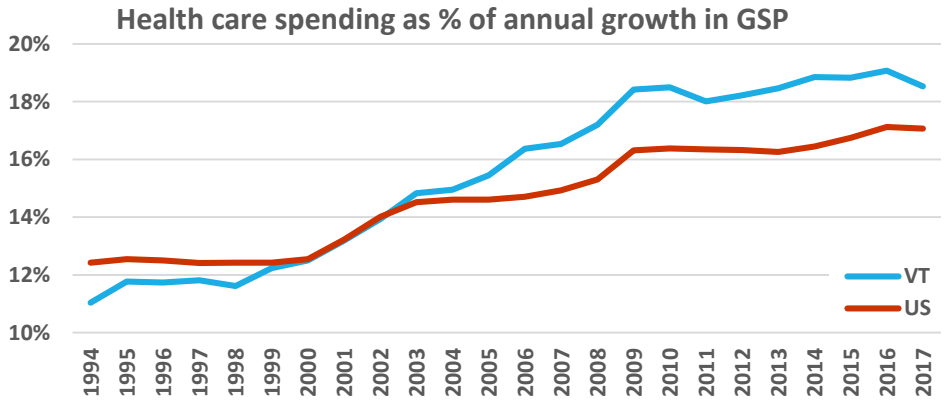
Note: Steve Maier was appointed designee for Tony Morgan effective December 6, 2019

Introduction:
Financial Sustainability and Cost Containment

Cost Growth is Unsustainable

Cost Growth

- In 2017, the most recent year of data available, health care spending in Vermont grew 1.7%.
- Vermont's health care share of gross state product devoted to health care spending was 18.5% in 2017, vs. 11.8% in 1995.



Health Outcomes

- Chronic diseases are the most common cause of death in Vermont.
- In 2014, **78% of Vermont deaths** were caused by chronic diseases.
- Medical costs related to chronic disease were over **$2 billion in 2015** and are expected to rise to nearly $3 billion by 2020.
- Vermont's **death rates from suicide and drug overdose** are higher than the national average.

Aging, less healthy population and poor social determinants of health exacerbate this trend

Health Outcomes Must Improve

Source: 2017 Vermont Health Care Expenditure Analysis; Vermont Department of Health; Kaiser Family Foundation

The Vermont All-Payer Accountable Care Organization Model

Implementing
Provider-Led ACO

- Payment Structure
- Data and Information
- Technical Assistance

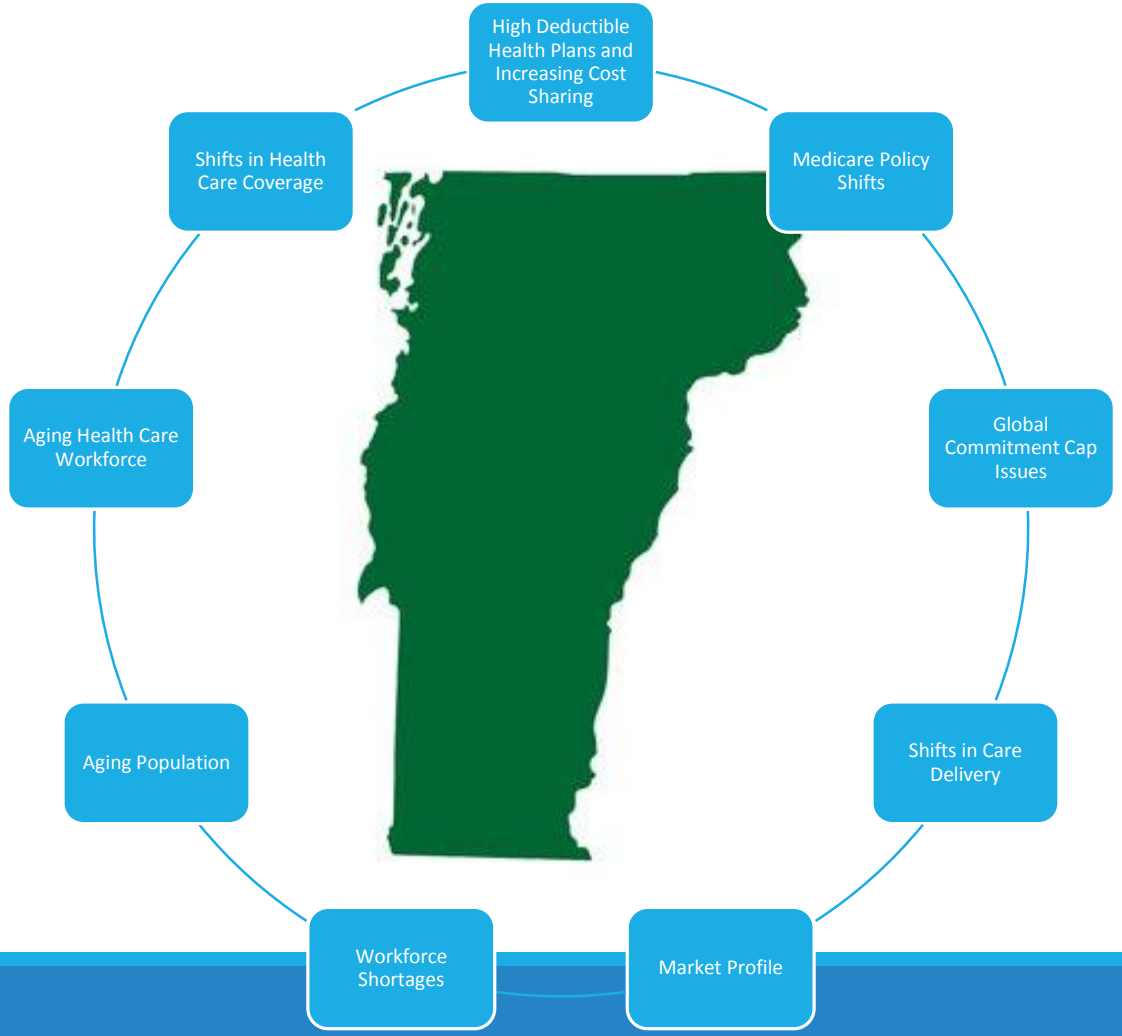
Leads to Changes in
Care Delivery

- Shift to Prevention
- Accountability
- Collaboration

Which Support Desired
Outcomes

- Improved Access to Primary Care
- Reduced Prevalence and Morbidity of Chronic Disease
- Fewer Deaths Due to Suicide and Drug Overdose

Introduction: Health Care is Changing



Introduction: National Trends & Pressures Impact Vermont

Vermont health care providers are not immune from national pressures focused on reducing reimbursements in fee for service and destabilizing the Affordable Care Act

High Deductible Health Plans & Increasing Cost Sharing

- Value (Cost x Quality) More Important to Patients
- Uncompensated Care again on the rise

- Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019

Medicare Policy Shifts

- Centers for Medicare & Medicaid Innovation programs (bundles; ACOs; medical home);
- Reduced FFS payment (MACRA; Sequestration) and Value Incentives (MIPS)
- New Payment Models (e.g. SNF, home health)

- Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019

Medicaid Budget Neutrality

- Federal Medicaid budget neutrality requirements for 1115 waivers could limit federal resources for addressing provider financial sustainability

- Source: AHS Presentation to Task Force, Dec 5, 2019

Shifts in Care Delivery

- Hospital inpatient care moving to outpatient settings
- Primary Care medical home programs expanding (Majority of practices in Blueprint for Health in Vt)
- Expansion of telehealth
- Focus on Integrated Care
  - Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019

Market Profile

- Vermont hospital system was already (14 nonprofits) highly regulated, non-competitive
- About 2/3 of physicians employed by hospitals
  - Source: GMCB Fair Reimbursement Report
- Vermont insurance also consolidated (2 insurers)
- New entrants (eg "minute clinics"; ASC; Walmart; CVS/Aetna) Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019

Workforce Shortages

- Largest growing jobs sector in November 2019
  Source: CNBC, Here's Where the Jobs Are 12/6/19
- Tight national and local labor market
- Aging workforce
- Provider burnout
- Rising higher education costs

Introduction: National Context
CMMI Direction: Continuing with Value-Based Payment

STROUDWATER

- If there was any doubt about the Trump administration's desire to push healthcare towards a value-based system, Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler makes things clear:

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to ***blow up fee for service…*** *That's one of our prime goals—is to get rid of fee for service."*

- However, getting rid of fee for service is easier said than done given the industry's current reliance on the existing infrastructure.

34%	10.5%	>50%
of healthcare payments tied to an APM in 2017	of Medicare payments in traditional legacy arrangements not linked to quality	of Medicare FFS payments with some level of pay-for-performance

Source: FierceHealthcare, *CMMI's Adam Boehler wants to 'blow up' fee for service,* Evan Sweeney, 11/29/18 *https://www.fiercehealthcare.com/payer/cmmi-s-adam-boehler-wants-to-blow-up-fee-for-service*

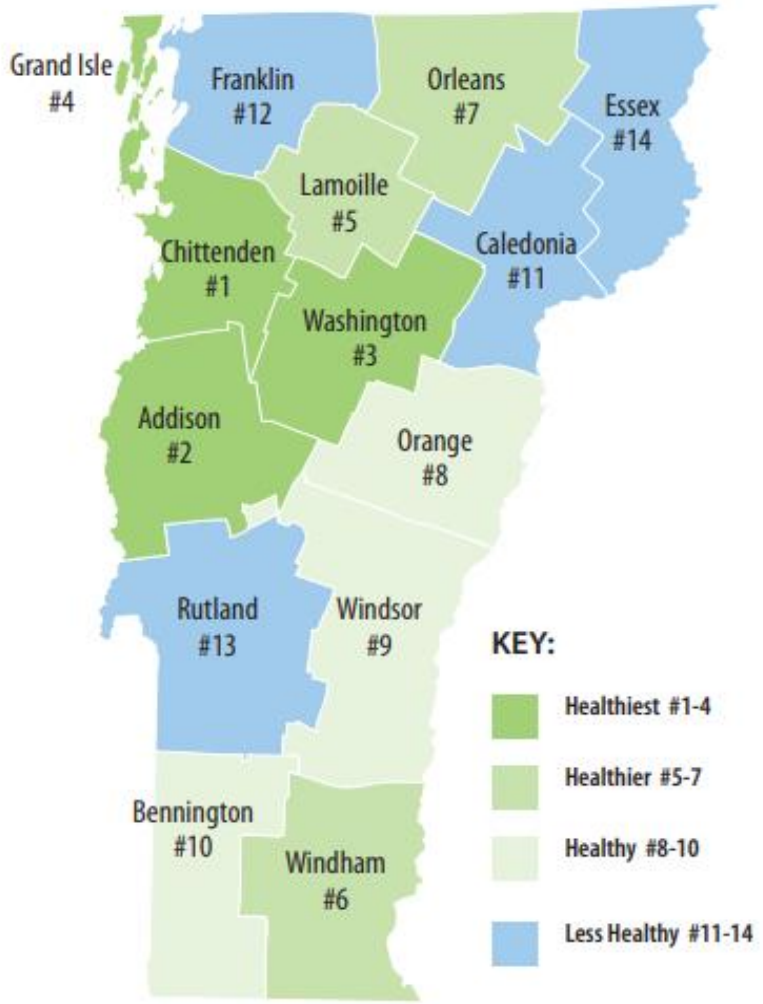
Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019; CMS Newsroom

Seema Verma, September 2019:

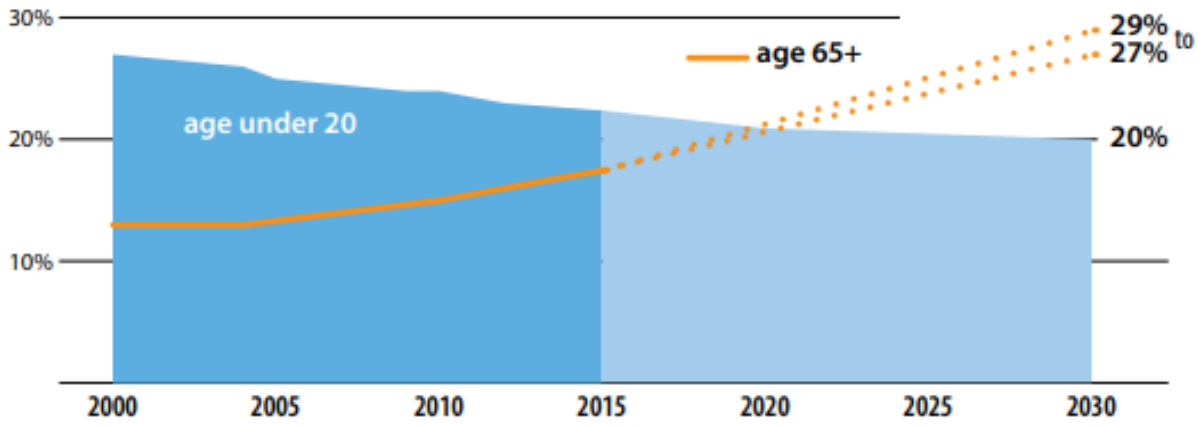
"And finally, in order to deliver lower cost higher quality care, we must move past the status quo, and past a fee-for-service payments to a system in which we're paying providers to keep people healthy, reduce costs and deliver better outcomes."

Source: https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-american-hospital-association-regional-policy-board-meeting

Introduction: Rural Vermont Older and Less Healthy



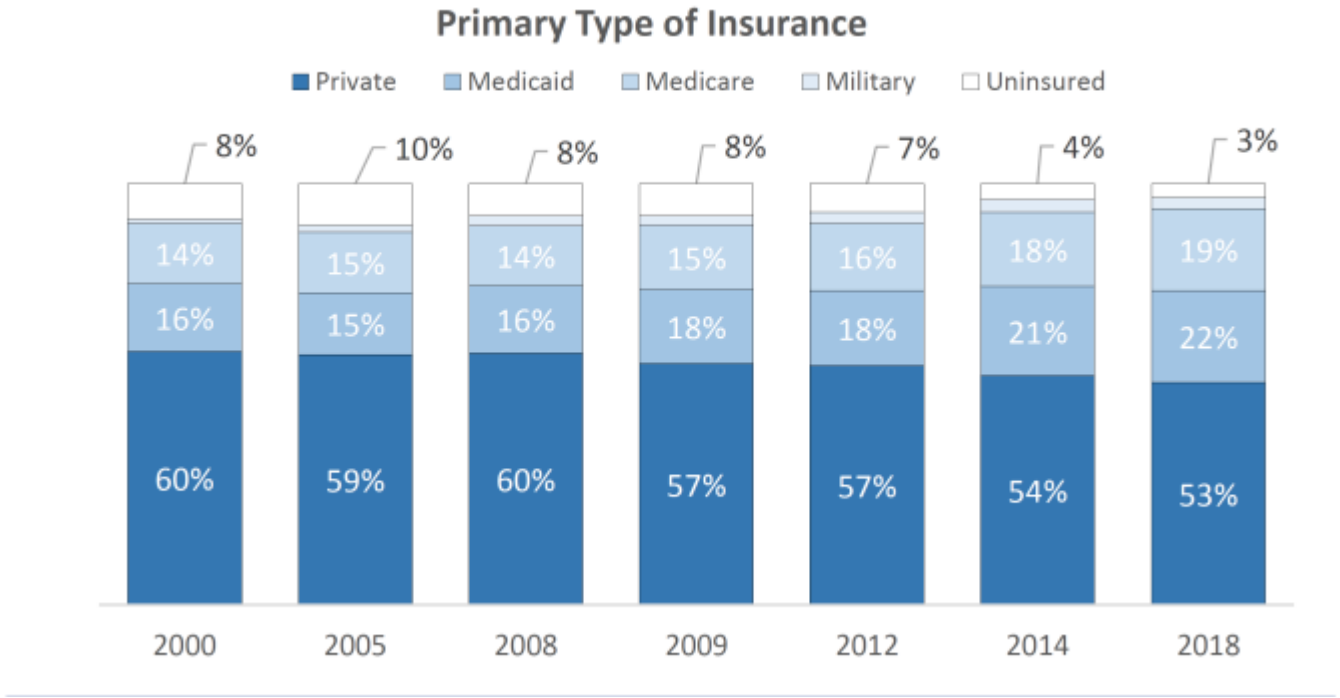
- Vermont is one of the most rural states in the nation, based on size of cities and towns
- Vermont is the 3rd oldest state and is aging at a faster rate
- % of Vermonters age 65+ is growing while the % under age 20 is declining
- In Vermont, the least populated and most rural counties are the oldest and have the poorest health outcomes



Source: State Health Assessment Plan: Healthy Vermonters 2020; Vermont Department of Health State Health Assessment

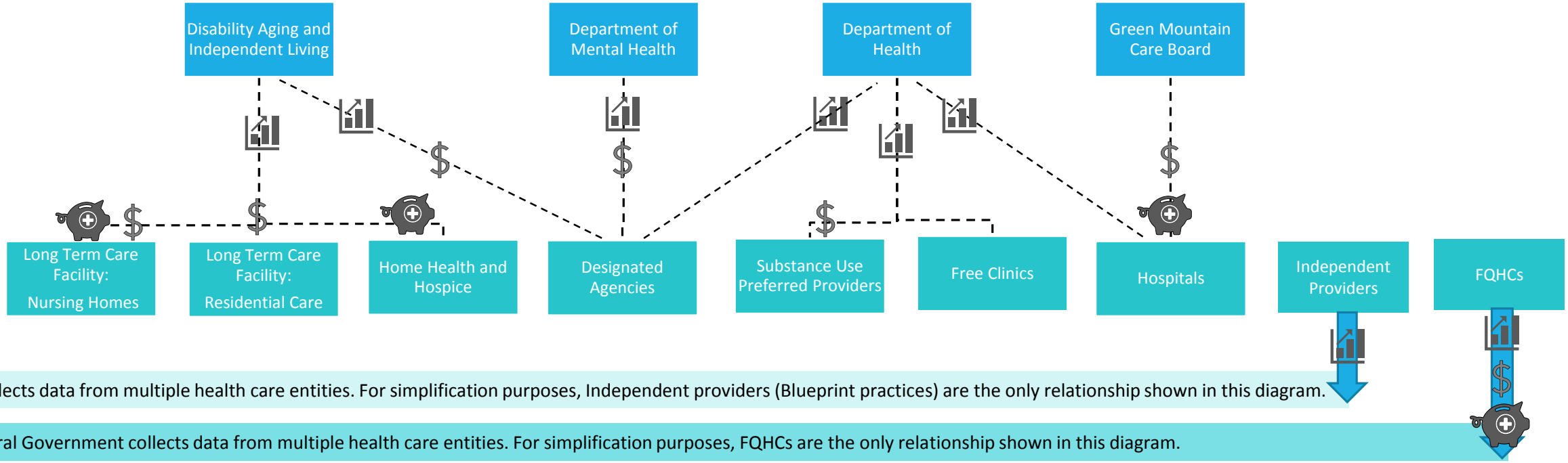
Introduction: Vermont Health Coverage by Type

Overtime, the proportion of Vermonters covered through Medicare and Medicaid has grown; while the proportion of coverage through private insurance has declined.



Source: Vermont Department of Health, 2018 Household Health Insurance Survey

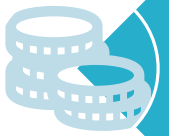
Financial Data and Reporting: System Level



Introduction: Priority Areas- National Perspective

Build and retain the rural workforce

Expand telemedicine services



Create appropriate payment models and value-based care programs that account for low patient volumes, and a reliance on Medicare and Medicaid

Allow rural communities to adjust their own health care services to better fit the community's needs, including changes to Critical Access Hospitals, small rural clinics, and rural hospitals

BIPARTISAN POLICY CENTER

Rural Health Care: Lessons Learned

JANUARY 2018

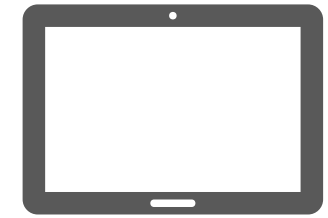
Source: Reinventing Rural Health Care, Bipartisan Policy Center

The Task Force: Priority Areas

Workforce

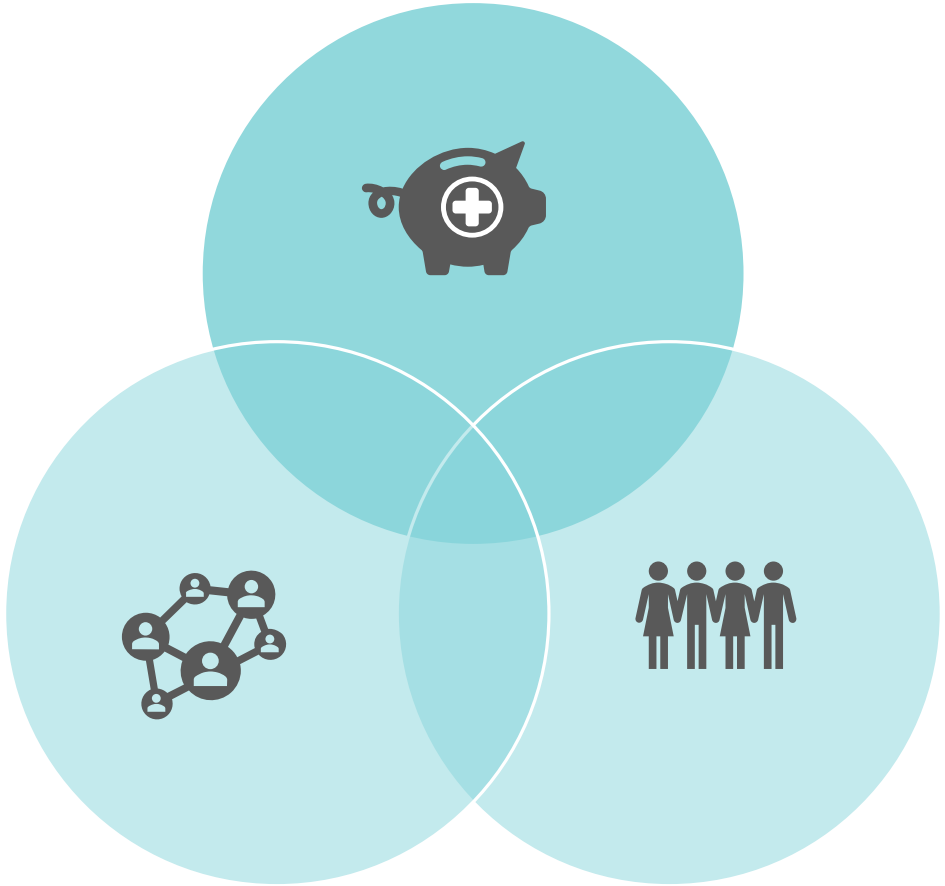
Care Management

Revenue Stability



Expanding Telehealth impacts all 3 priorities

Introduction: Recommendations



Task force recommendations aim to be:

- Focused on the three priority areas, including expanding telehealth as a cross-cutting issue
- Consistent with prior policy work
- Inclusive of financial and non-monetary solutions
- Beneficial to all health care sectors

Introduction: Beyond the Scope of the Task Force

Broader economic development challenges:

