Vermont Health Policy

Perspectives

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Vermont Association of Hospitals and Health Systems • 148 Main Street • Montpelier, Vermont 05602 • 802-223-3461

President's Message: The Potential of Alignment

Over the past six months, three major health care reform efforts have begun: Act 53 "An Act Relating to Hospital and Health Care System Accountability, Capital Spending and Annual Budgets," The Vermont Blueprint for Health, and the Vermont Association of Hospitals and Health Systems (VAHHS) Stock Farm Group. Others, such as mental health care reform are also underway. If successful, all of these efforts will improve the delivery of health care services. However, their success depends in large part on their ability to persevere, remain focused and most importantly, stay aligned with each other. Fortunately, the alignment has already begun to take shape, but the hard work is just beginning.

Last year, the legislature enacted Act 53. In addition to changing the Certificate of Need and Hospital Budget laws, Act 53 put the Banking Insurance Securities and Health Care Administration (BISHCA) and the Vermont Department of Health (VDH) in charge of reviving a better coordinated statewide planning process. This process, while squeezed into a nearly impossible time-frame, will evaluate our health care system and provide recommendations on improving the balance between available resources and needed services. The process will produce a report now known as the Health Resource Allocation Plan (HRAP). The HRAP will be used to guide future Certificate of Need decisions and hopefully provide strategic direction for changes in services, workforce and investment (such as information technology).

At the last meeting of the HRAP Advisory committee, this 13 member board took a bold step. The HRAP Advisory Committee proposed the adoption of the reform aims of the Institute of Medicine (IOM) as an overall framework for their reform principles. The Institute for Healthcare Improvement (IHI) shortens these aims into a "no needless" credo. However they're phrased, they seek to significantly improve the reliability and quality of health care in Vermont by aiming for:

- **No needless deaths**
- **No needless pain**
- **No helplessness**
- **No unwanted waiting**
- **No waste**

The HRAP Advisory Committee took this important step in part to align with the Vermont Blueprint for Health, VAHHS, the Vermont Medical Society, and more recently, the Vermont Business Roundtable, all which have adopted the IOM/IHI aims. Making change in health care is hard enough. It would be impossible with all the stakeholders working out of sync. Creating this tangible, "black and white" alignment of our collective vision is an important first step in building and maintaining collaboration and alignment among public and private stakeholders.

Aligning where we want to end up is one thing – aligning *how* we get there is quite another. The Vermont Blueprint for Health and the VAHHS Stock Farm Group are currently grappling with this critically important challenge. As background, the "Blueprint" is the Governor's plan to help our delivery system change from an acute care to a chronic care system - a system that is pro-active, patient-centered and seamless. The Blueprint steering committee consists of leaders from all the key stakeholders: the Vermont Medical Society, all of the health insurance plans, the Vermont Program for Quality in Health Care (VPQHC), VAHHS, nursing and Medicaid. The VAHHS Stock Farm Group (SFG) is a hospital reform committee consisting of four hospital CEOs, two VAHHS staff and two senior hospital staff. The SFG has produced an outline of broad-based reform initiatives recently endorsed by the VAHHS board. A key SFG reform initiative is to align with the Vermont Blueprint for Health, but how will that alignment take place?

Two top priorities for aligned effort will include coordination to improve diabetes care and development of an information technology plan that promotes "system-ness" and thereby reduces waste and improves the continuity and quality of

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PATIENT CARE: VERMONT HOSPITALS TEAM UP TO IMPROVE QUALITY

National studies show that the quality of care patients receive in Vermont hospitals is among the highest in the country. Determined to keep quality high and to continue to improve the care their hospitals provide, quality professionals from Vermont hospitals meet regularly in a collaborative forum convened by VAHHS in partnership with the Northeast Health Care Quality Foundation (NHCQF). At a recent meeting of the Hospital Quality Improvement Group, Jill Olson, Vice President of Continuing Care and Quality at VAHHS, interviewed Lawrence Ramunno, MD, MPH, CDE. Ramunno is the Chief Quality Officer for NHCQF.

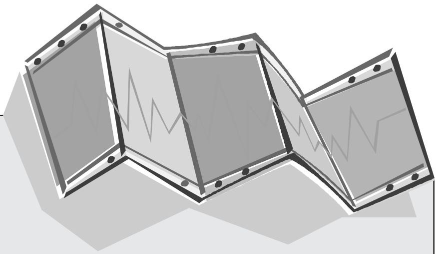
Olson: So what were the hospitals doing here today?
Ramunno: Through mutual voluntary agreement, hospitals have been working over the last year to share information about the work and quality in their institutions. The Vermont Association of Hospitals and Health Systems and our organization [the Northeast Health Care Quality Foundation] jointly decided to focus on the current Centers for Medicare/Medicaid Services Quality indicators, which are used also by the Joint Commission and the National Quality Forum, so everybody can focus on one set of topics. These quality measures are focused on very common conditions that patients who go to hospitals experience, such as pneumonia or heart failure.