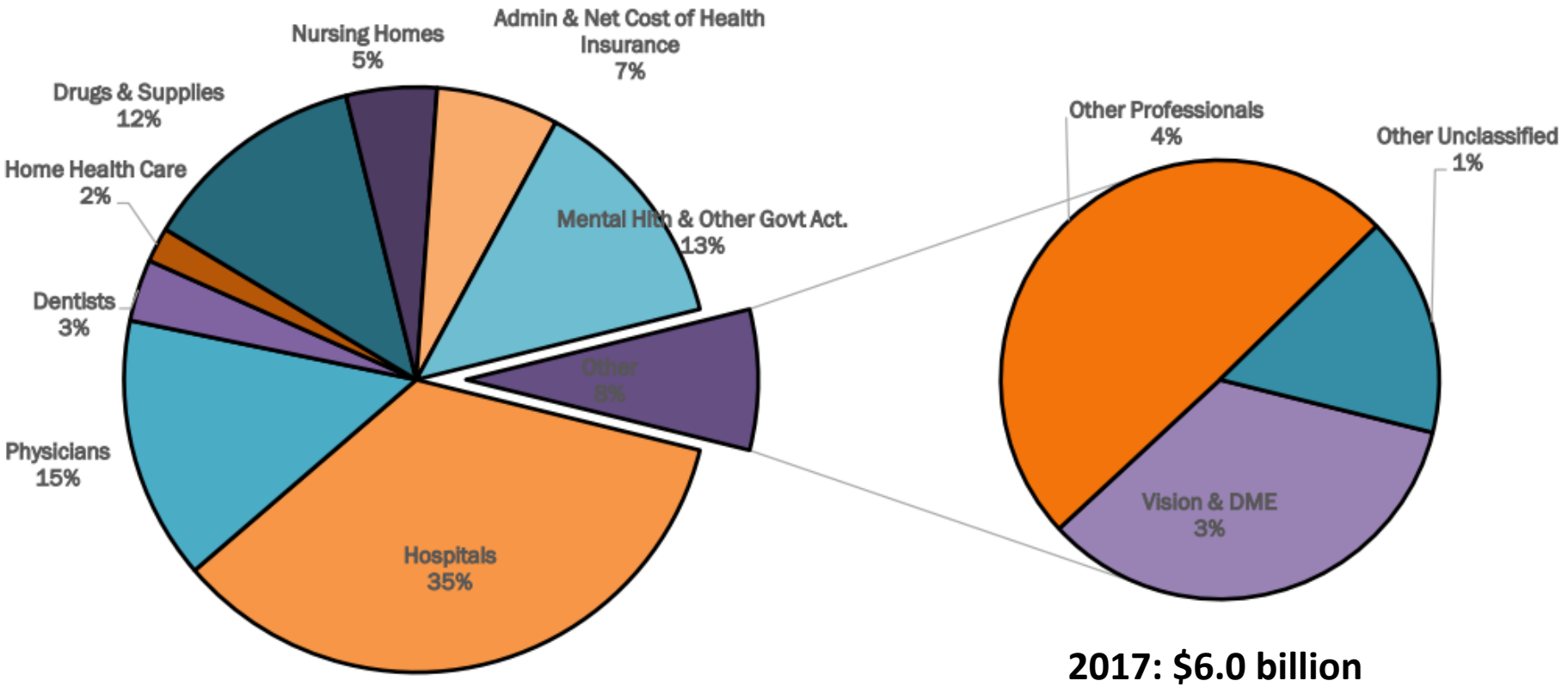

Transportation


Childcare


Housing

Rural Health Delivery in Vermont

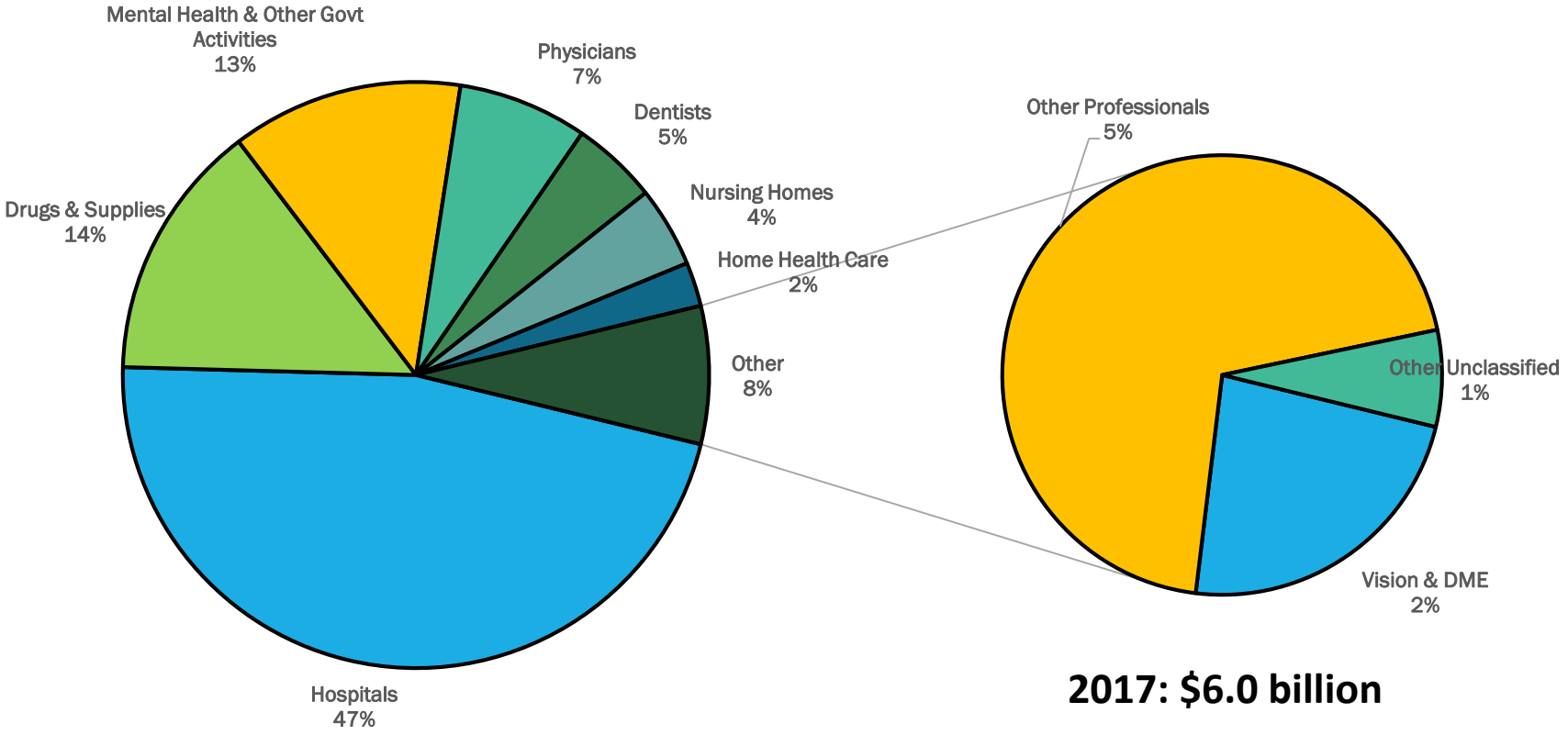
Vermont Health Care: Residents
% of total health care expenditure (2017)



2017: $6.0 billion

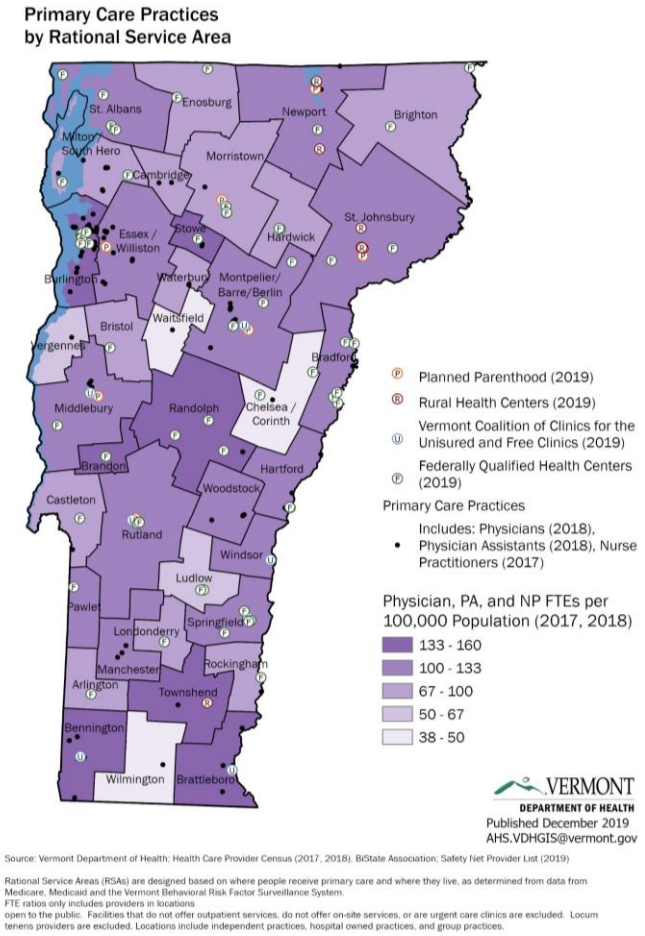
Source: GMCB Expenditure Analysis, 2017 Vermont Resident Analysis

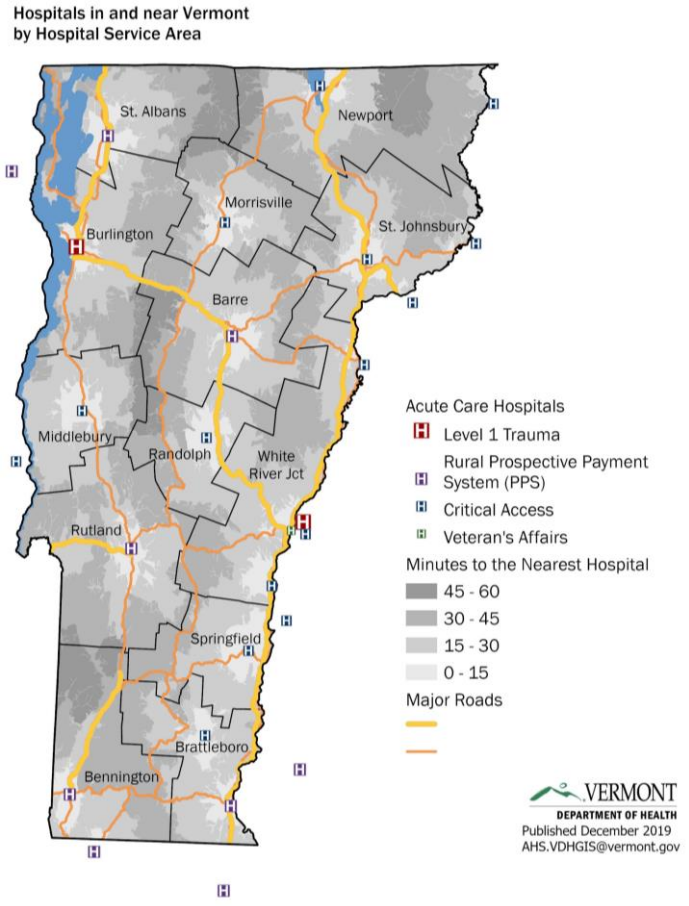
Vermont Health Care: Providers
% of total health care expenditure (2017)

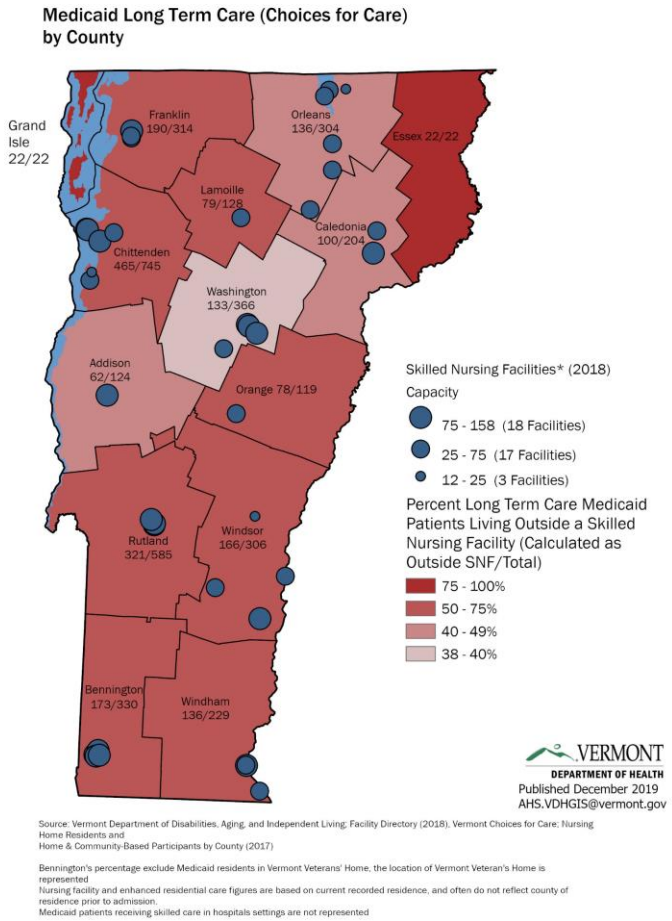


Source: GMCB Expenditure Analysis, 2017 Vermont Provider Analysis

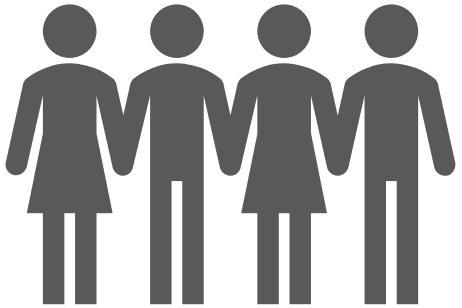
Health Care Resources: Inventory





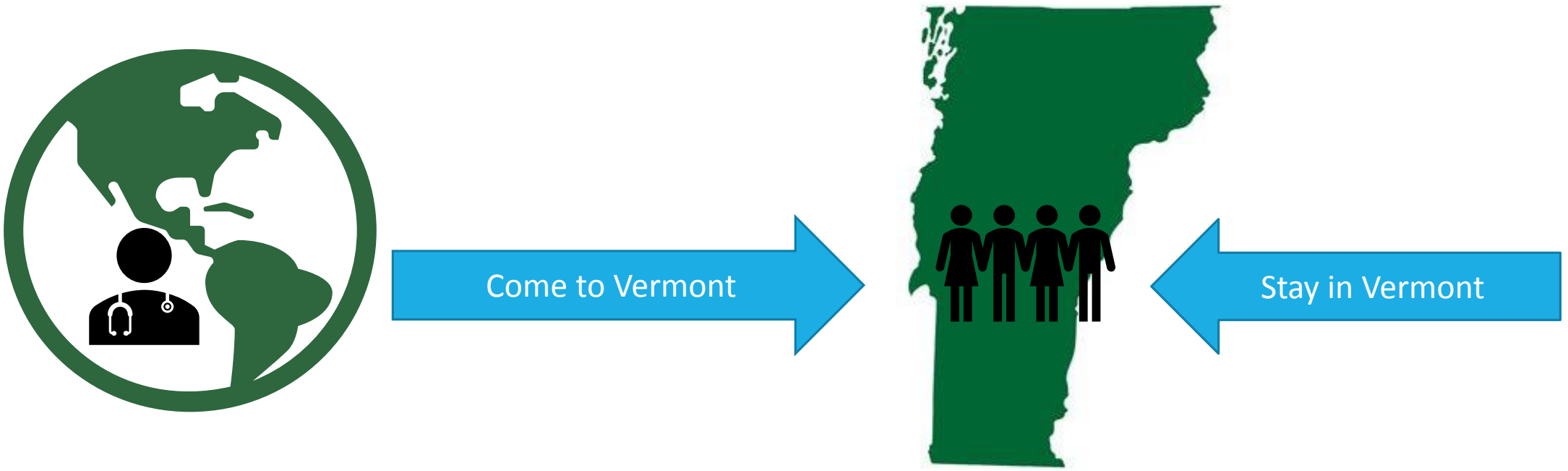


Note: a full inventory of health care resource maps is available in the Additional Resources section of this report

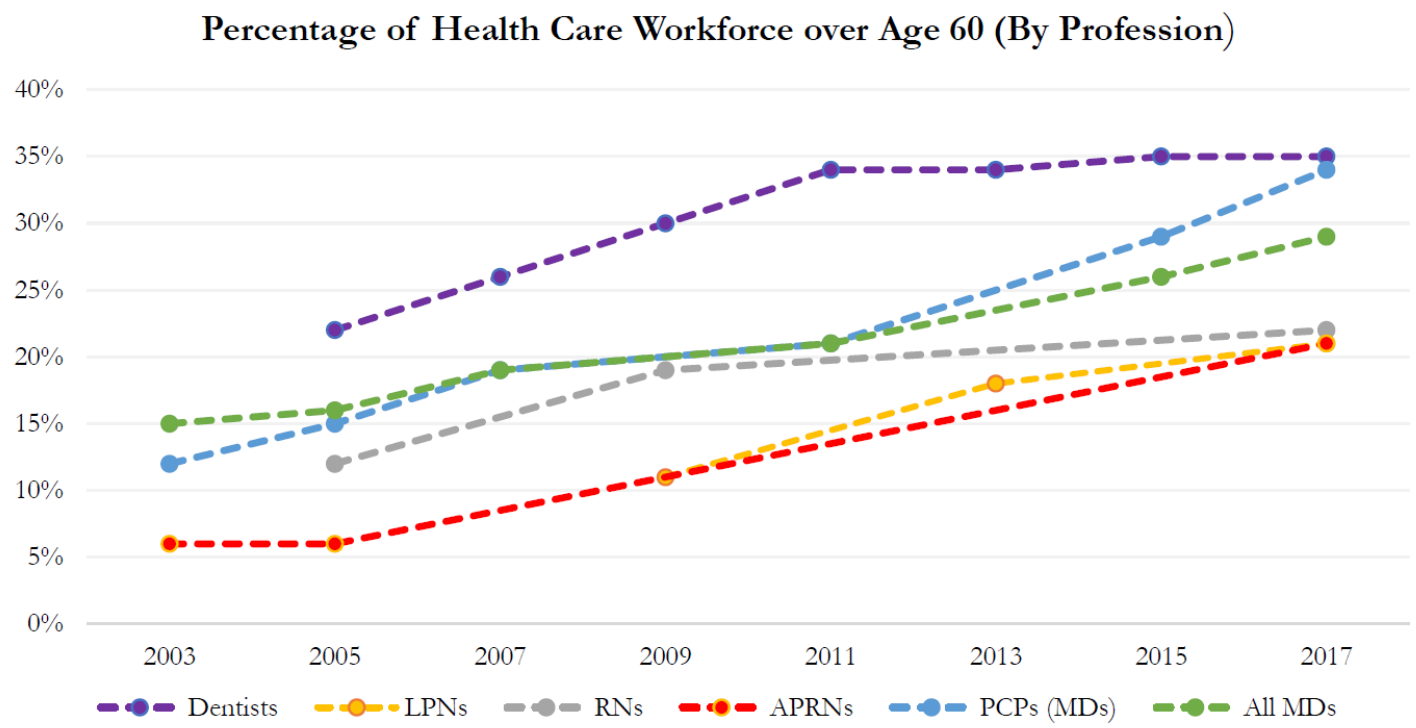


Work Force

Workforce: Issues



Workforce: Aging health care workforce and decline in licensed professionals



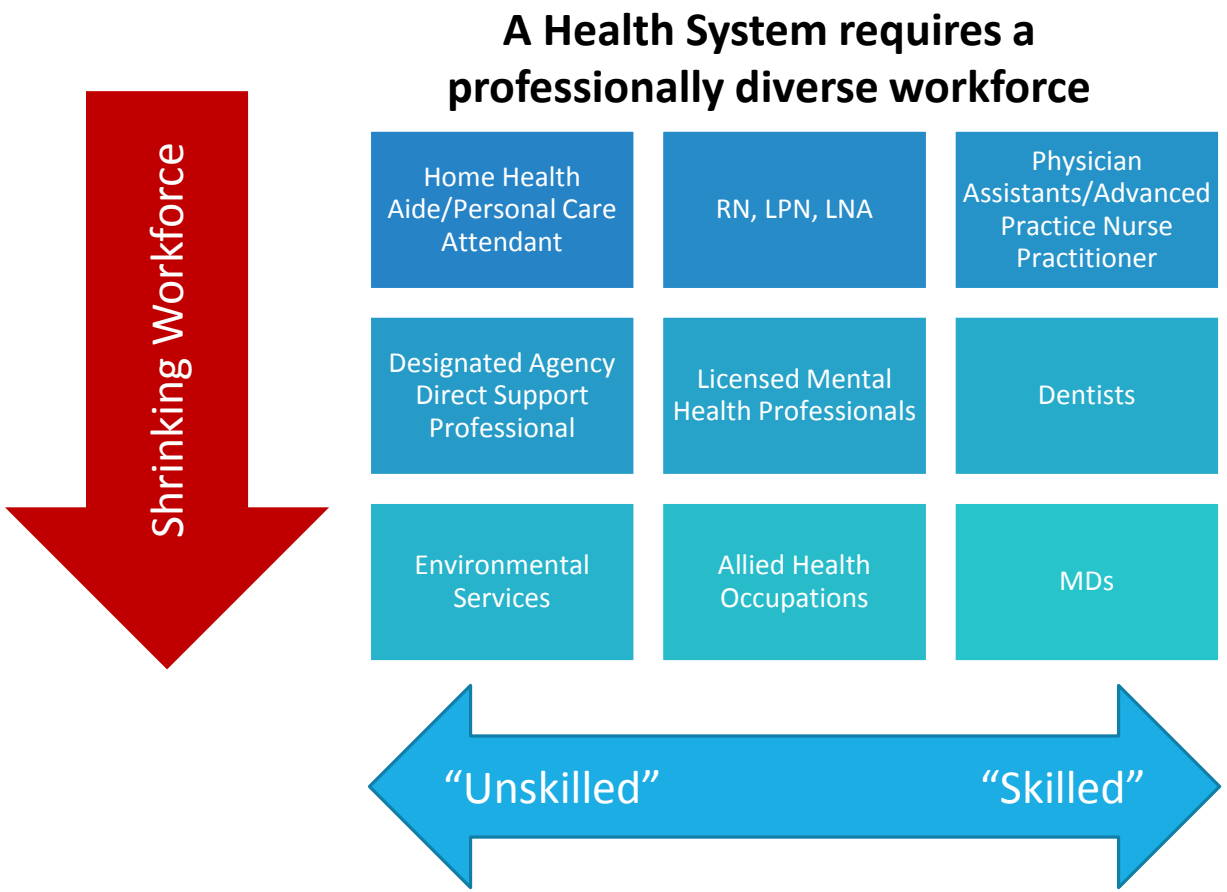
Vermont's health care workforce

- Vermont's health care workforce is aging and approaching retirement
- The number of licensed healthcare professionals is decreasing

Percentage Decreases in Licenses from 2010 to 2018	
License Type	**Percentage Decrease**
Licensed Nursing Assistant	6.1%
Licensed Practical Nurse	8.1%
Registered Nurse	24.5%
Primary Care Physician	9.1%

Source: Workforce White Paper

Workforce: Issues



Workforce Vacancies in Every Sector

- 3,900 nursing-related job vacancies by 2020 (low estimate, primarily hospital data)
- 70.5 primary care providers shortage
- 571 long-term care vacancies currently
- 386.5 home health nursing vacancies currently
- 28% annual turnover rate in FY19 at designated agencies (over 400 vacancies)

Turnover Rates

	Long Term Care	Home Health
RNs	31.4%	23%
LPNs	34.5%	23%
LNAs	45.2%	27%
PCAs	52.1%	26%

Vacancies are expected to grow as Vermont's health care workforce ages

Source: Workforce White Paper

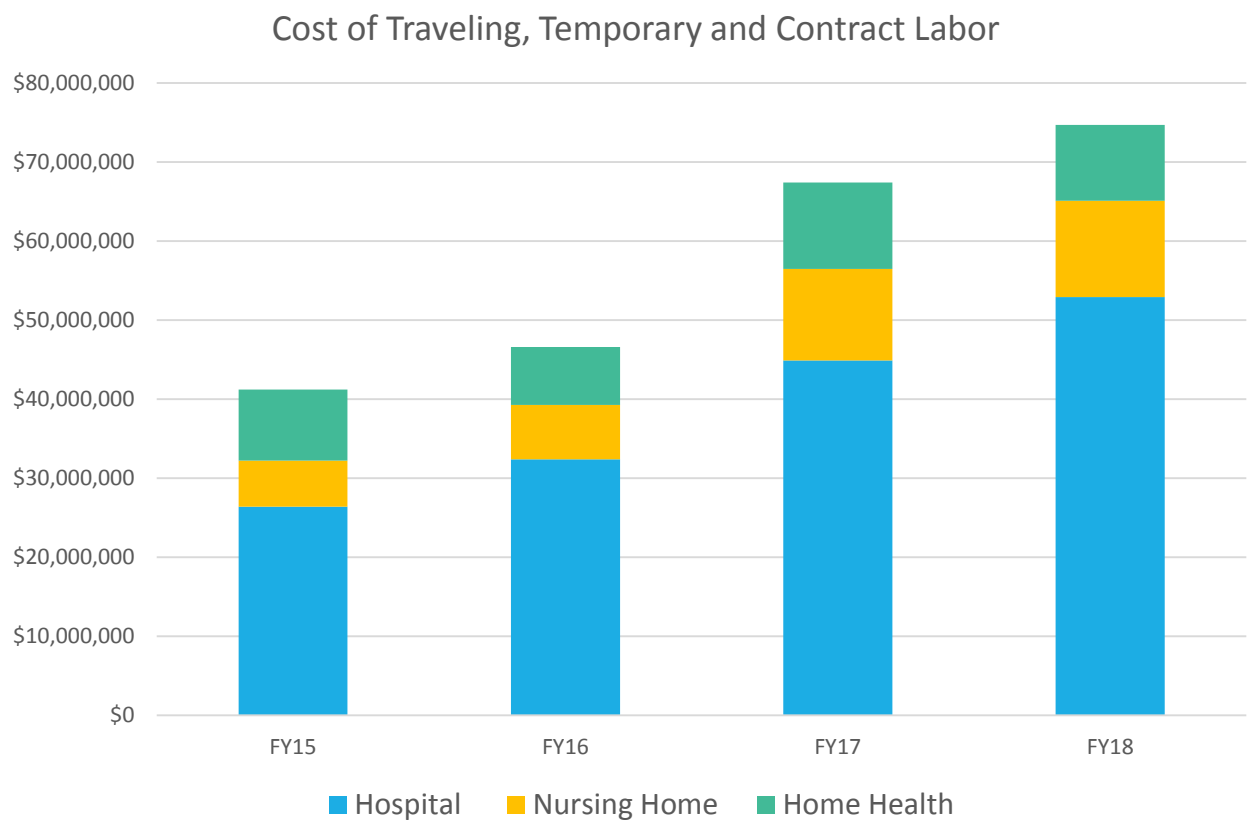
Workforce: Bottlenecks and Challenges

Vermont's health care workforce crisis is driven by several immediate factors:

- Student Debt
- Education and credentialing challenges
- Licensing challenges
- Provider "burn out"
- Aging workforce
- Marketing Vermont as employment destination
- Housing and Childcare
- Transportation
- Employment for partner
- Tight national and local labor market
- Insufficient Medicaid rates to cover wage increases

Source: Workforce White Paper

Workforce: Cost of Vacancies



Workforce Vacancies = Traveling, Temporary and Contract Employees

- These employees fill gaps in staffing needs
- For example, traveling nurses are typically twice the cost of staff
  - Travel term is typically 13 weeks
  - Travelers typically serve in hospital settings, however, travelers in other health care sectors is growing

Financial Impact

- $74.7 million in FY18
- FY19 preliminary data show continuation of this trend
  - Hospitals: $56.4 million
  - Home Health & Hospice: $10.5 million
  - Skilled Nursing Facilities: $12.0 million

Notes: "Temporary and contract employees" include travelers (nurses), locum tenens (physicians), and other contract employees; Home Health includes contract labor and services; Hospital data collected from 11 hospitals, including The Brattleboro Retreat

Workforce: Actions taken to date

Under these pressures, Vermont has been innovative to improve recruitment and retention.

Provider Best Practices

- Increased Wages
- Financial Incentives such as:
  - Sign-on bonuses
  - Loan repayment
  - Tuition reimbursement
  - Paid time off
  - Premium pay for nighttime and weekend shift
  - Internships
  - Referral bonuses
- Provider and Higher Education Collaboration

Note: initiatives at the entity level may unintentionally exacerbate regional workforce competition. For example, sign-on bonuses at one Vermont entity may attract workers from another Vermont entity. The increased cost of recruitment may have a zero sum systemwide impact and are costly to individual entities.

Government and Non-Profit Organization Initiatives

- Area Health Education Centers (AHEC) and loan repayments
- Vermont Student Assistance Corporation (VSAC) grants and scholarships
- Establishment of Medication Nursing Assistants- Act 38 of 2015
- Establishment of Dental Therapists- Act 161 of 2016
- Interstate Medical Licensing Compact
- Direct pathway for military medics to become licensed nurse assistants
- Workforce data collection initiatives
- Commissioned studies
- Department of Labor recruitment initiatives

Workforce: Recommendations

Task Force Recommendation	Action Required By		
	Legislature	Administration	Office of Professional Regulation (Sec of State)
Occupational Licensing Reforms:			
Enter the Interstate Nurse Licensure Compact	X		
Change clinical faculty requirements	X		X
Create a Pathway for Military Medics to LPN	X		X
Remove statutory barriers to Physician Assistant Employment	X		
Align mental health clinician licensing requirements	X		X
Accept PGY-1 Licenses as an immediate pathway to licensure of dentists	X		X
Explore licensing pathways for foreign dentists	X		X
Explore licensing pathways for foreign physicians	X	X	
Explore joining the psychology interjurisdictional compact (PSYPACT)	X		X

Workforce: Recommendations

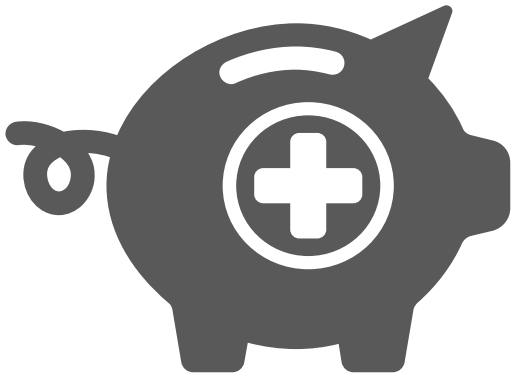
Task Force Recommendation	Action Required By		
	Legislature	**Administration**	**Private**
Higher Education Reform			
Lower minimum age of admission for LPN program			X
Re-open University of Vermont's Psychiatric-Mental Health Nurse Practitioner Program	X		X
Expand Apprenticeship programs for non-degree allied health careers		X	
Financial Incentives			
Increase scholarship funding	X		
Increase loan repayment funding	X		
Implement Tax Incentives	X		

Workforce: Recommendations

Task Force Recommendation	Action Required By			
	Legislature	Administration	Federal	Private
Maximize Existing Workforce				
Telehealth (recommendations in telehealth section of report)				
Reduce Administrative Burden				
Streamline Quality Measures		X	X	X
Reduce/eliminate prior authorizations				
Eliminate where lacking evidence to support benefit		X	X	X
Expand ACO prior authorization pilot		X	X	X
"Gold Card"		X	X	X
Remove Medicare credentialing restrictions to expand access to mental health & substance abuse			X (APM 2.0)	
Increase State Recruitment Efforts				
Establish a state-led immigration and New American initiative	X	X		
Establish statewide marketing campaign	X	X		
Prioritize health care on the Vermont Workforce Development Board		X		

Workforce: Recommendations- Federal Issues

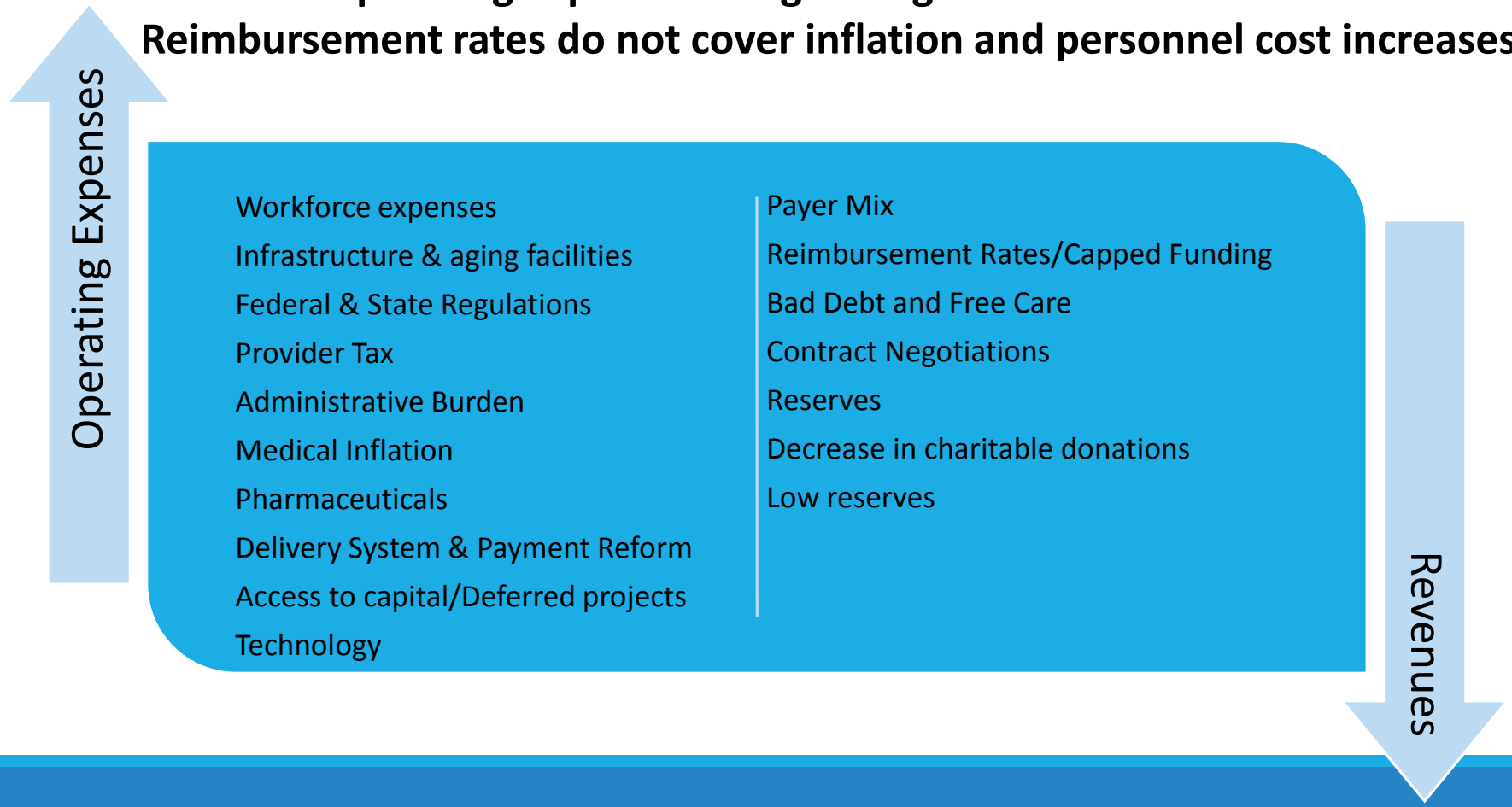
- Vermont can rarely utilize the National Health Service Corps and Nurse Corps programs due to competition with other states for limited federal resources. Federal funding should be increased to access these programs by all states, or several awards should be reserved for each state.
- Implementation of the Public Service Loan Forgiveness program has been challenging.
  - U.S. Department of Education must clarify requirements and increase access to the program
- Increase the Federal State Loan Repayment Program Grant to Vermont
- Raise the H-2B cap to alleviate workforce shortages



Revenue Stability

Revenue Stability: Issues at the Entity Level

Operating expenses are growing faster than revenues
Reimbursement rates do not cover inflation and personnel cost increases



Revenue Stability: Financial Metrics

To assess financial sustainability of each health care sector, the Task Force attempted to collect 3 years of data for each health care sector. The Task Force selected the following financial metrics to review based on their applicability to all health care sectors and based on the data that was available:

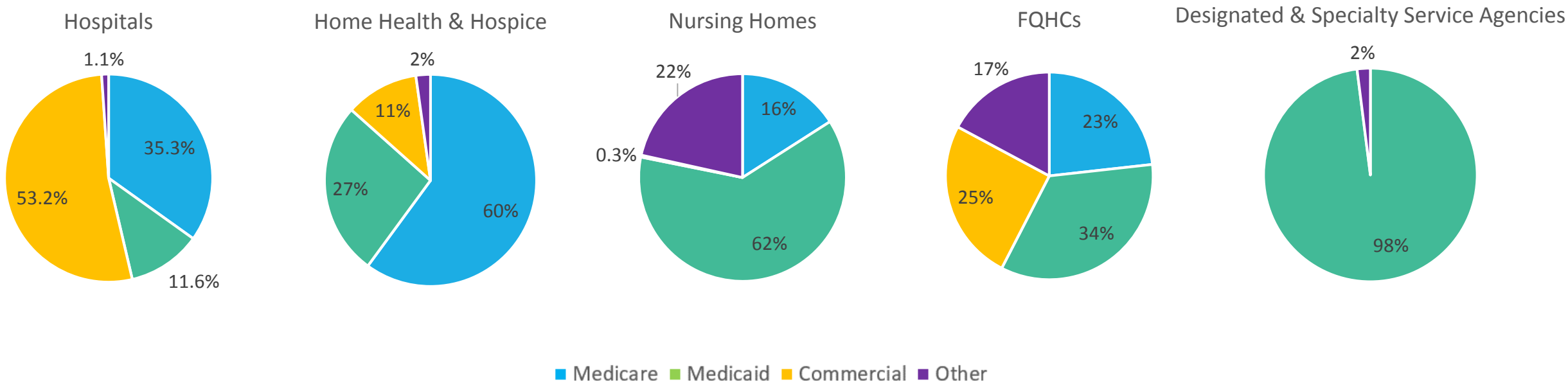
1. **Operating and Total Margin:**
   - **Operating Margin:** is an indication whether an organization's **patient revenues** cover its expenses. It excludes revenue from grants, investments, donations, and other sources.
   - **Total Margin:** is an indication whether an organization's **total revenues** cover its total expenses. Unlike operating margin, it includes revenue from grants, investments, donations and other sources.
2. **Days Cash on Hand:** is a liquidity measure that indicates the number of days that an organization can continue to pay its operating expenses with its available cash
3. **Payer Mix:** is the percentage of revenue coming from each payer- commercial, government, self-pay or other. Government payers typically reimburse at a lower rate than commercial.

Data Limitations

- **Financial years:** may differ within sectors. For example, home health agencies do not share a common fiscal year.
- **Audited financials:** audited financial data is preferred, but was not available for all sectors
- **Limited availability:** financial metrics were not available for all sectors. Additionally, data is limited to the most recent three years.
- **Systemwide analysis:** while system looks are useful to assess sector-wide performance, they do not adequately portray the financial health of individual entities.

Revenue Stability: 2018 Payer Mix (System Level)

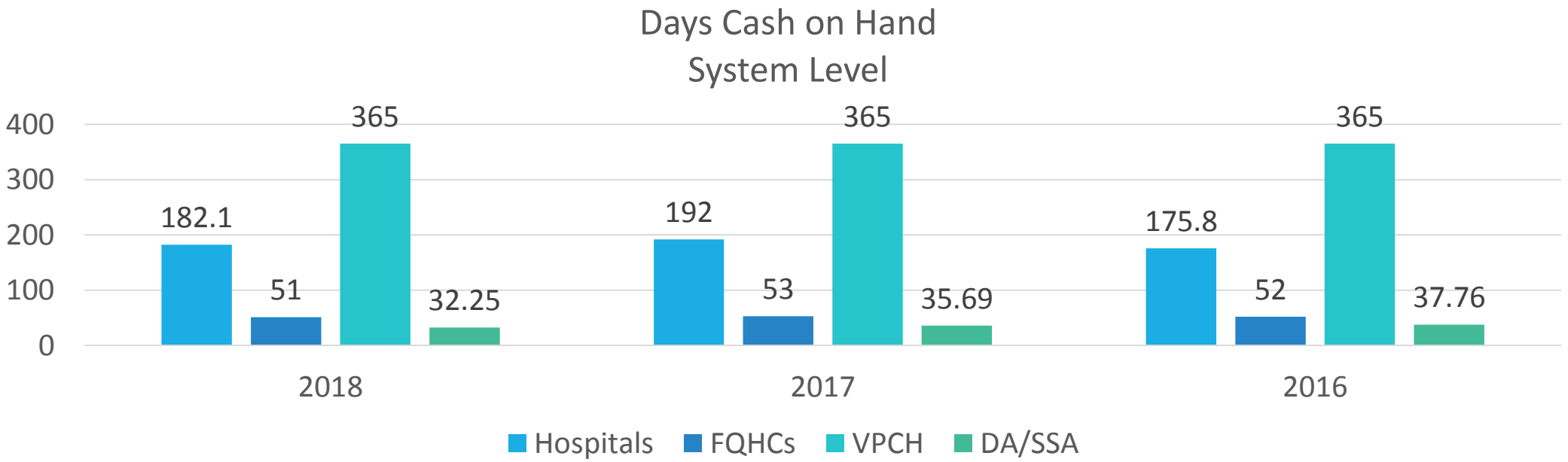
Payer Mix is the percentage of revenue coming from each payer- commercial, government, self-pay or other. Government payers typically reimburse at a lower rate than commercial.



Source: Green Mountain Care Board; Bi-State Primary Care; Department of Mental Health, Department of Aging and Independent Living
Note: "Other" includes disproportionate share payments (DSH) and self-pay. Hospital chart does not include the Brattleboro Retreat at this time.

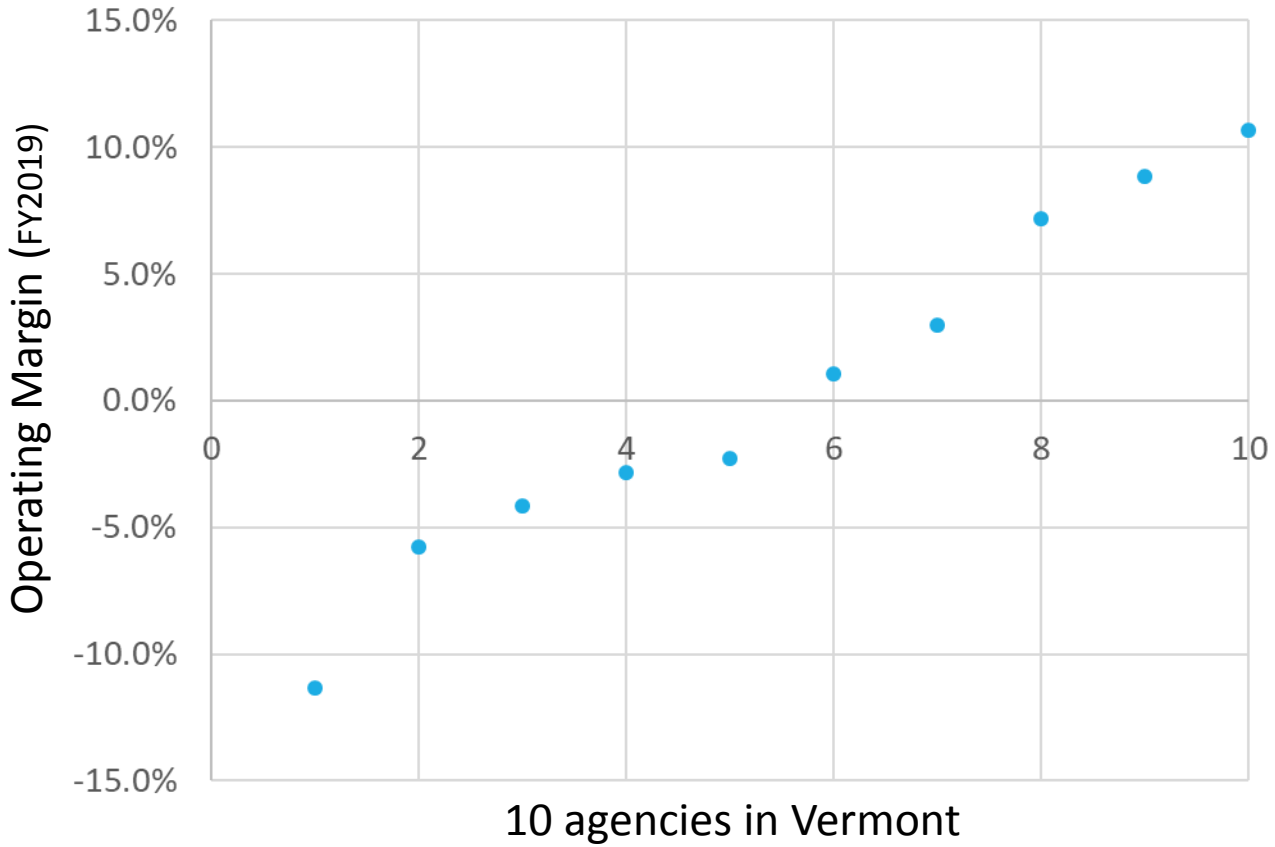
Revenue Stability: Days Cash on Hand (System Level)

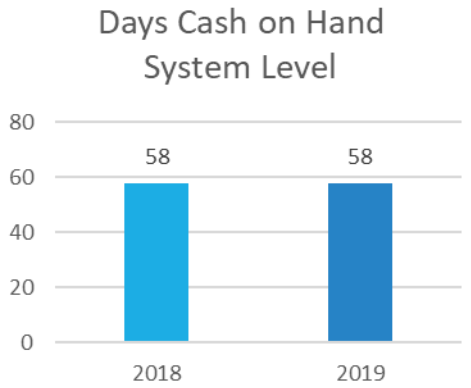
Days Cash on Hand is a liquidity measure that indicates the number of days that an organization can continue to pay its operating expenses with its available cash.

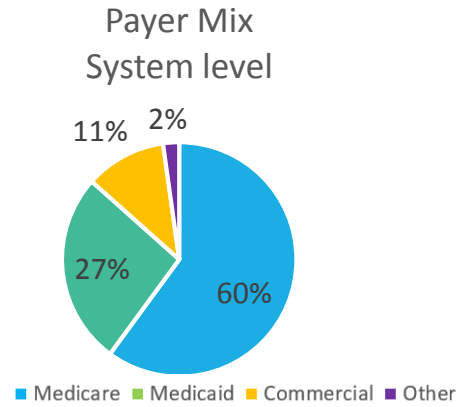


Source: Green Mountain Care Board; Bi-State Primary Care; Department of Mental Health, Department of Aging and Independent Living
Notes: Home Health & Hospice data for 2016 and 2017 unavailable. System look does not demonstrate significant variability of days cash by entity within a sector. Hospital chart does not include the Brattleboro Retreat at this time.

Revenue Stability: Home Health and Hospice



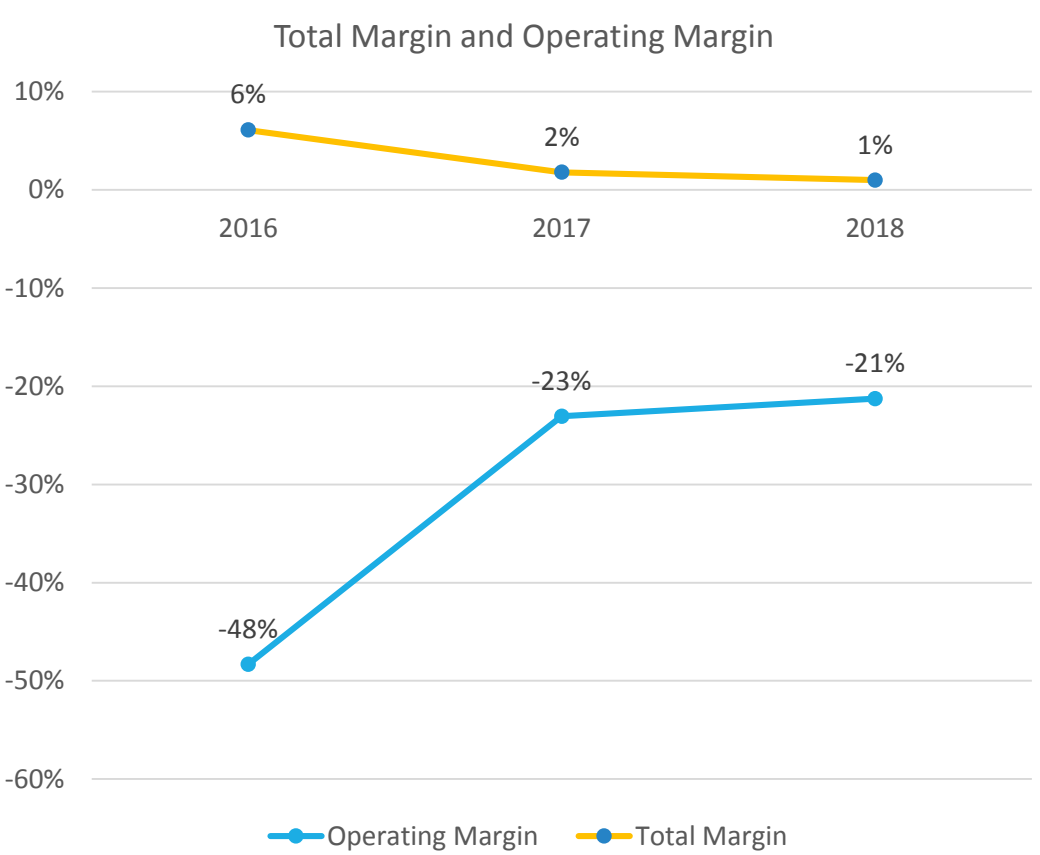


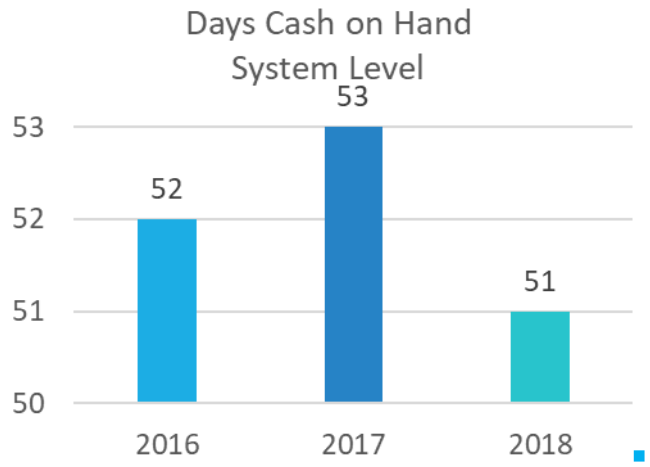


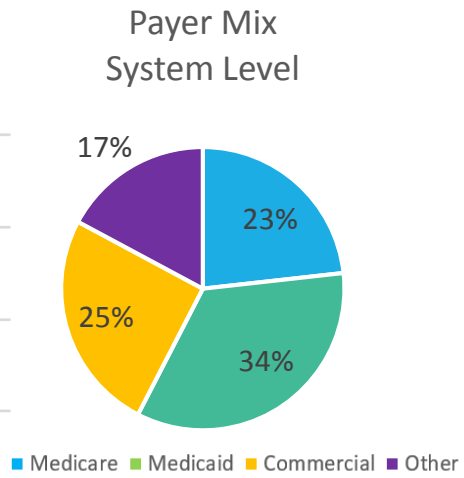
- 50% of home health and hospice agencies experienced negative operating margins in FY19
- Data Limits
  - Data is not audited
  - Data is reported by state fiscal year, not agency fiscal year

Source: Department of Aging and Independent Living

Revenue Stability: FQHCs







- FQHCs receive grant funds from the Health Resources and Services Administration (HRSA) to support uncompensated care and their sliding scale. These funds are not factored in operating margin and are factored in total margin.
- FQHC margins have been declining since 2009

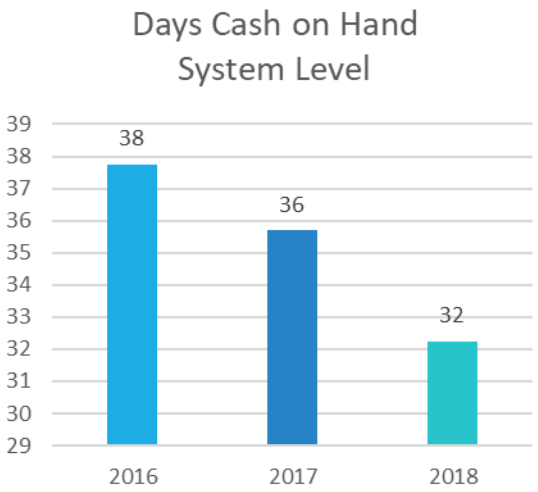
Source: Bi-State Primary Care

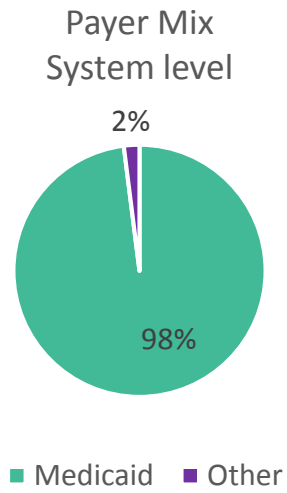
Revenue Stability:
Designated and Specialty Service Agencies

Total Margin

	FY15A	FY16A	FY17A	FY18A	FY19	5 -year avg
CM	1.4%	1.3%	1.0%	0.5%	1.6%	1.2%
CSAC	1.1%	3.0%	0.9%	1.4%	0.9%	1.5%
NCSS	2.4%	1.8%	1.3%	1.1%	3.4%	2.0%
HCRS	-1.4%	-1.0%	1.9%	2.0%	0.9%	0.5%
HC	0.8%	0.3%	0.6%	2.6%	1.8%	1.2%
LCMH	1.6%	1.4%	0.9%	-0.8%	0.4%	0.7%
NFI	1.2%	2.1%	1.4%	1.8%	0.4%	1.4%
NKMH	1.0%	-1.0%	1.6%	2.2%	1.9%	1.2%
RMHS	-1.0%	0.2%	1.2%	0.1%	1.0%	0.3%
UCS	0.2%	1.2%	0.5%	1.6%	0.2%	0.8%
WCMH	-0.8%	0.9%	0.3%	0.2%	1.6%	0.5%
CCS (DS Only)	0.7%	-0.1%	1.6%	0.4%	0.7%	0.7%
FF (DS Only)	4.7%	3.2%	2.9%	2.3%	0.9%	2.8%
LSI (DS Only)	2.8%	2.5%	4.7%	3.0%	4.2%	3.4%
GMSS (DS Only)	0.0%	1.7%	2.2%	1.5%	-0.1%	1.1%
UVS (DS Only)	0.0%	0.4%	0.4%	0.3%	0.7%	0.3%
System Total Margin%	**0.3%**	**0.6%**	**1.2%**	**1.4%**	**1.5%**	**1.0%**

Source: Vermont Care Partners





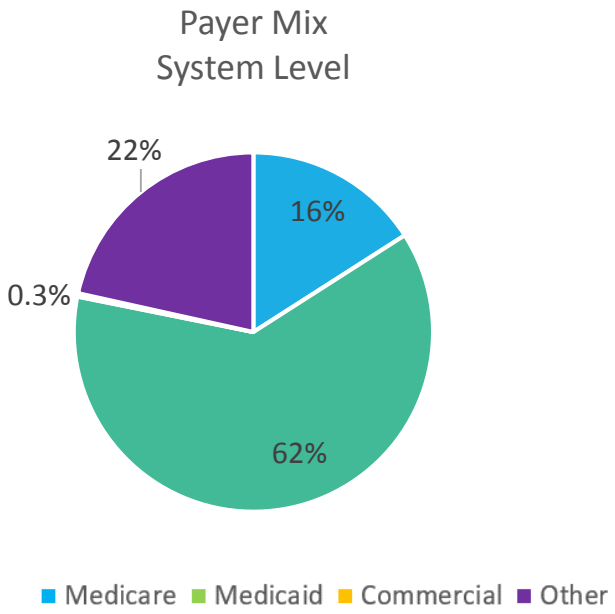
- Designated and Specialty Agencies are 98% Medicaid
- Data limits:
  - FY19 total margin data is preliminary

Revenue Stability: Long Term Care Facilities

Audited financial statement, and other data is collected by AHS, including to monitor on-going financial stability and to provide early identification of nursing homes in financial distress. This data was not available for this report.

- Extraordinary Financial Relief (EFR) is a process available when a nursing home is in immediate danger of closing
- There have been less than 5 EFR requests over the last 5 years

Source: Nursing Home Oversight Working Group report from 2019; Department of Disabilities, Aging and Independent Living, Division of Rate Setting, August 2019



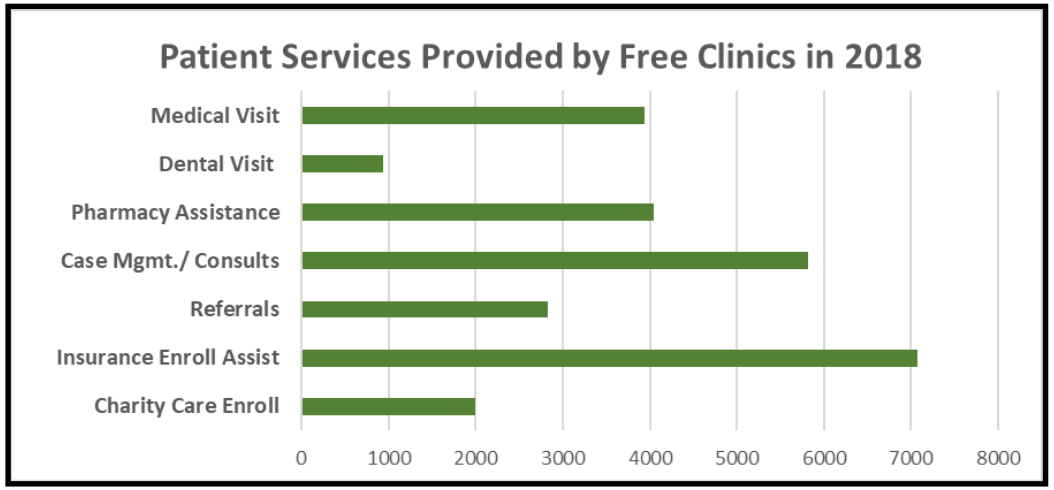
Revenue Stability: Independent Providers

- In Vermont, financial metrics and other quantitative evidence of the financial state of independent practices is not available
- In the U.S., one analysis shows:
  - Improvement in total profit per physician over 2017 (from $2,396 in 2017 to $2,510), but projected to break even
  - Improvement of operating margin from a loss of over $13k in 2016 to a profit of $2,396 in 2017
    - Source: RevCycle Intelligence, 2019; Fierce Healthcare, 2018 [*Note*: Original study done by AMGA only available for purchase]

- Qualitative surveys with physicians' attitudes or perceptions about their financial state and ability to sustain their independent or small practice say:
  - 50% of independent doctors surveyed by TD Bank have or would consider purchasing, buying into, merging or selling their practice, most within four years. Of these, 46% said it's too expensive to run a practice today. Source: Healthcare Finance News, 2017
  - GMCB Vermont Clinician Landscape Study identified the following takeaways:
    - Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology
    - The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement

Revenue Stability: Vermont Free Clinics

Who Provided Free Clinic Services in 2018?	
Many Volunteers	
75 MDs (medical)	6 Dental Hygienists/ Asst.
8 MDs (psych)	11 Mental Health Professionals
32 DMDs (dentistry)	47 Medical and Dental Students
55 RNs	60 Medical Interpreters
39 Mid-levels (NP, MA, EMT, etc.)	319 Other Volunteers
Organized and assisted by 30 paid staff	

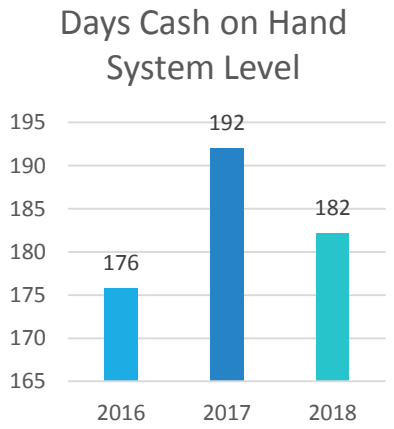


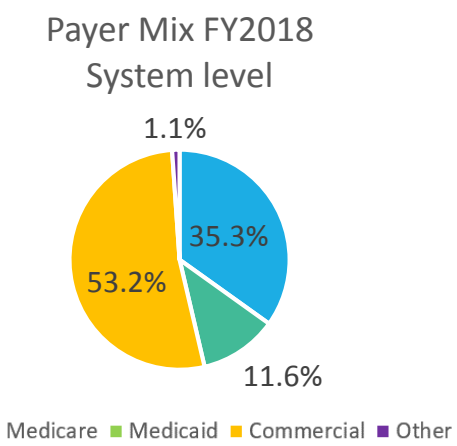
- Financial metrics and other quantitative evidence of the financial state of these clinics is not available.
- Free Clinics do not charge for services or receive reimbursements from payers.
- Statewide the clinics' revenue is:
  - $2.5 million in cash, including $1.0 million in Medicaid dollars
  - $3.2 million of in-kind support from local hospitals, providers, and volunteers, which include care, facilities, x-rays and labs, free medications and dental equipment
- Their expenses are:
  - $2.4M in cash
  - $2.8M of in-kind expenses
- The clinics estimate saving $7.5M in avoided hospital expenses annually.

Revenue Stability: Hospitals

	Operating Margin (%)						Budget-to-Actual NPR/FPP Variance
	Actuals FY17	Actuals FY18	Budget FY19	Projection FY19	Budget FY20	5-Year Average	FY19 September Year-to-date
Brattleboro Memorial Hospital	-3.1%	-2.4%	0.0%	0.8%	1.3%	-0.7%	-0.2%
Central Vermont Medical Center	-0.9%	-3.8%	1.4%	-2.1%	0.1%	-0.3%	-1.6%
Copley Hospital	-0.6%	-3.3%	0.3%	-3.4%	1.4%	-0.9%	-4.6%
Gifford Medical Center	-1.6%	-10.7%	2.5%	-0.8%	2.9%	-1.3%	-10.5%
Grace Cottage Hospital	-6.9%	-2.9%	0.7%	-6.7%	-1.2%	-5.0%	-2.9%
Mt. Ascutney Hospital & Health Ctr	2.7%	1.9%	0.0%	-2.9%	1.0%	1.0%	-3.3%
North Country Hospital	-2.3%	-2.3%	1.1%	1.9%	1.6%	-0.2%	-1.7%
Northeastern VT Regional Hospital	1.9%	1.7%	1.8%	1.8%	2.0%	1.9%	3.8%
Northwestern Medical Center	-1.2%	-3.4%	2.3%	-8.0%	-0.2%	-1.5%	-5.5%
Porter Medical Center	2.7%	1.8%	3.7%	5.2%	3.8%	2.8%	0.5%
Rutland Regional Medical Center	1.6%	0.5%	2.3%	0.4%	2.3%	2.0%	-0.9%
Southwestern VT Medical Center	3.7%	4.6%	3.6%	3.3%	3.4%	3.7%	-0.6%
Springfield Hospital	-7.1%	-12.8%	2.1%	-18.4%	-2.0%	-6.9%	-21.6%
The University of Vermont Medical Center	5.2%	3.4%	2.8%	2.2%	3.1%	4.1%	0.9%
System Total	**2.7%**	**1.1%**	**2.4%**	0.6%	**1.3%**	**2.3%**	-0.9%

Source: Green Mountain Care Board

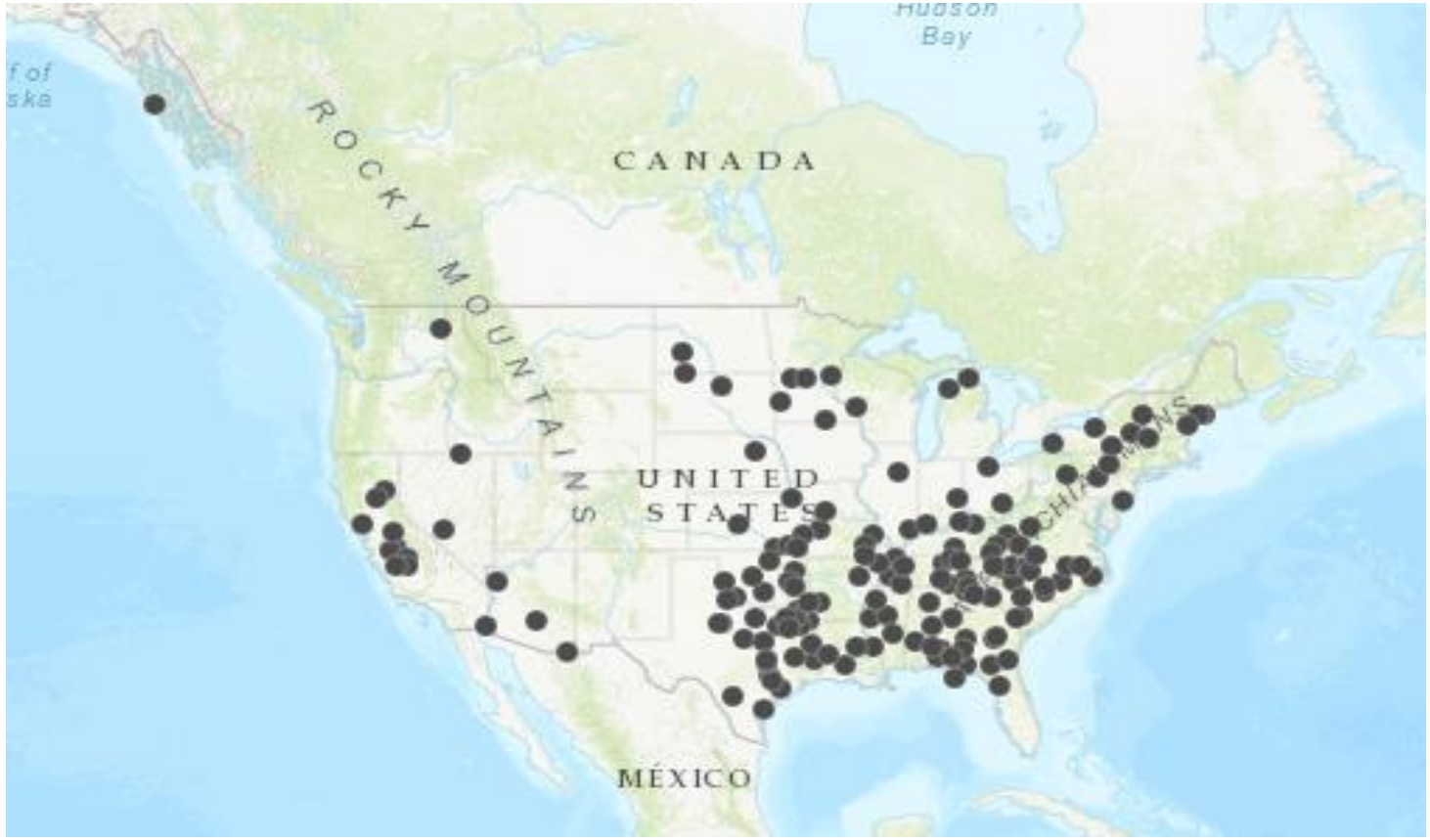




- 50% of hospitals are projecting negative operating margins in FY19
- 78% of hospitals are projecting to miss their FY19 budget targets (measured by "budget-to-actual NPR/FPP variance)
- As operating margins decline, hospitals become more reliant on other revenue such as donations and the 340B pharmacy program.

Vermont's hospital system is comprised of both large and small hospitals- critical access, Medicare dependent and prospective payment hospitals. Benchmarking on a system level are not useful given the diversity in hospital types

Revenue Stability: National Hospital Closures



- **118** acute care hospital closures nationwide since 2010
- Springfield Hospital filed for Chapter 11 bankruptcy June 2019
- 50% of Vermont hospitals projecting operating losses in FY19

Source: University of North Carolina Rural Health Research Program

Revenue Stability: Hospital Closures Impact in Vermont

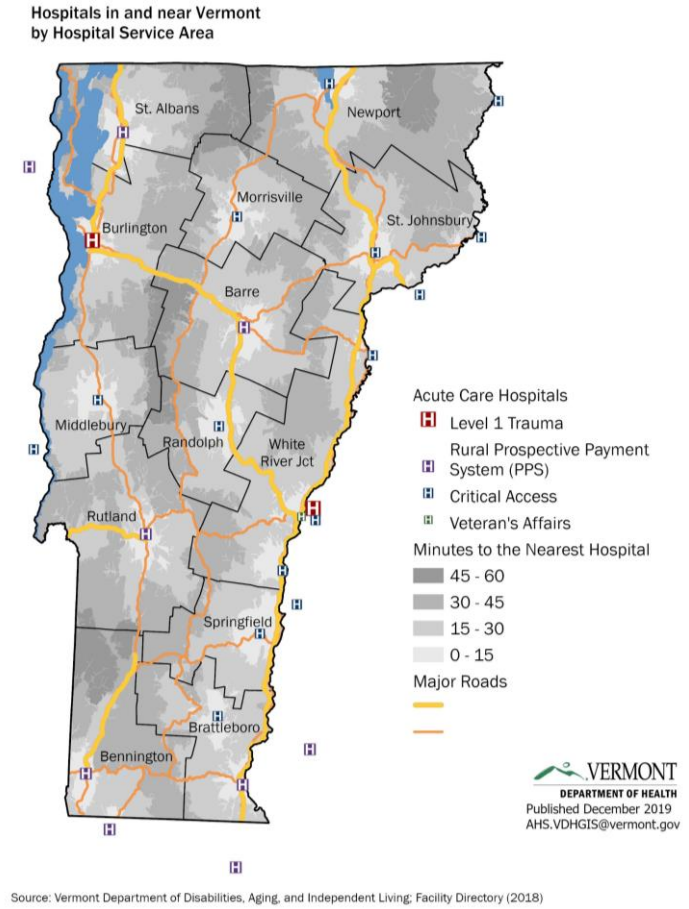
As required by Act 26 of 2019, the Task Force must consider potential consequences of the failure of one or more rural hospitals in Vermont.
Rural Hospitals provide critical services to Vermont patients and other health care organizations:

- Flow of services from the hospital and to the hospital
- Emergency Care
- Shared Services
- Community Services
- Specialty Services

Hospitals are geographically dispersed in Vermont, the closure of one acute care hospital would leave a service void in that part of the State.
Closure of a Vermont hospital may result in:

- Decreased access to services
- Wait times for certain services, potentially
- Reduced jobs in a community
- Negative economic impacts to communities

The GMCB has engaged 6 acute care hospitals in financial sustainability planning in FY20. This is an ongoing effort.



Revenue Stability: Hospital Closures Financial Impacts

Hospitals have an economic impact on their communities by:

- Providing employment
  - In Northern New England, health-care workers are 10% of each state's workforce
  - Closure of a community's sole hospital is estimated to reduce per capita income by 4% and increase unemployment by 1.6% in that community
- Purchasing services

"Ripple Effect"

- Each hospital job supports two additional jobs
- Every $1.00 spent by a hospital supports approximately $2.30 of additional business activity in the community

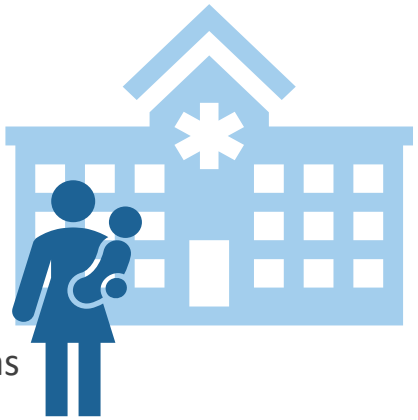
Vermont Hospital Ripple Effect			
# of hospital jobs	Effect of hospital jobs on total jobs in state economy	Hospital Payroll	Effect of hospital payroll and benefits on total labor income
17,022	33,964	$1.3 billion	$2.2 billion

Source: Hospitals are Economic Anchors in their Communities, American Hospital Association, 2016; Declining Access to Health Care in Northern New England, Regional Brief 2019-01,NE Public Policy Center, Federal Reserve Bank of Boston (2019)

Revenue Stability: Hospital Closures Other Impacts

When a sole, acute care hospital in a county closes

- 19.3% decline in physician supply, including primary care



Reduction in services- Example: maternity care

- 9% of rural communities in the U.S. have lost maternity services over the past decade
- 54% of rural communities in the U.S. do not have an acute care hospital with any obstetric services
- In the U.S., maternal mortality is higher among women living in rural areas versus women living in urban areas
- In Northern New England (Maine, NH, VT), 22 of 75 acute care hospitals lack a maternity ward
- In Vermont, Springfield Hospital closed its obstetrics department in 2019

Aligning services is complicated:

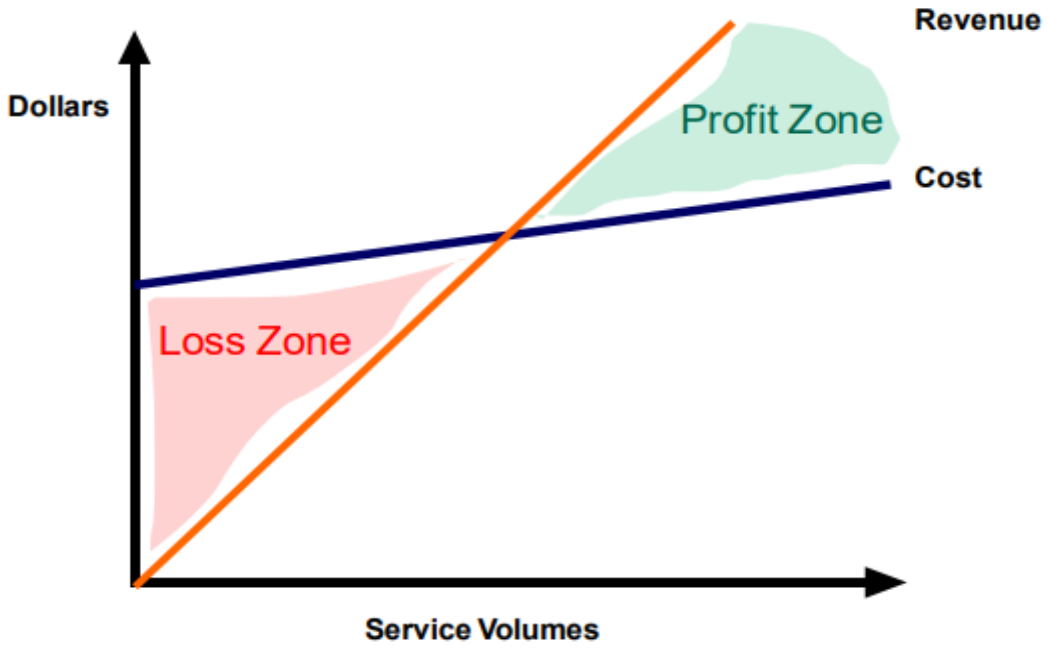
- Right sizing for a declining and aging population
- Impacts on access & travel times
- Health outcomes
- Community preferences

Source: Health Affairs, When Rural Hospitals Close, The Physician Workforce Goes, December 2019; Declining Access to Health Care in Northern New England, Regional Brief 2019-01,NE Public Policy Center, Federal Reserve Bank of Boston (2019)

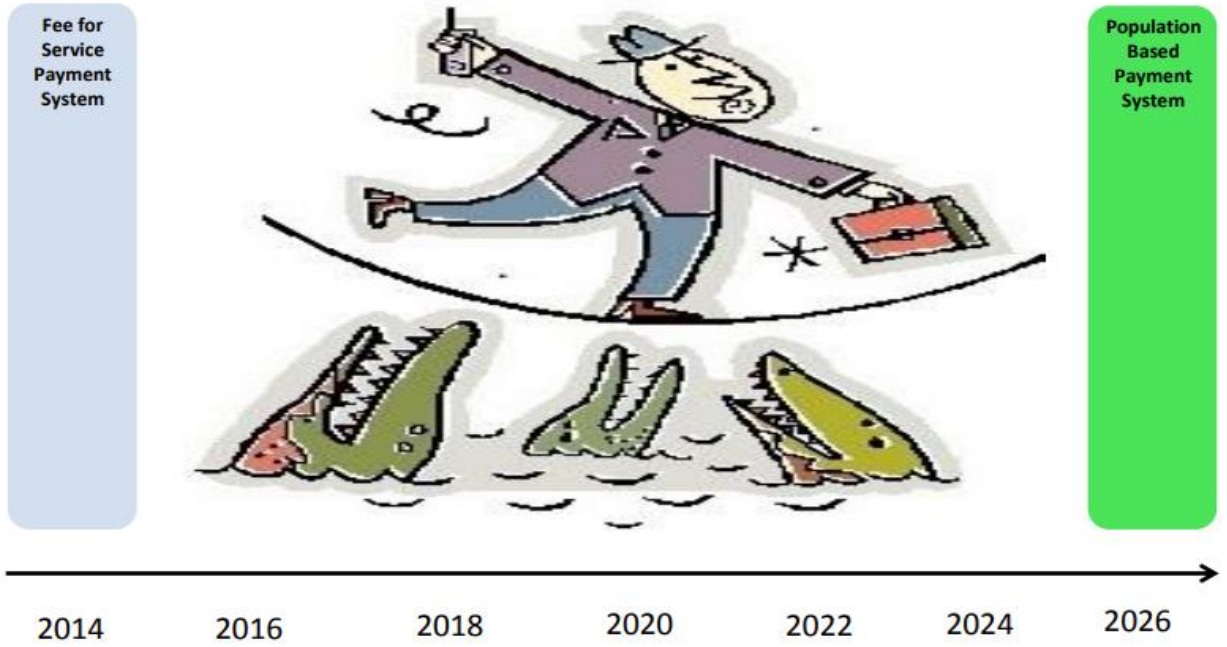
Revenue Stability: Areas of Discussion

"As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant. New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted."

Value Equation



Crossing the Shaky Bridge



Source: Eric Shell, The New Future of Rural Healthcare: Strategies for Success, Presentation to GMCB (2019)

Revenue Stability: Areas of Discussion

The State of Vermont is in a resource constrained environment and is also actively engaging in cost containment to reduce the growth in health care rates that are closer to economic growth rates.

The Governor and the General Assembly determine priorities for state funding based on many considerations. However, there is no structure currently in place to prioritize scarce state resources based on *sustainability of our health care sectors*.

The following efforts are also underway, but have different goals or are not comprehensive:

- The Health Resources Allocation Plan, which is under development at this time, is meant to identify and prioritize health needs of Vermonters and identify gaps in resources. It does not currently review the sustainability of each health care sector. It could help identify *current* access issues or clinical priorities.
- The Green Mountain Care Board is engaging in sustainability planning with 6 hospitals, with an additional hospital engaged in reorganization through bankruptcy. The goal is to engage hospitals, their Board of Directors and others as necessary to discuss how to ensure that Vermonters have access to vital services given the current financial environment.

Revenue Stability: Areas of Discussion

The Task Force identified two broad areas that would assist all providers in sustainability:

1. Targeted increases in reimbursement
2. A reduction of administrative burden

Each provider has identified industry-specific recommendations as examples, but these have not been endorsed globally by Task Force members.

National experts and the federal Rural Health Task Force identify telehealth (discussed in a later section of report) and moving from fee for service to value-based payment as a way for rural health care providers to weather national pressures, increase stability, and improve value.

- Health care reform is challenging for small independent primary care providers because they lack the infrastructure and personnel to analyze the implications of participation and perform the administrative work required to accomplish practice transformation.

Source: Reinventing Rural Health Care, Bipartisan Policy Center; Eric Shell, The New Future of Rural Healthcare: Strategies for Success, Presentation to GMCB (2019)

Revenue Stability:
Examples of Targeted Revenue Suggestions

Examples	Hospitals	Designated Agencies	Home Health & Hospice	Long Term Care	Independent Providers, including mental health and substance abuse providers	FQHCs	Free Clinics
Daily Reimbursement for Emergency Departments for patients in mental health crisis with long stays	X						
Implementation of Act 82 of 2017 to set reimbursement rates that "are reasonable and adequate to achieve the required outcomes for required populations."		X					
Annual inflationary increase per the recommendation of the Older Vermonters Working Group. Approximately $375,000 Gross (including federal match) per 1.0% of increase	X		X	X			
Review and consider the recommendations in the Ongoing Financial Sustainability section (p. 10) of the Nursing Home Oversight Working Group Report submitted in 2019	X			X (Nursing Homes)			
AHS should evaluate the cost associated with providing Enhanced Residential Care and Assistive Community Care Services relative to Medicaid reimbursement to ensure the rates are adequate to support those services.				X (Residential care homes/assisted living residences)			
Reinstate Medicaid primary care case management payment to $2.50 PMPM for any rural primary care practice (legislative change)					X	X	
Reinstate Medicaid vaccine administration rates to 2017 levels					X	X	

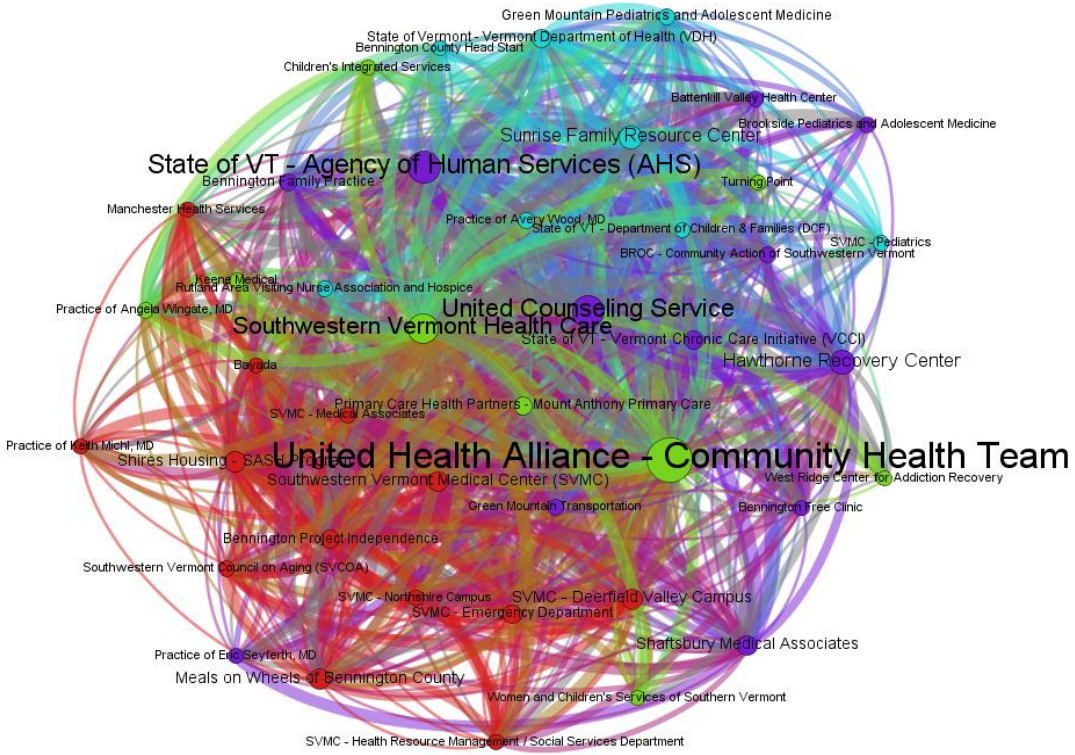
Revenue Stability:
Examples of Reducing Administrative Complexity

Examples	Hospitals	Designated Agencies	Home Health & Hospice	Long Term Care Facilities	FQHCs
Streamline GMCB hospital budget process	X				
Reduce the number of legislative reports required of the GMCB	X				
Standardize rules and data submission across AHS departments where possible		X			
Cost reporting could be simplified	X	X	X (use audited financials)		X (federal)
Review and consider the recommendations regarding Certificate of Need and transfer of nursing home ownership contained in the Nursing Home Oversight Working Group Report submitted in 2018	X			X	

Note: Independent providers' suggestions on reducing administrative burdens are included in the consensus recommendations related to workforce.

Care Coordination

Care Coordination:
Interactions between entities



Health care sectors should work as a system to provide care to Vermonters in the most appropriate setting.

Care coordination reduces costs by promoting early intervention, disease management, and prevention.

Care coordination is a core service of home and community-based service providers.

Care coordination efforts in progress by the Blueprint for Health and OneCare Vermont are working to increase the efficiency and effectiveness of these interactions by providing clinical expertise, data, and communication tools to providers.

Source: Blueprint for Health Bennington
Note: Health Care Resource Maps available in Resources section of this report

Care Coordination: Issues

Continued investment required for existing care coordination functions in home and community-based services

Transition in payment reform & delivery reform: both too fast and too slow

Payer limitations to telehealth, telemonitoring, & providing care in home settings (see telehealth section)

Continued evolution of technology tools

- Greater data integration, fewer disparate tools, possible broadening use of Care Navigator to a more providers and social services agencies

Variation in care model(s) across communities: balance needed between local control versus standardization

Continued provider concerns about appropriate information sharing

- 42 CFR legal constraints related to substance misuse services
- Need for broader understanding and mechanisms about patient consent/privacy and understanding how to appropriate share information in a streamlined way

Reimbursement limits in FFS for provider communication (mental health in particular)

In a zero-sum workforce environment, new care coordination initiatives can shift direct service staff to coordination activities

Care Coordination: Examples of Success

Bennington Community Care Team

The Community Care Team is an innovative program that helps social service providers throughout the community coordinate their work for the clients and patients they share. The program improves the lives of patients and clients by meeting their needs more efficiently. The change has related to a 44% decrease in Emergency Department visits among the participants.

Brattleboro Memorial Hospital Post-Acute Care

This program provides a Medical Director to the Nursing Homes for long term care patients and sub-acute rehab patients in need of skilled nursing and has recently expanded to assisted living facilities. The MD's are part of the BMH Medical Staff. The PAC team has been able to decrease utilization in the ED's for patients due to frequent rounding in the Nursing Homes and consistent on call coverage for off hour questions/concerns.

Northwestern Counseling & Support Services

Northwestern Medical Center contracts with NCSS to fund Blueprint Community Health Team positions, promoting a holistic model of care through embedded mental health services and care coordination. Supporting patients to receive mental health care at their medical home reduces barriers to access caused by stigma, giving patients access to the full range of all mental health services available at the designated agency. The contracts also support greater communication and collaboration at a systems level between the partners.

UVM Home Health & Hospice Longitudinal Care Program

Patients with full onset chronic illness(es) and/or complex acute catastrophic conditions are enrolled when "discharged" from Medicare-eligible skilled home health services. They continue to receive nursing, community health worker visits & telemonitoring services. The program has successfully reduced hospital admissions and emergency department visits – and their attendant costs. This program is one of the rare interventions that has demonstrated a short-term return on investment that also represents an improvement in the experience of care for patients and families. The VNAs of Vermont is partnering with OneCare Vermont to expand the program to other home health agencies serving Vermonters.

Source: Southwestern Vermont Medical Center; Northwestern Counseling and Support Services; Brattleboro Memorial Hospital, UVMHHH

Care Coordination: Key Themes

Care Coordination spans the full continuum of health care providers

Care models need more time to develop and mature

Primary care should continue to be a focus, but…

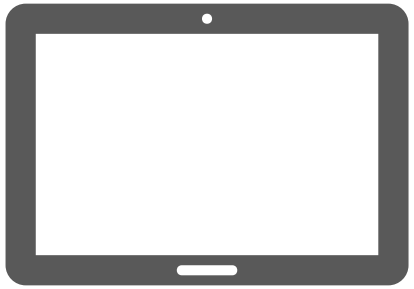
- The definition of primary care should be extended to include care happening outside of the physician's office (e.g. home, nursing homes, telehealth, etc.)
- Designated agencies and other community-based providers provide extensive care coordination, but workforce vacancies and turnover impacts consistency
- Current care coordination models require infrastructure that may not be feasible for smaller, independent practices or certain kinds of providers
- "Buy don't build": utilize low-cost, experienced care coordination expertise at existing home and community based service providers

Care Coordination: Recommendations

Task Force Recommendation	Action Required By			
	Legislature	Administration	All Payer Model 2.0	Private
Support current efforts: • Maintain and build investment in existing care coordination functions in home and community-based services • Allow provider-led ACO reform efforts to mature • Allow delivery system time to continue to change	X	X	X	X
Provide investment in delivery system reform efforts	X	X	X	X
Continued investment and improvement of technology that supports effective coordination of care and could reduce administrative burdens	X	X		X
Promote the coordination of data sharing across AHS and ACO (e.g. integrate social determinant of health data)		X		X
Increase access for Medicaid patients to telemonitoring (see telehealth section)				

Care Coordination: Recommendations

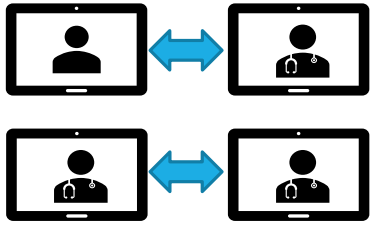
Task Force Recommendation	Action Required By			
	GMCB	Administration	All Payer Model 2.0	Private (including payers)
Continue to mature & expand adoption of the OCVT Care Model by:				
Evolving OneCare's Complex Care Payment Model			X	X
Expanding to additional payers and increase # Vermonters under an aligned care model (scale)			X	X
Continuing to evaluate pilot innovations (expand or sunset as appropriate)			X	X
Continuing to explore and evolve pediatric models to ensure appropriate level of care coordination			X	X
Ensure Sustainability of Community-based Blueprint/ACO Model by Demonstrating: positive outcomes for patients; financial return on investment (ROI)			X	X
Improve alignment of reporting, screening, and performance indicators	X	X	X	X



Telehealth

Telehealth: Modalities

Telemedicine
"synchronous"



Video Visit
Provider to Patient
Providing care directly to patient at a remote location ("originating site")

Video Consult
Provider to Provider
Provider to provider consultation concerning patients in emergent episodes

Store and Forward
"asynchronous"

E-Consult
Provider to Provider
Enables providers to provide asynchronous consultation

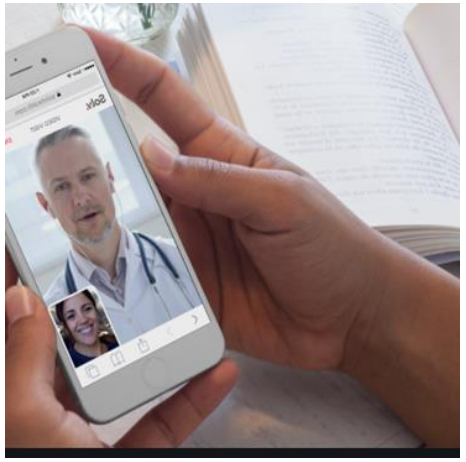
Remote Patient Monitoring
"telemonitoring"

Remote Patient Monitoring (RPM)
Patient to Provider
Monitoring key patient health measure such as weight, blood pressure, oxygen, from a patient's home

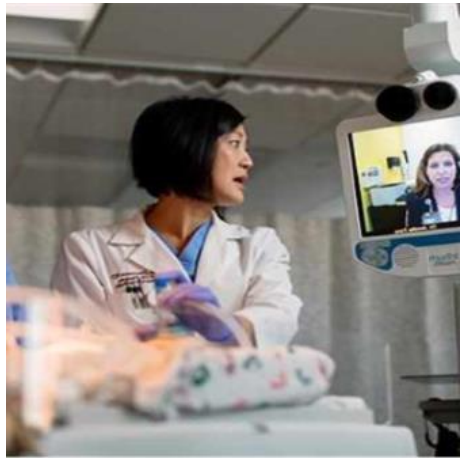
Telehealth should be used to enhance access, but not supplant face-to-face relationships between providers and patients.

Telehealth: Examples

Telemedicine

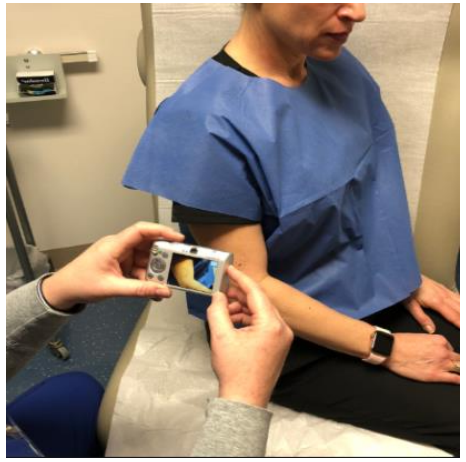


TelePsychiatry



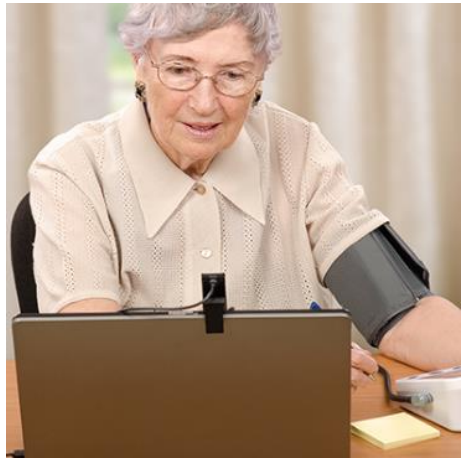
TeleEmergency

Store and Forward



TeleDermatology
eConsult

Remote Patient Monitoring



Remote Blood
Pressure & Pulse

Telehealth in Vermont FAQs

- Parity for approved telehealth services
- Must be clinically appropriate and within the provider's licensed scope of practice
- Patient must consent (unless emergency)
- Prescriptions permitted
- Telehealth consultations are not recorded

Telehealth: Impact in Rural Communities

Potential Benefits of Telehealth

- Mitigates access issues, reducing wait times for specialty care
- Cost effective follow up visits
- Mitigates costs associated with patient lost work time, transportation and childcare
- Supports Care Management, Workforce and Financial Sustainability

Effective Telehealth Programs for Rural Communities

- Chronic care management interventions
- Emergency Care
- Home Monitoring
- Intensive Care Units
- Long-term Care
- Psychotherapy and remote counseling
- Interpreter services

Source: NCSL, Increasing Access to Health Care Through Telehealth; American Journal of Managed Care

Telehealth: Regional Impact & Limitations

Regional Impact
University of Vermont Medical Center

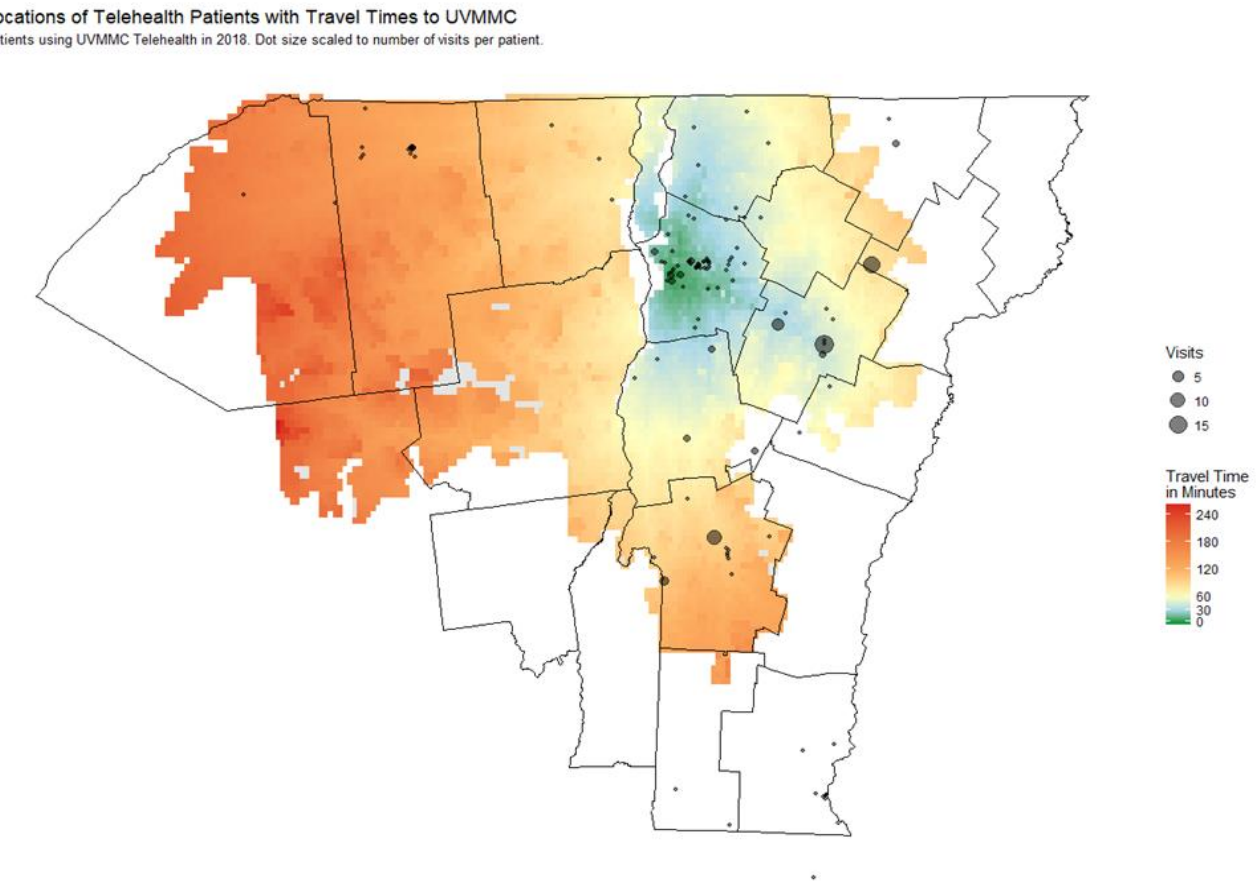
- No-show rates: for in-person specialty visits as high as 30% vs video visits as low as 2%
- Evaluated 561 video visits in 2018
  - 47,000 driving miles
  - 1007 hours of driving time
  - An estimated 6.6 tons of CO_2 emissions avoided

Limitations

There are barriers to telehealth today, including:

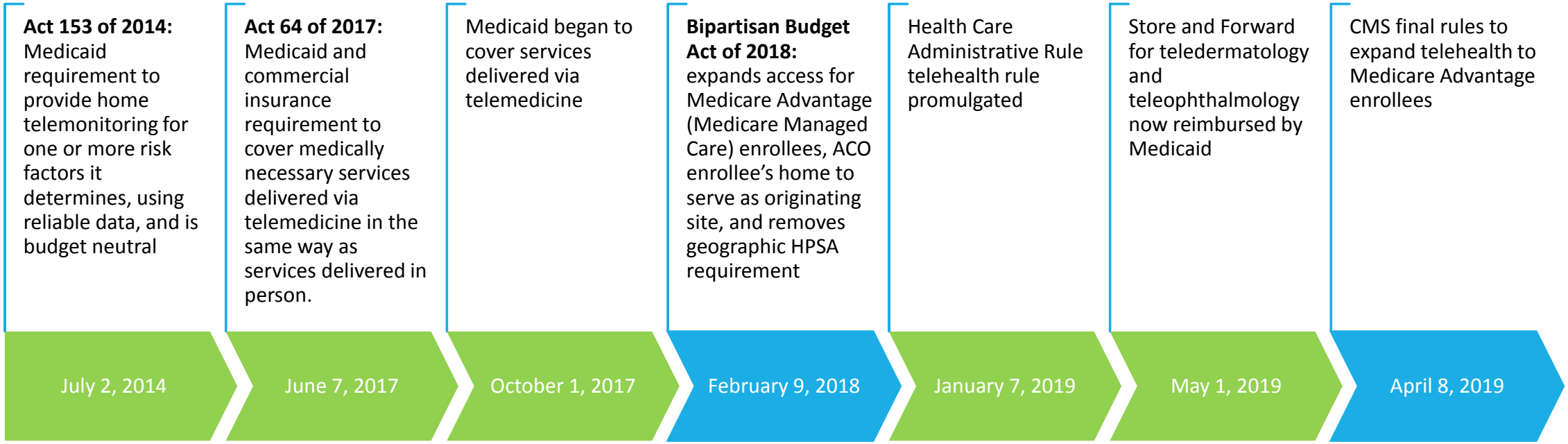
- Who can be paid to deliver telehealth services
- What services can be reimbursed
- What technology can be used
- Incorporating telehealth into the regular workflow

Broadband limitations are also a factor



Source: University of Vermont Health Network

Telehealth: in Vermont



Green: State of Vermont Initiatives
Blue: Federal Initiatives

Source: Department of Vermont Health Access

Telehealth Reimbursement in Vermont (DRAFT)

	Commercial 8 V.S.A. § 4100k	Medicaid Rule 3.101	Medicare	Medicare Advantage	Medicare- APM Telehealth Expansion Waiver
Patient's Home Approved Originating Site	Yes	Yes	No Exemptions: substance use disorder or a co-occurring mental health disorder, end-stage renal disease home dialysis, stroke Yes- ACO waiver (effective 2019)	Yes- starting in 2020	Yes
Extends beyond Health Professional Shortage Area (HPSA)	Yes	Yes	No	Yes- starting in 2020	Yes
Qualified Provider	Licensed, certified, or otherwise authorized by law to provide professional health care services in this State	Provider who is working within the scope of his or her practice and enrolled in Vermont Medicaid	Physicians, nurse practitioners, physician assistants, nurse midwives, registered dieticians, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, nutrition professionals (Does not include physical therapy,	?	• Follows Medicare • Requires that provider is part of the ACO
Store and Forward	Insurer may cover Ophthalmology and Dermatology E-consult: unclear	Limited to Ophthalmology and Dermatology E-consult: Allowable	Services are not limited, starting in 2020 E-consult: Allowable, codes 99452 and 99451		Store and Forward: allows Ophthalmology and Dermatology
Remote Patient Monitoring	Limitations unclear	Limited to Congestive Heart Failure diagnosis	Home health agencies are not reimbursed for RPM, however, can include on their cost report	Yes	
Other Limitations	Commercial does not reimburse at same rate as in-person visit		Federally Qualified Health Centers (FQHCs): Medicare does not reimburse FQHCs as a distant site.		

Note: Subject to change

Telehealth: Expansion Initiatives

Medicare Limitations

CMS Initiatives

- Starting January 2019, updated Value-Based Insurance Design (VBID) model of care to give providers treating people on Medicare Advantage more access to telehealth in place of in-person checkups
- Starting 2020, Medicare Advantage members no longer restricted by geographic restrictions and homes are eligible originating sites

Pending Federal Legislation

- H.R. 4932 “Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act of 2019”: promotes expansion of Medicare telehealth services
- Reducing Unnecessary Senior Hospitalizations (RUSH) Act: aims to give skilled nursing facilities (SNFs) more incentives to use telehealth

Store and Forward Limitations

State Proposals

- Dental Access and Reimbursement Working Group (Act 72 of 2019): recommendation for DVHA to further study Medicaid store and forward teledentistry and include recommendation in FY2021 budget presentation

Planning Initiatives

Vermont

- Vermont Program for Quality in Health Care (VPQHC) facilitation of a Telemedicine Technical Assistance Working Group
  - Broad group of stakeholders
  - Established under current 9416 contract statutory funding

Telehealth: Recommendations

Task Force Recommendation	Action Required By				
	Legislature	**Administration**	**All Payer Model 2.0**	**Private**	**Federal**
Store and Forward- E-Consults					
• Expand coverage to Teledentistry	X	X			
• Expand reimbursement to include consultations or other services, such as between **primary care and specialty** (state samples include consultation, diagnostic, therapeutic and interpretive services, psychotherapy and pharmacological management services)	X	X			
• Expand reimbursement from Medicaid and commercial insurers to align with Medicare reimbursement	X	X			
Remote Patient Monitoring					
Expand Medicaid coverage beyond Congestive Heart Failure • Allow monitoring whenever clinically appropriate • Expand to commonly accepted applications such as COPD, asthma and diabetes • Examples from other states include diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding		X			
ACO Waiver: Ensure ACO telehealth waiver supports primary care and mental health at skilled nursing facilities			X		
Funding: Grants for Telehealth planning and programs	X	X	X	X	X

Additional Resources

Additional Resources

I. Telehealth Definitions
II. Related Task Forces & Reports
III. Inventory
IV. Bibliography of Articles & other materials circulated
V. Public Comments

Materials from the Task Force Meetings are available on the GMCB Website

Telehealth: Definitions

Term	8 V.S.A. § 4100k	Health Care Administrative Rule 3.101	Modalities
Telemedicine (synchronous)	Means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.	Means health care delivery by a provider who is located at a distant site to a beneficiary at an originating site for purposes of evaluation, diagnosis, consultation, or treatment, using telecommunications technology via two-way, real-time, audio and video interactive communication, through a secure connection that complies with HIPAA.	Video Visit (live) Video Consult (live)
Store and Forward (asynchronous)	Means an asynchronous transmission of medical information to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty and by which the health care provider at the distant site reviews the medical information without the patient present in real time.	Means an asynchronous transmission of a beneficiary's medical information from a health care professional to a provider at a distant site, through a secure connection that complies with HIPAA, without the beneficiary present in real time.	eVisit eConsult
Remote Patient Monitoring (telemonitoring)	N/A	Means a health service that enables remote monitoring of a beneficiary's health-related data by a home health agency done outside of a conventional clinical setting and in conjunction with a physician's plan of care.	Home Health

Related Task Forces & Reports

During the course of our work, it became clear that there were others charged with related or overlapping issues. Due to time constraints, the Task Force was not able to coordinate or align with all other efforts. Below is a listing of other information which may be useful in discussing financial sustainability:

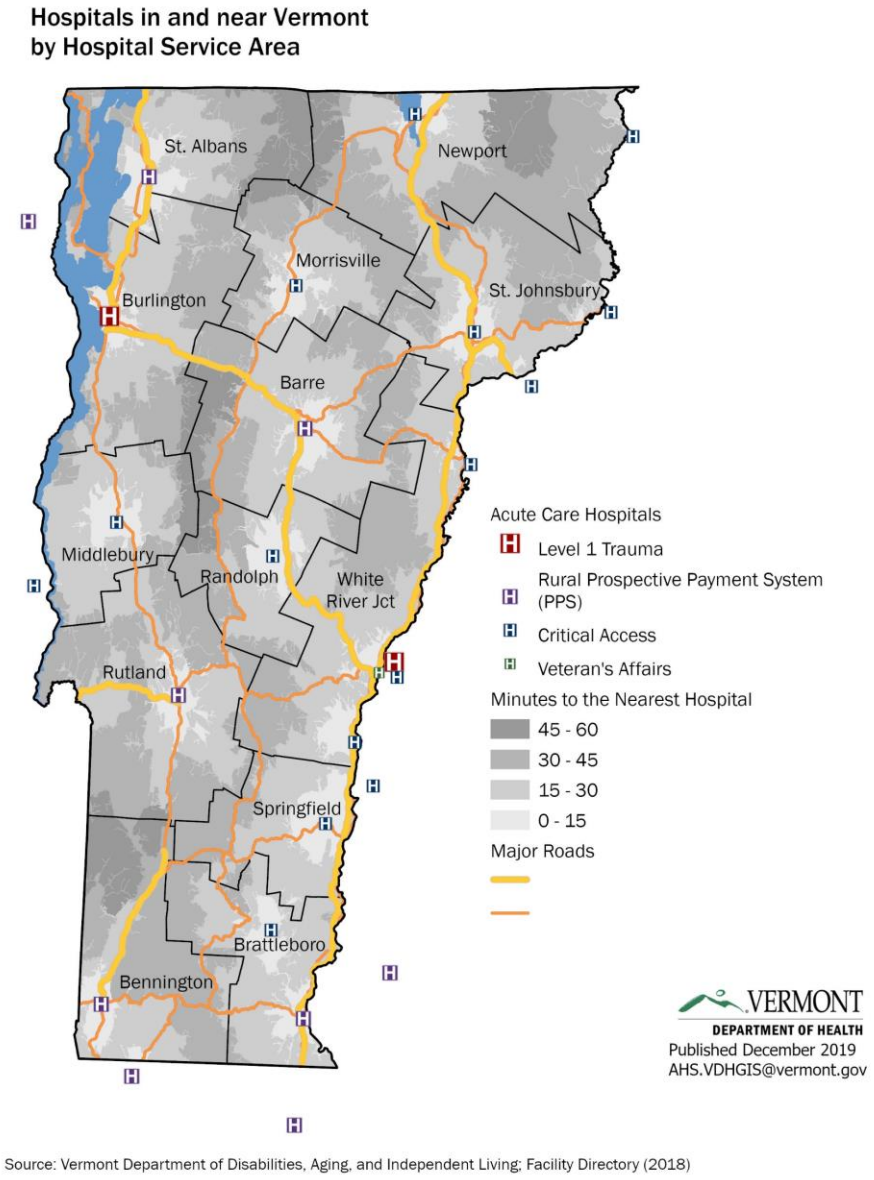
- Office of Professional Regulation (not available yet)
- Dental Task Force, November 1, 2019
- DMH Strategic Plan (not available yet)
- Older Vermonters Act Working Group Report, November 25, 2019
- GMCB Primary Care Spend Report, due January 15, 2020 (not available yet)
- Green Mountain Care Board evaluation of Howard Center Budget, January 2016

Inventory

Inventory

Act 26 of 2019 required the Rural Health Services Task Force to inventory the current system of rural health delivery in Vermont, This section contains maps of Vermont's health care system with explanatory text.

Inventory information will continue to evolve through the Health Resources Allocation Plan (HRAP). The Health Resources Allocation Plan, established in 18 V.S.A. § 9405, is published by the Green Mountain Care Board and identifies Vermont's critical health needs, goods, services, and resources. More information about the Health Resource Allocation plan is available on the Green Mountain Care Board website.



Source: Vermont Department of Disabilities, Aging, and Independent Living; Facility Directory (2018)

Hospitals in and near Vermont

Most rural Vermont communities are served by one of 5 rural mid-size hospitals, 8 Critical Access Hospital (CAHs), or by academic medical centers in Burlington and Hanover, NH. For many Vermonters living in border towns, their nearest emergency, inpatient or specialty care is located at hospitals in New Hampshire, New York or Massachusetts. Vermont veterans can get most of their care at Veterans Administration hospital, located in White River Junction.

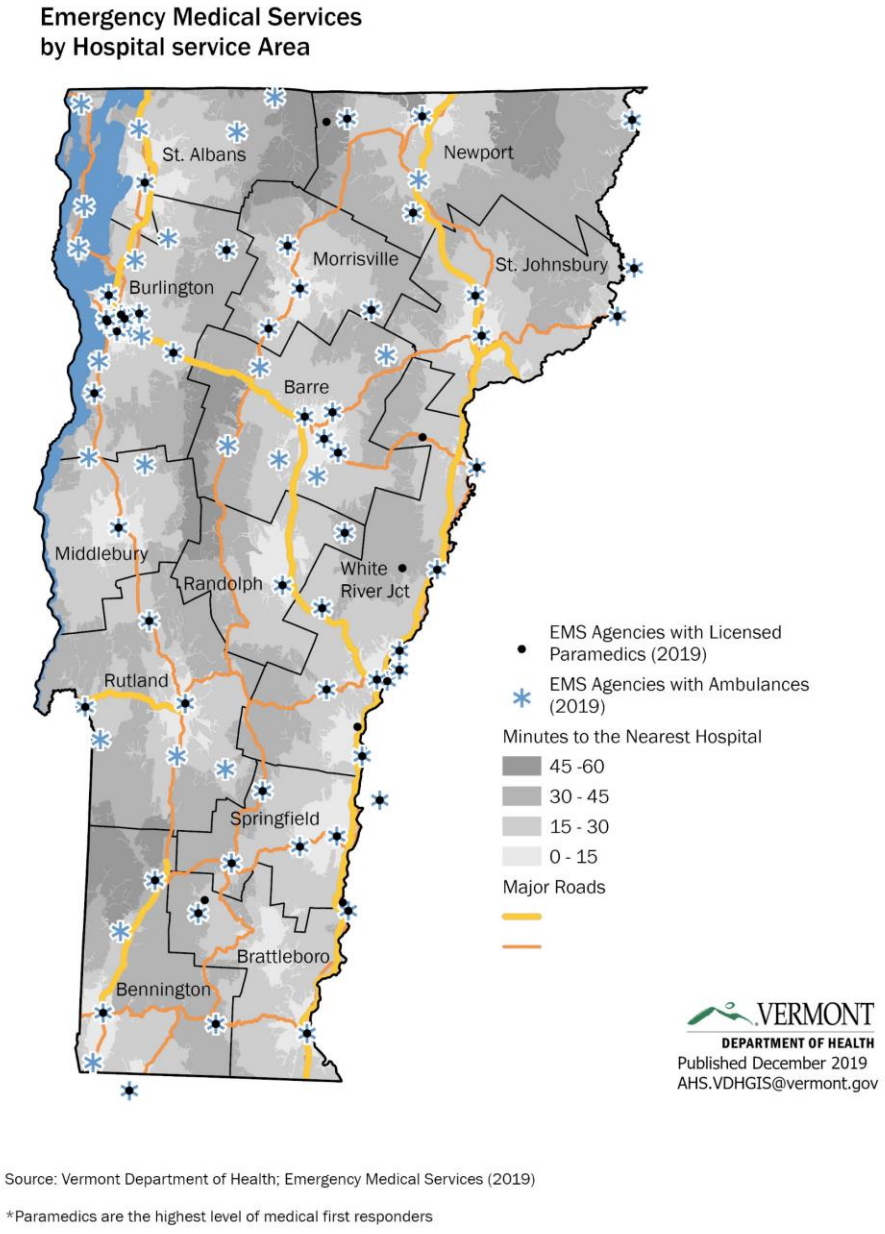
Medicare and Medicaid beneficiaries make up large portions of patients at each of these hospitals. Care provided to Medicare beneficiaries at mid-size and large hospitals is reimbursed through the CMS Prospective Payment System (PPS). CAHs are reimbursed for Medicare beneficiaries on a cost-based system to help ensure sustainable revenue flow even with low volumes of services.

The geographic boundaries of this map represent Vermont's defined Hospital Service Areas (HSAs).

Distances from nearest hospitals

According to newest GIS mapping data, nearly all locations in Vermont served by roads are within a 60-minute drive to a hospital either in Vermont or within 10 miles of Vermont borders. However, there are many areas that are more than 45 minutes away from the nearest hospital emergency room, shown in the darkest shades on the attached map. While these distant areas typically have low populations, they are important recreation areas for hiking, skiing, camping etc, as well as logging.

For more information, contact: https://vahhs.org/our-members



Source: Vermont Department of Health; Emergency Medical Services (2019)

*Paramedics are the highest level of medical first responders

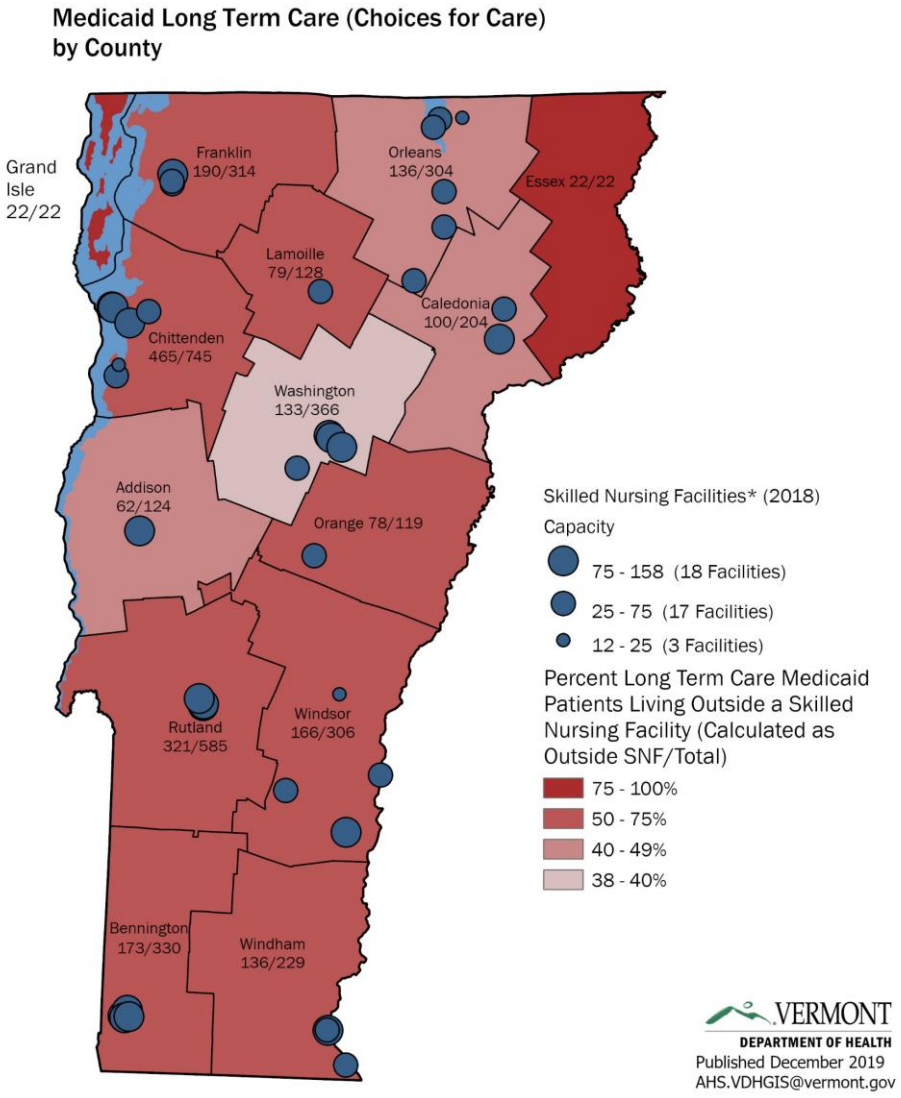
Emergency Medical Services

Vermont's 251 towns (in all 14 counties) are served by 169 mostly independent and volunteer Emergency Medical Services (EMS) agencies, including 80 transporting agencies and 89 first responding agencies. All of these agencies are indicated on the attached map with a blue star. Those EMS agencies with licensed paramedics are signified by a black dot on the blue star.

The geographic boundaries of this map represent Vermont's defined Hospital Service Areas (HSAs).

These agencies work closely with their local hospitals and emergency department staff to address emergent health issues facing their neighbors. In many cases, the Director of Emergency Medicine at the local hospital serves as the Medical Director of several EMS agencies. Vermont, like many rural states, is struggling to replace retiring EMS personnel. Employment patterns are evolving in rural communities and more potential EMS volunteers are commuting farther from home for work, and not available for EMS involvement, training or service. Since 2017, at least one EMS agency has closed due to financial and staffing shortages.

For more information, contact: https://www.healthvermont.gov/emergency/ems



Medicaid Long term care (Choices for Care)

Nursing Facilities

Nursing homes provide nursing care and related services for people who need nursing, medical, rehabilitation, or other special services. They are licensed by the state and may be certified to participate in the Medicaid and/or Medicare programs. Certain nursing homes may also meet specific standards for subacute care or dementia care.

Home Health Agencies and Hospice Providers

Home Health Agencies provide health services in the home. Services include nursing, personal care, physical therapy, homemaker services, hospice care, and social work services.

Choices for Care (CFC)

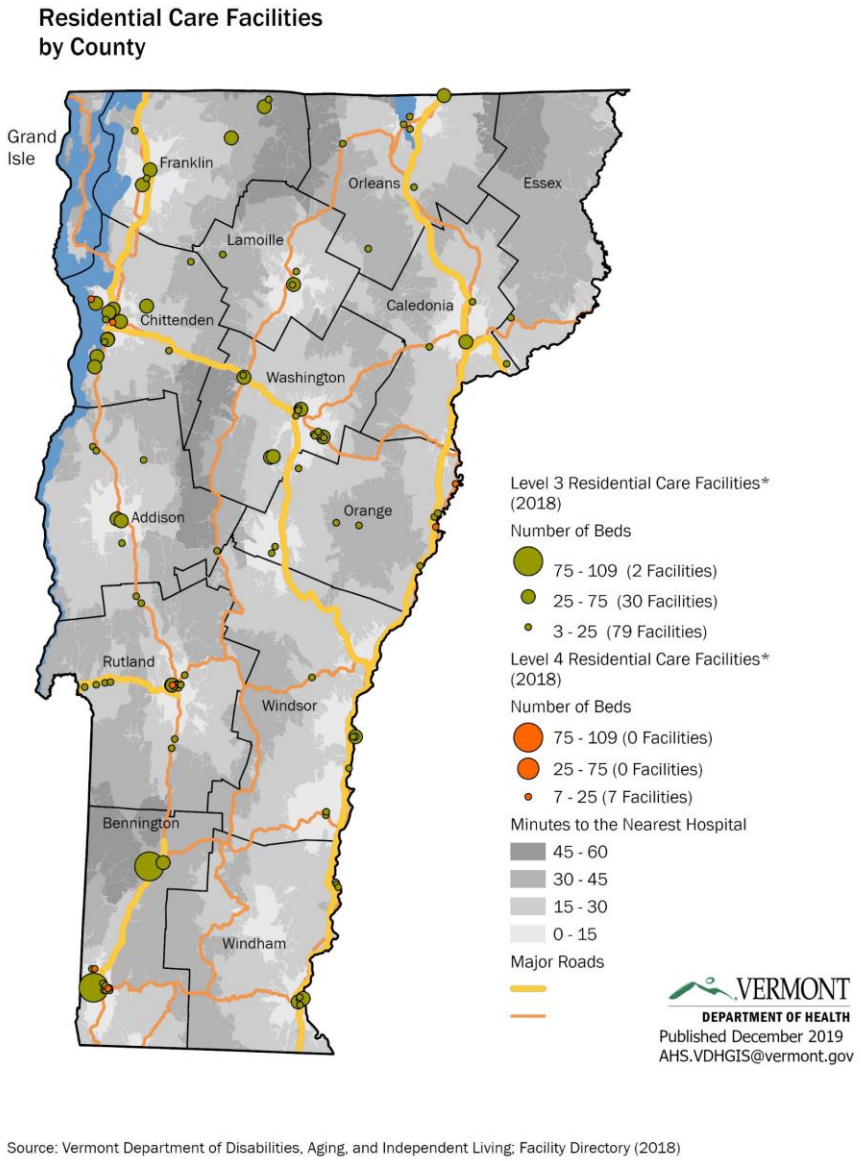
Choices for Care is a long-term care services program providing care and support to Vermonters at least 18 years old who require nursing home level of care. CFC helps those who are eligible receive their services in a home setting or in an authorized care facility.

Vermont has prioritized aging in place, setting a goal of 50% of Medicaid beneficiaries needing skilled nursing care to receive that care in their homes instead of more expensive facilities. The percentages for 2017 are shown on the attached map and range from 38% to 100%. Of important note is that since there are no skilled nursing facilities in either Essex County and Grand Isle County, 100% of Medicaid beneficiaries are receiving skilled nursing care at home or have moved to a facility in another county, potentially many miles away from their home community and families.

Vermont skilled nursing facilities (SNFs) range in size from 12 to 158 beds. However, most SNFs and home health agencies suffer nursing shortages. We do not show data related to nurse staffing at home or in the facilities identified here.

In addition, Medicaid reimbursement rates for Choices for Care does not cover costs of the program.

For more information, contact: https://dail.vermont.gov/services/programs



Source: Vermont Department of Disabilities, Aging, and Independent Living; Facility Directory (2018)

Long-term care – Residential Care Homes (RCH) - Level 3 & Level 4

Residential care homes are state licensed group living arrangements designed to meet the needs of people who cannot live independently and usually do not require the type of care provided in a nursing home. When needed, help is provided with daily activities such as eating, walking, toileting, bathing, and dressing. Residential care homes may provide nursing home level of care to residents under certain conditions. **Level 3** homes provide nursing overview, but not full-time nursing care. **Level 3** homes do not provide nursing overview or nursing care.

There are 111 Level 3 Residential Care Homes in Vermont and only 7 Level 4 Residential Care Homes.

We have shown these facility locations on the map also showing drive times to nearest hospital. Most homes are within 30 minutes to a nearby hospital, but several are more than 45 minutes.

For more information, contact: https://dail.vermont.gov/services/programs

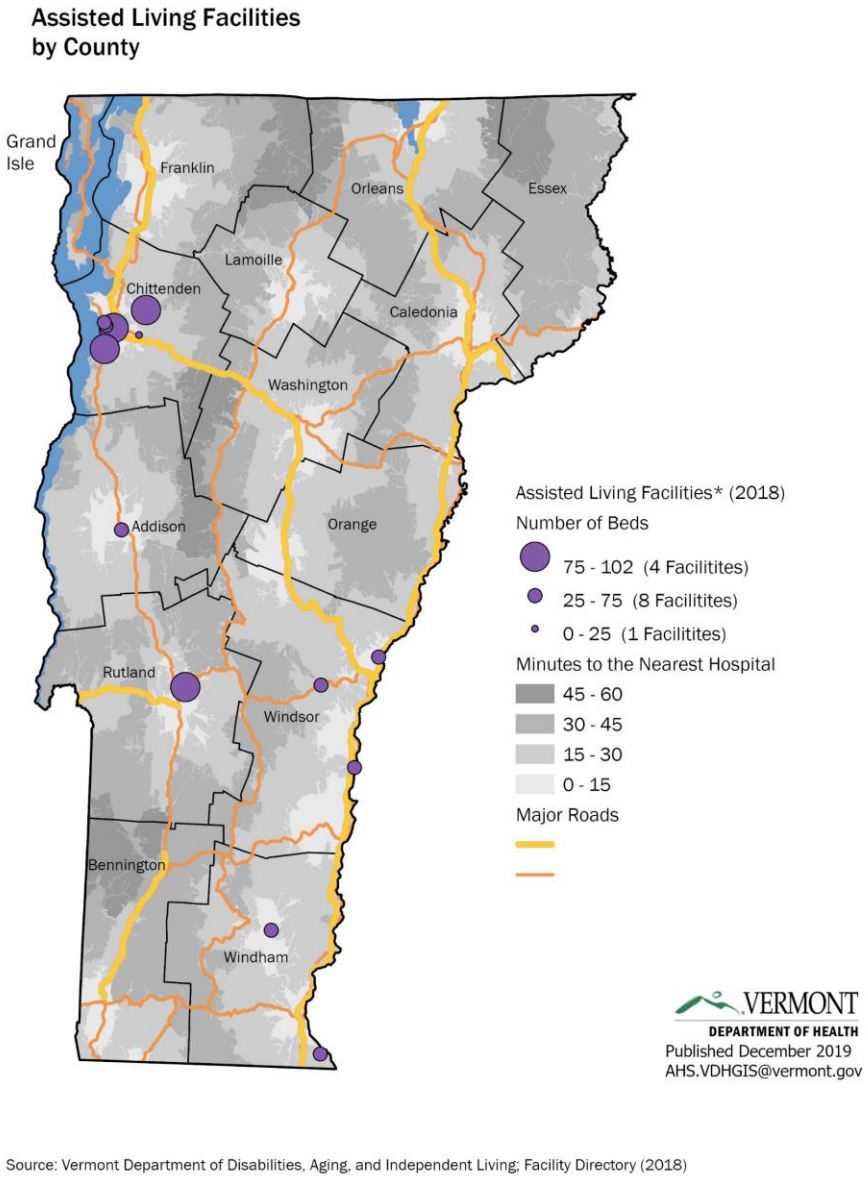
Long-term care – Assisted Living Facilities

Assisted Living Facilities

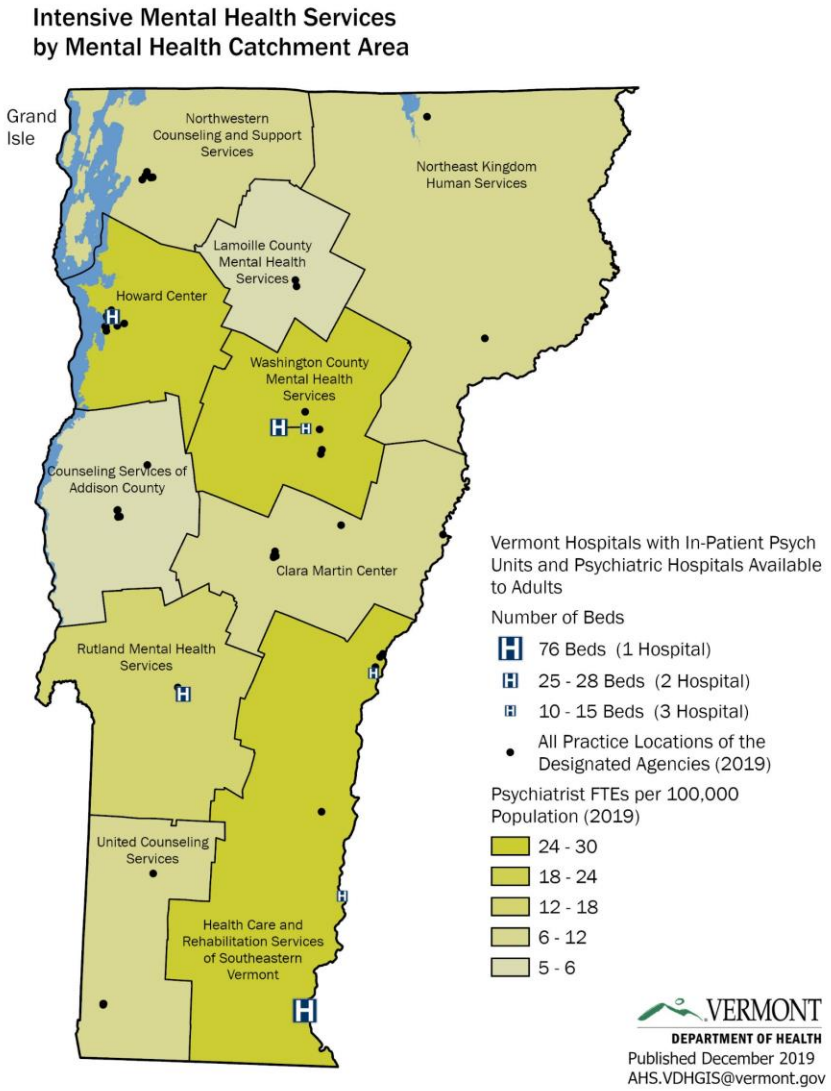
Assisted Living Facilities are state licensed residences that combine housing, health and supportive services to support resident independence and aging in place.

There are only 15 Assisted Living Residences in Vermont as of October 2019; with most beds in Chittenden County.

For more information, contact: https://dail.vermont.gov/services/programs



Source: Vermont Department of Disabilities, Aging, and Independent Living; Facility Directory (2018)



Source: Vermont Department of Health; Health Care Provider Census (2016), Vermont Department of Mental Health; Psychiatric Hospitalization (2019), Vermont Department of Mental Health; Designated Agencies (2019)

Mental health RSAs (MCHAs) reflect the established catchment areas of the 10 designated mental health agencies in Vermont.

FTE ratios only includes providers in locations open to the public. Facilities that do not offer outpatient services are excluded.

Intensive Mental Health Services by MH Catchment Area

The Department of Mental Health currently designates six hospitals to provide psychiatric inpatient care in Vermont. All six hospitals provide services to adults while the Brattleboro Retreat provides inpatient services to adults, children and youth requiring psychiatric hospitalization.

UVM Medical Center, Burlington (28 beds)
Vermont Psychiatric Hospital, Berlin (25 beds)
Central Vermont Medical Center, Berlin (14 beds)
Rutland Regional Medical Center, Rutland (21 beds)
Windham Center at Springfield Hospital (10 beds)
Brattleboro Retreat, (89 adult beds, 30 youth beds)
VA Medical Center, White River Junction (12 beds) (serving veterans only)

Community Mental Health Services

The Department of Mental Health designates one Designated Agency (DA) in each geographic region of the state to provide the Department's mental health programs for adults and children.
Designated Agencies are private, non-profit service providers that are responsible for ensuring needed services are available through program delivery, local planning, service coordination, and monitoring outcomes within their region (shown on the attached map).
https://mentalhealth.vermont.gov/

Developmental Disabilities Services

There are 15 private non-profit developmental disabilities services providers in Vermont, contracted by Department of Aging and Independent Living (DAIL), who offer a variety of services to people with developmental disabilities. Supports include service coordination/case management, home supports, employment services, community supports, family and respite supports, clinical intervention and crisis services. Ten DAs provide services primarily within a defined MH Catchment Area as shown on the attached map. There are five additional Specialized Service Agencies (SSA) are separate entities also contracted by DAIL that provide developmental services in multiple regions.

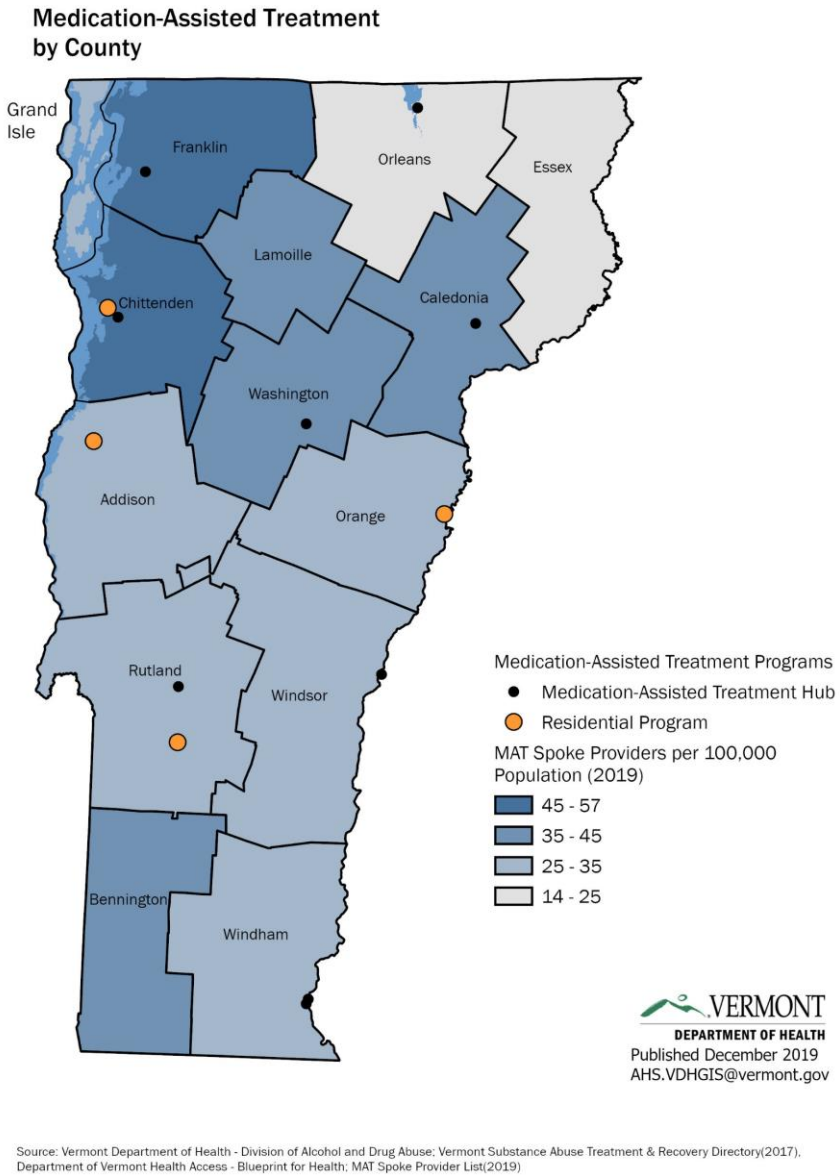
https://dail.vermont.gov/services/programs

Mental Health Workforce

The MH workforce includes Psychiatrists, Social Workers, Psychologists, MH Counselors and Marriage and Family Therapists and other provider types. Psychiatrists are physicians that focus on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders and are an essential part of the mental health care workforce.

On the MH map, we show distribution of practicing Psychiatrists full-time equivalents (FTEs) per 100,000 Vermonters. Statewide, 89.2% of psychiatrists report accepting new patients in 2016, and 12.9% plan to reduce their hours within the next 12 months and 5.9% reported plans to retire.

Data source: https://www.healthvermont.gov/sites/default/files/documents/pdf/psychiatrist16.pdf



Source: Vermont Department of Health - Division of Alcohol and Drug Abuse; Vermont Substance Abuse Treatment & Recovery Directory(2017), Department of Vermont Health Access - Blueprint for Health; MAT Spoke Provider List(2019)

Medication Assisted Treatment (MAT) Hubs by County

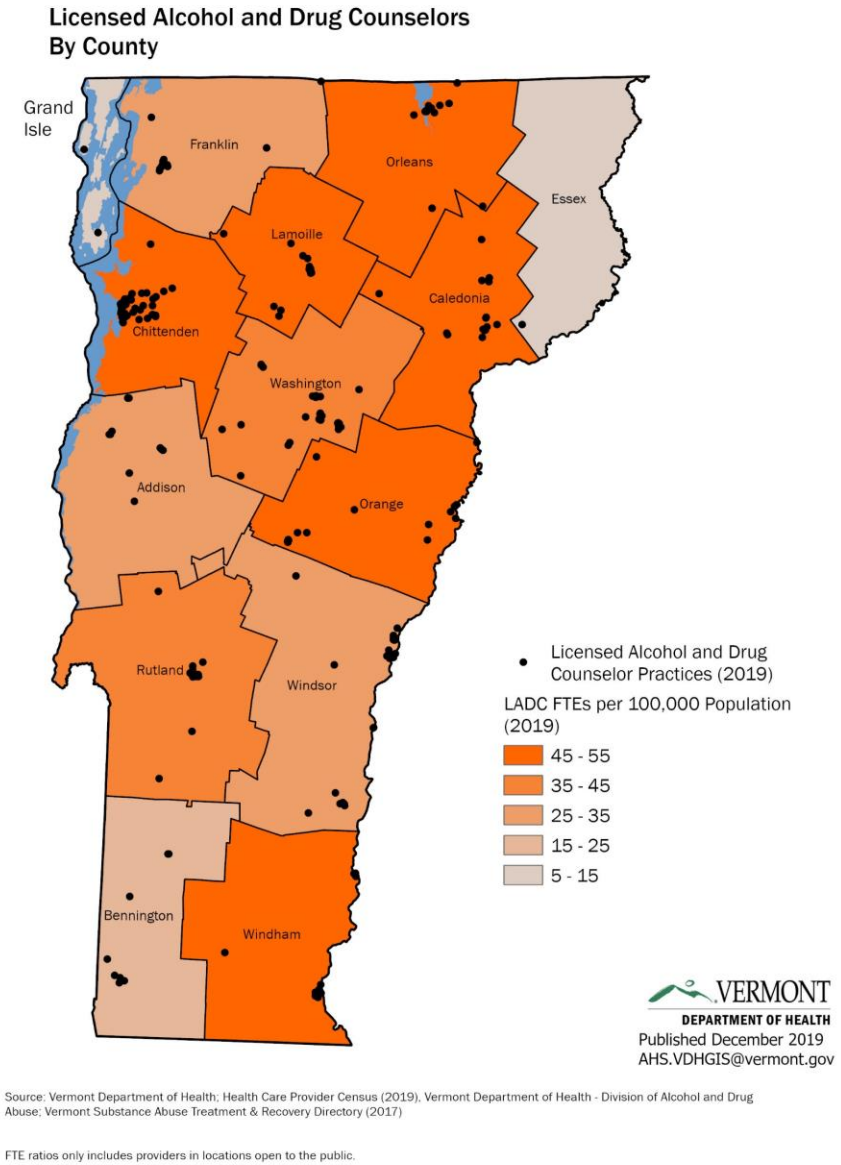
The Hub & Spoke System of Care provides medication assisted treatment (MAT) and counseling to Vermonters addicted to opioids, such as prescription opioids or heroin. Opioid Treatment Programs (OTPs) or "hubs" provide high intensity treatment with methadone, buprenorphine or naltrexone. "Spokes" are medical practices, such as primary care practices, which provide treatment with buprenorphine or naltrexone.

The attached map shows locations of OTP hubs, residential programs (treating opioid and other addictions) and the relative distribution of practices that provide MAT within each county.

Residential Programs offer counseling and group services while living at a treatment center from several days to a few weeks. Outpatient Programs provide assessment and counseling services while living at home. This may include meeting with a counselor one-on-one or going to a group meeting one or two times a week. Intensive Outpatient Programs usually last for about 2-3 hours a day, 3 days a week, for several weeks while you live at home.

Recovery Centers provide peer supports, substance-free recreation activities, volunteer opportunities and community education and recovery supporting services such as Alcoholics Anonymous or Narcotics Anonymous meetings. Recovery Centers are available in many communities in Vermont but are not plotted here.

Data sources:
https://www.healthvermont.gov/alcohol-drug-abuse/programs-services/treatment-options



Licensed Alcohol and Drug Counselors (LADCs) by County

Licensed Alcohol and Drug Abuse Counselors (LADCs) use psychotherapy, along with other methods, to assist an individual or groups of individuals understand alcohol and drug abuse dependency problems and define goals and plan actions reflecting the individuals' interests, abilities, and needs. To be licensed in Vermont, LADCs must have completed a master's degree in a human services field or a health care profession and 300 hours of substance abuse education, have two years (at least 2000 hours) of supervised practice, and pass an exam. Vermont also regulates Certified Alcohol and Drug Abuse Counselors and Apprentice Addiction Professionals who have lesser education and supervised practice hour standards.

Workforce

493 Licensed Alcohol and Drug Abuse Counselors (LADCs) renewed their licenses during the census period during 2019. Of the 493 respondents, 424 (86.0%) indicated that they were active and providing direct patient care in Vermont as Licensed Alcohol and Drug Abuse Counselors. Of the 69 respondents currently reporting a non-active status, 28 (40.6%) indicated they planned to start providing direct patient care in Vermont within the next 12 months.

Many LADCs maintained more than one mental health care license or roster position. 168 were mental health counselors, 85 were clinical social workers, 16 were psychologists. 7 were non-licensed non-certified rostered psychotherapists, 4 were marriage and family therapists and 2 were nurse practitioners.

Client population served by 493 LADCs:

- 41.5% (176) of counselors served youth age 4-17.
- 95.3% (404) of counselors served adults age 18-64.
- 55.7% (236) of counselors served older adults 65 and older.
- 36.8% (156) of counselors served military populations.
- 76.8%* (318) of counselors participated in counseling patients receiving medically assisted treatment. *Missing data for 10 individuals.

The most common setting for LADCs was private practice [36.8%], followed by substance use disorder clinics [11.6%] and community health centers [10.6%].

Data source: https://www.healthvermont.gov/sites/default/files/documents/pdf/HS_Stats_LADC19_report.pdf

Primary Care Practices by Rational Service Area (including FQHCs, RHCs, PPNNEs, Free clinics)

The following two maps show locations of over 225 primary care practices identified by health care providers in our bi-annual workforce censuses. These practices represent about 55 Federally Qualified Health Centers (FQHCs) in all 14 counties; nine Rural Health Clinics (RHCs) located in Newport, Barton, St. Johnsbury, Lyndonville and Townsend and 12 Planned Parenthood Health Centers. The balance of PC practices are owned by a hospital or an independent solo or group practice. There are also six free clinics operating full- or part-time in Rutland, Barre, Brattleboro, White River Jct., Bennington and Middlebury staffed by volunteer health care providers. While many practices offer sliding fee scales to their patients, Safety Net providers like FQHCs, RHCs, PPNNE centers and Free Clinics are required to provide care regardless of their patient's insurance status or ability to pay.

The primary care medical workforce includes physicians, nurse practitioners and physician assistants.
The data shown on this map represents the distribution of a total of 1,054 primary care practitioners, representing a total of 758.5 full-time equivalents (FTEs). Vermont's 38 Rational Service Areas (RSAs) represent the general care seeking patterns of Vermonters for primary care.

While federal shortage designations for primary care are based only on physician FTEs, this combined map represents the relative distribution of all primary care practitioners in Vermont regions, including: 615 Physicians (435.9 FTEs) in 2018; 328 Advance Practice Registered Nurses (235.5 FTEs) in 2017; and 111 Physician Assistants (87.1 FTEs) in 2018.

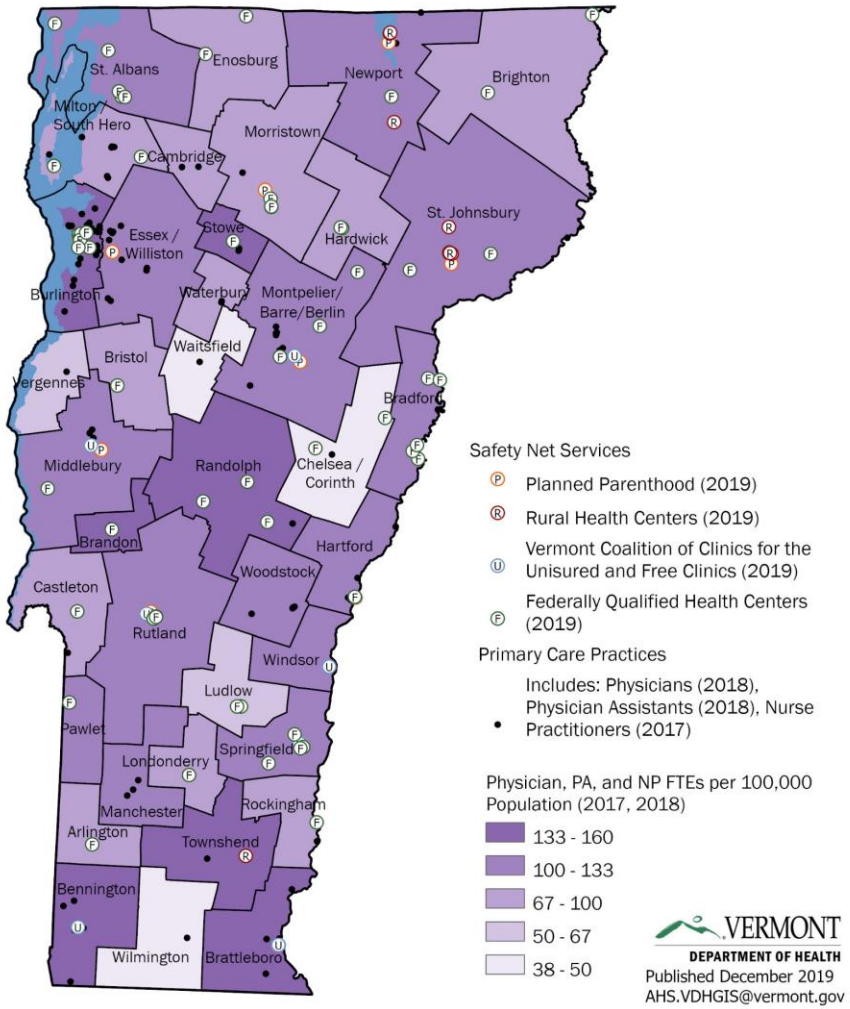
Vermont's primary care workforce is aging, along with our population. In 7 of 14 counties, at least 41% of the primary care physicians were over age 60. In 2018, 15% of primary care physicians reported plans to retire or reduce hours in Vermont within 12 Months. Physicians are highly concentrated in Chittenden County (142.5 FTEs); Essex County has 1.3 FTEs, Grand Isle County had 1.9 FTEs. In addition, some primary care physicians are not accepting new patients, especially internists (53-58%), Family Practice (75-80%). Counties with fewer PC physicians accepting new patients are Essex, Chittenden, Bennington & Caledonia (59-79%).

Advanced Practice Nurse Practitioners (APRNs) include Nurse Practitioners and Certified Nurse Midwives and make up an increasingly important part of the primary care workforce. Since 2015, APRNs in primary care increased from 276 to 328, and APRNs younger than 40 increased from 110 in 2015 to 170 in 2017, and the percent of APRNs over age 60 decreased from 31% to 27%.

In 2018, 111 Physician Assistants (PAs) worked in primary care representing (87.1 FTEs). Most PAs work in Health Clinics/Centers, Single Specialty Group and Hospital Outpatient settings.

Data source:
https://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/health-care-workforce

Primary Care Practices by Rational Service Area



Safety Net Services

- Planned Parenthood (2019)
- Rural Health Centers (2019)
- Vermont Coalition of Clinics for the Unisured and Free Clinics (2019)
- Federally Qualified Health Centers (2019)

Primary Care Practices

- Includes: Physicians (2018), Physician Assistants (2018), Nurse Practitioners (2017)

Physician, PA, and NP FTEs per 100,000 Population (2017, 2018)

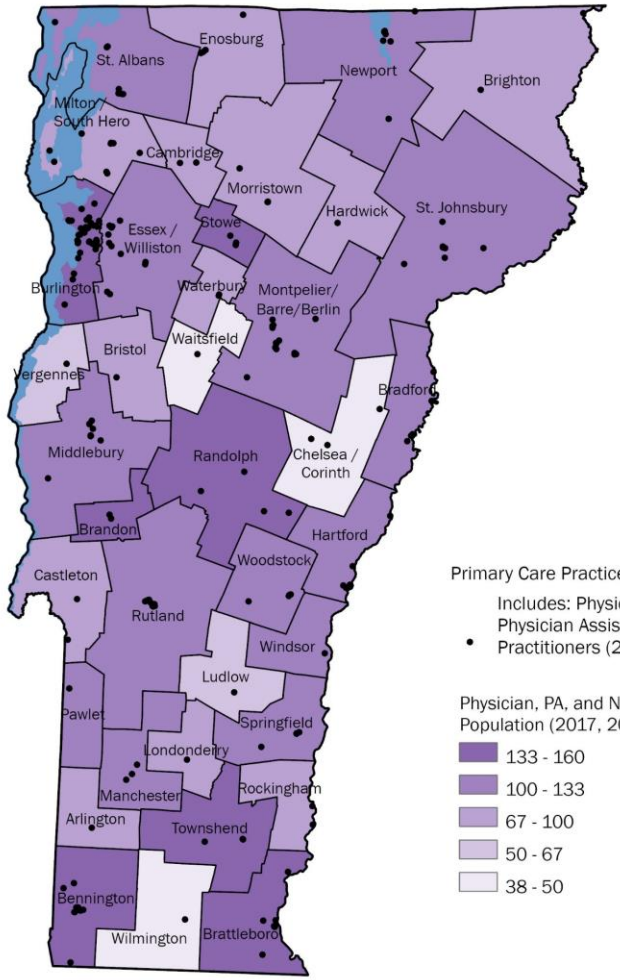
- 133 - 160
- 100 - 133
- 67 - 100
- 50 - 67
- 38 - 50

VERMONT DEPARTMENT OF HEALTH
Published December 2019
AHS.VDHGIS@vermont.gov

Source: Vermont Department of Health; Health Care Provider Census (2017, 2018), BiState Association; Safety Net Provider List (2019)

Rational Service Areas (RSAs) are designed based on where people receive primary care and where they live, as determined from data from Medicare, Medicaid and the Vermont Behavioral Risk Factor Surveillance System.
FTE ratios only includes providers in locations
open to the public. Facilities that do not offer outpatient services, do not offer on-site services, or are urgent care clinics are excluded. Locum tenens providers are excluded. Locations include independent practices, hospital owned practices, and group practices.

Primary Care Practices by Rational Service Area



Primary Care Practices

- Includes: Physicians (2018), Physician Assistants (2018), Nurse Practitioners (2017)

Physician, PA, and NP FTEs per 100,000 Population (2017, 2018)

- 133 - 160
- 100 - 133
- 67 - 100
- 50 - 67
- 38 - 50

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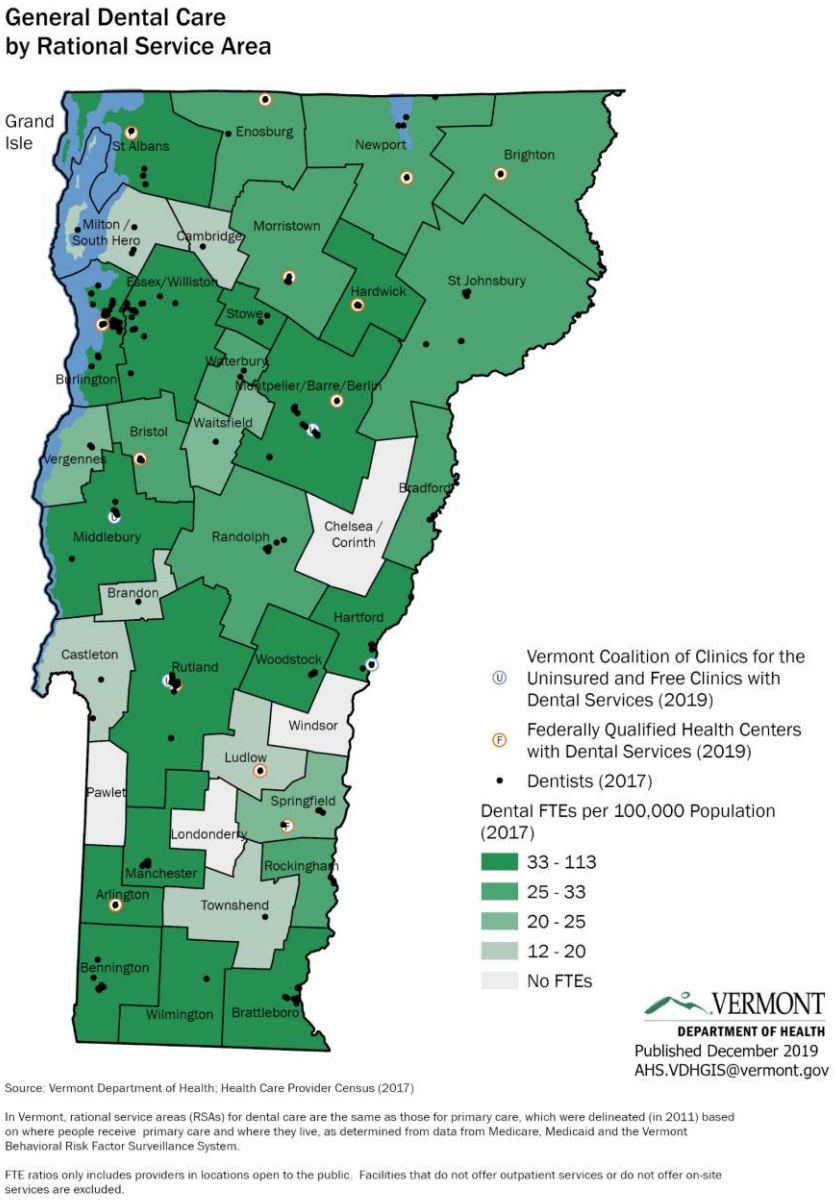
Source: Vermont Department of Health; Health Care Provider Census (2017, 2018), BiState Association; Safety Net Provider List (2019)

Rational Service Areas (RSAs) are designed based on where people receive primary care and where they live, as determined from data from Medicare, Medicaid and the Vermont Behavioral Risk Factor Surveillance System.
FTE ratios only includes providers in locations
open to the public. Facilities that do not offer outpatient services, do not offer on-site services, or are urgent care clinics are excluded. Locum tenens providers are excluded. Locations include independent practices, hospital owned practices, and group practices.



General Dental Practices (2017) by Rational Service Area (RSA)

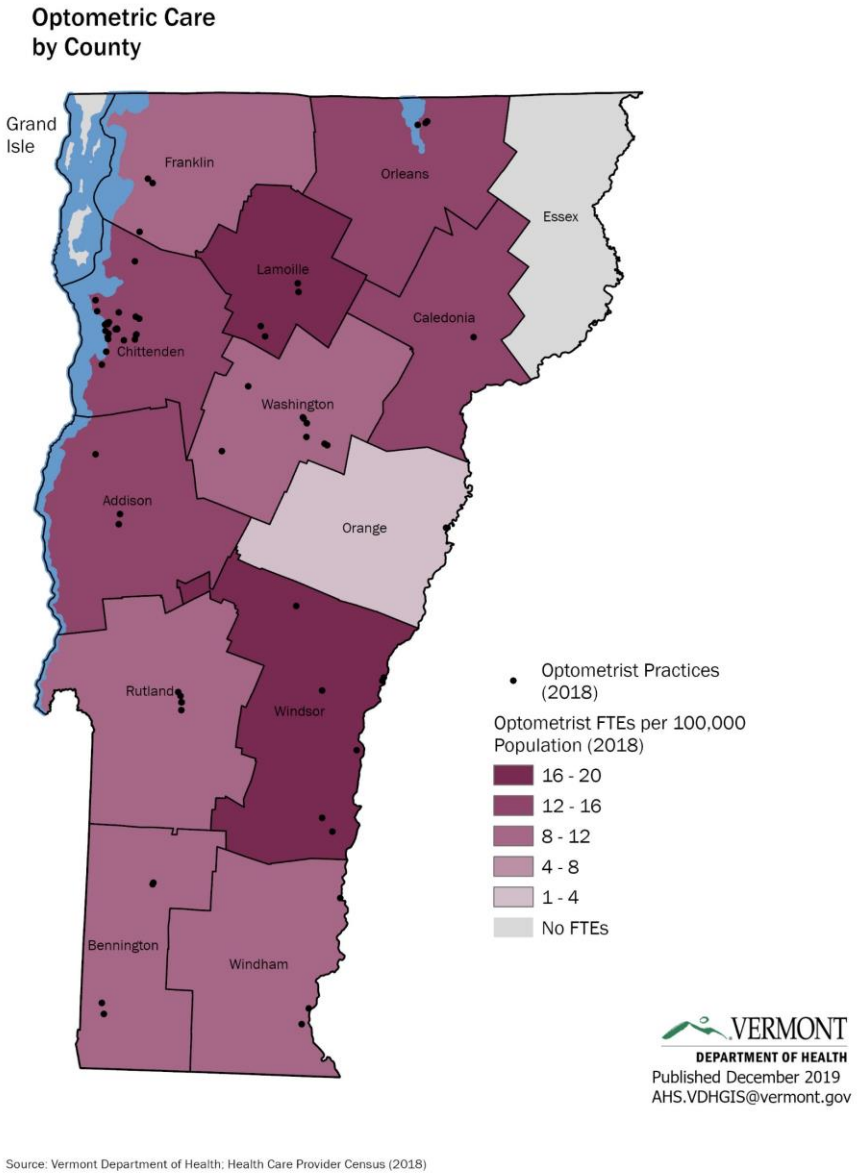
This map shows locations of independent dental practices as well as FQHCs and Free Clinic dental practices and the distribution of general dental FTEs among 38 Rational Service Areas (RSAs). Rational Service Areas (RSAs) for primary care are groupings of towns that reflect primary care seeking patterns for Medicare and Medicaid beneficiaries determined in 2001. These same 38 RSA boundaries were applied to dental care in 2011.

Of the 381 dentists working in Vermont, 82% are primary care dentists, including 299 general dentists and 14 pediatric dentists. Most dentists (67%) practiced at single site privately owned clinics, 20% practiced at multi-site privately owned clinics, 8% practiced at FQHCs and 1% at hospital-owned clinics.

The dental workforce is aging along with other providers. 35% of dentists are 60 or older, 2.9% of dentists plan to retire or leave Vermont practice in the next year, and 3.7% plan to decrease their hours. In Rutland County, 58% of the primary care dentists are 60 or older; 100% in Grand Isle County.

While average wait time to primary care dental appointments has decreased from 2.6 to 2.0 weeks, statewide, 31% of primary care FTEs and 46% of specialist FTEs are in Chittenden County. However, the percentage of dentists accepting new Medicaid patients has declined since 2015. In 2017 only 60% reported accepting new Medicaid patients, and only 33% accept 5+ new Medicaid patients / month.

Data source:
https://www.healthvermont.gov/sites/default/files/documents/pdf/DDS17ppt.pdf



Source: Vermont Department of Health; Health Care Provider Census (2018)

Optometric Care by County

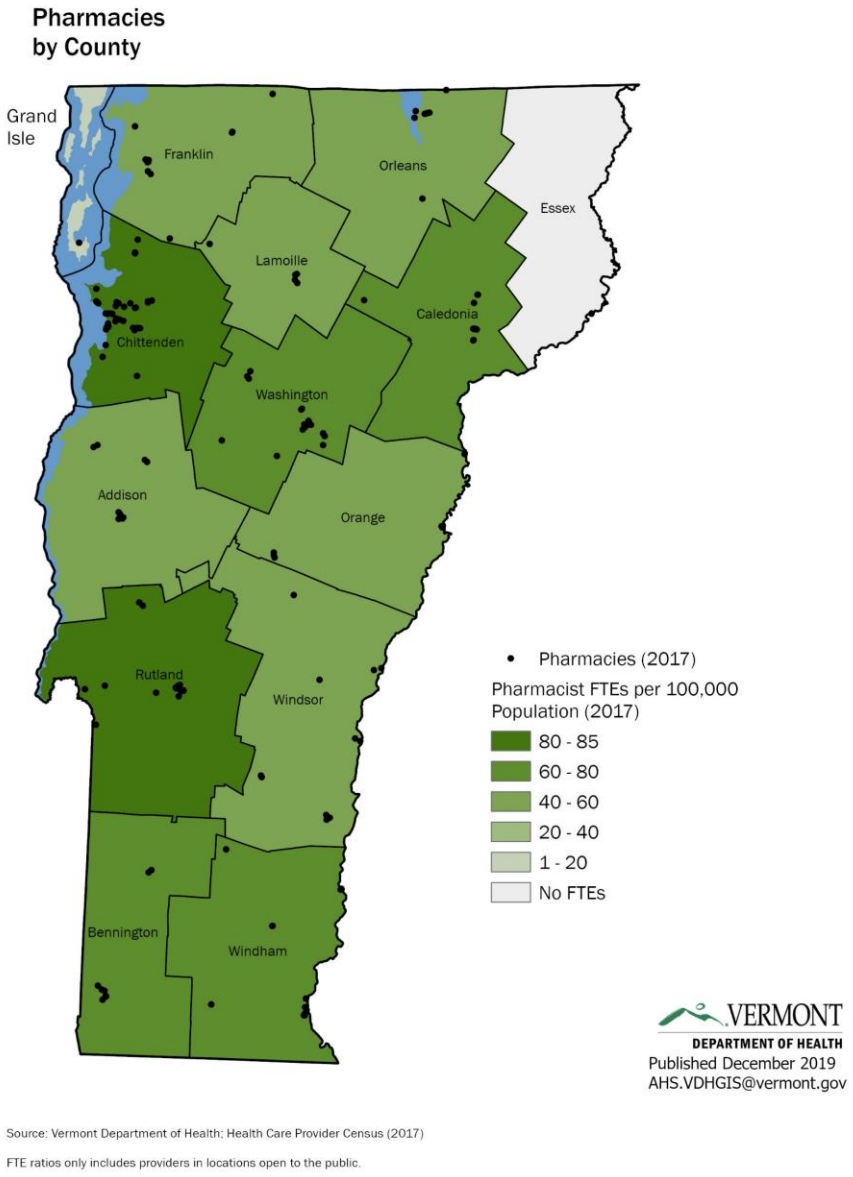
An optometrist is an eye doctor who has earned the Doctor of Optometry (OD) degree. Optometrists examine eyes for both vision and health problems, and correct refractive errors by prescribing eyeglasses and contact lenses. Optometrists diagnose and treat some eye diseases with pharmaceutical agents.

In 2018, 107 optometrists renewed their Vermont license. 96 (90%) indicated that they were active and providing direct patient care (82.4 FTEs) in Vermont, and 36 (38%) worked 40 hours or more per week at their main work site, and 49 (51%) worked 40 hours or more per week at all their work sites combined. For optometrists' main practice location, the most common settings were private group practice (44%) and private solo practice (42%).

32 optometrists (34% of total FTEs) were age 60 and older, 84% accepted Medicaid patients (at their main practice site), 91% accepted Medicare patients (at their main practice site).

Optometrists are unevenly spread around the state but are not over-concentrated in Chittenden County. Lamoille County and Windsor Counties have the highest ratio of FTE: population.

Data source:
https://www.healthvermont.gov/sites/default/files/documents/pdf/optometrists_2018_report.pdf



Pharmacies by County

Pharmacists are important parts of the health care workforce and delivery system. By statute in Vermont the practice of pharmacy includes: the interpretation and evaluation of prescription orders; drug compounding, dispensing, and labeling; participation in drug selection and drug utilization reviews; proper and safe storage of drugs and the maintenance of their proper records; advising on the therapeutic values, content, hazards, and use of drugs; providing patient care within the pharmacist's authorized scope of practice; optimizing of drug therapy through the practice of clinical pharmacy; and offering and performing the acts, services, operations, and transactions necessary in the conduct, operation, management, and control of a pharmacy.

Workforce

In 2017, 1,055 pharmacists renewed their licenses and 609 (57.9%) indicated that they were active practicing pharmacists in Vermont. Of those, 63.1% (384) of pharmacists worked in a retail setting, while 25.6% (156) worked in a hospital. Another 61 non-active pharmacists indicated they were planning to start working as a pharmacist in Vermont within the next 12 months.

Since 2015, there was an increase in number of pharmacists and FTEs: 609 pharmacists compared to 552, and 475.7 FTEs increased from 457.1 FTEs. There was also an increase in the percentage of pharmacists under 35: 32.7% up from 30.1% in 2015 and the median age decreased from 43 to 42.

Half of pharmacists 50.9% (310) worked 40 or more hours per week at their main site, and only 120 pharmacists (16.1% of total FTEs), were age 60 and older.

The highest ratio of pharmacist FTEs to 100,000 population was in the Burlington Health Care Area, followed by Rutland and Bennington. Randolph and Upper Valley had the lowest FTE ratios, and there are no pharmacies in Essex County or Grand Isle County.

Data source:
https://www.healthvermont.gov/sites/default/files/documents/pdf/Pharm2017.pdf

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For additional references on the workforce section of this report, please see the Rural Health Task Force Workforce Subcommittee Report posted on the following webpage: https://gmcboard.vermont.gov/content/rural-health-services-task-force

Public Comments

Public Comment Summary

- The Vermont Futures Project's recommendations on workforce align with many of the Task Forces' recommendations. The Project emphasized the importance of innovation and entrepreneurship, specifically: Establish a private sector center to boost innovations around the key Vermont sector strength of healthcare services for rural and aging in place populations. Focus on in-home support and healthcare for the aging in place Vermont population. The center will conduct cutting edge research to develop Intellectual Property and spin off new businesses to monetize the opportunities. Due to limited resources we recommend partnerships with existing groups such as the MIT and Hartford CT centers for aging support.
- The Task Force received one consumer comment on overall themes and content.
- The following organizations provided technical and clarifying comments:
  - Vermont Association of Hospitals and Health Systems (VAHHS)
  - The Vermont Program for Quality in Health Care, Inc. (VPQHC)

The Task Force received public input at every meeting. Comments from the Vermont Medical Society, Health First and Bi-State Primary Care were provided through the Task Force member representing the relevant health sector.

Full text of public comments is available on the Rural Health Services Task Force website.