Olson: Can you give me an example of what some of the measures are?
Ramunno: Yes. In a simple case, if you're talking about heart failure, we look at a broad range of issues, from "has the patient had sophisticated testing, like assessment of their heart function and appropriate medications to treat it?" to "did they get adequate instructions when they were discharged to manage their care at home?" The measures also include things like whether the patient got appropriate protective antibiotics for infection before surgery or whether they got appropriate antibiotics for protection or treatment of pneumonia.

Olson: How do we know that these are the things that make a difference?
Ramunno: These measures have been developed over a long period of time through national consensus, looking at the available studies on these topics about what treatments make a difference – for example, what timing of delivery of antibiotics makes a difference.

Olson: So, if patients get the treatment outlined in those measures, they are more likely to do better when they leave the hospital?
Ramunno: Right. They're more likely to survive their stay, and they're more likely to go home in better shape and prolong both their long-term survival and also their function and ability to carry on with the activities of daily life.

Olson: The hospitals have all voluntarily agreed to participate in this quality initiative, and they're also voluntarily reporting some of their data?
Ramunno: That's correct. They've voluntarily, and I have to say enthusiastically, participated in this initiative. They clearly are expending a lot of intellectual capital and trying to improve, and even today we heard about some wonderful breakthroughs in improving their processes. Additionally, every Vermont hospital has agreed to participate in the American Hospital Association Voluntary Reporting



Vermont hospitals are all participating in a national, voluntary effort to report quality data that will be made available to the public. The quality indicators being tracked as part of this project have been identified by the Centers for Medicare/Medicaid Services as important to improving patient outcomes. The indicators are:

AMI (HEART ATTACK)

- Aspirin at arrival
- Aspirin at discharge
- Beta-Blocker at arrival
- Beta-Blocker at discharge
- ACE Inhibitor for left ventricular systolic disfunction (LVSD)

HEART FAILURE

- Left ventricular function assessment
- ACE Inhibitor for LVSD

PNEUMONIA

- Initial antibiotic timing
- Pneumococcal vaccination
- Oxygenation assessment

Initiative. They're submitting a subset of these measures to be publicly reported. The challenge, of course, is that the data of many Vermont hospitals will never get displayed. There's a volume cutoff for national reporting of 25 cases per measure, and despite the fact that they're submitting the data, many Vermont hospitals won't have enough patients qualified for those measures, even over a year.

Olson: Have the hospitals been willing to share information with each other?
Ramunno: Oh, readily. Today, for example, for three hours they talked about what they've done; what's worked; what didn't; what barriers they have; what they've tried and failed at; what they've tried and succeeded at. At each meeting, the discussions have become more involved, more detailed and more open, which is wonderful.

Olson: And what's the role of the CEO and the hospital boards in this work?
Ramunno: Well, we think it's incredibly important. Both VAHHS and the Northeast Health Care Quality Foundation have spoken directly with each of the hospital CEOs about the nuts and bolts of this project. Today we saw impact of that, with a number of institutions reporting engagement of the CEO in the process at the highest levels.

Olson: Other hospitals in other parts of the country must be working on improving quality measures. How is Vermont doing compared to those other hospitals?
Ramunno: With available information that we have so far, remembering that Vermont was already ranked second, for example, for heart attack care, Vermont's improvement is already among the top in the country. Vermont's advantage is that they're starting out front, and they can take advantage of collaborating with a small number of providers. Clearly, we couldn't have an intimate setting of 50 people in a room and cover all the hospitals for, say, Pennsylvania or Texas. But in Vermont, we can get everybody there and really have discussion.

Olson: Suppose a hospital is measuring one of the indicators and they come up with a number that falls short of the goal. What can they do? Is there a process that goes into place to get the hospital to look at what's happened and try to understand it in order to improve?
Ramunno: One of the things that we're trying to help hospitals understand is if they've not delivered a medicine, for example, that should have been delivered to a given patient, it's not a person's fault. Someone didn't fail. The system that they've put together has failed, so let's first understand the system and then either create a better system or repair the system that they have to make sure that every subsequent patient gets that care.

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patient care. Diabetes is a natural place to begin because VPQHC has already laid a foundation with its Diabetes Collaborative under IHI's guidance.

A sample of related challenges includes:

- Bringing Medicare "to the table," since Medicare is by far the largest payer for patients receiving preventive, acute and tertiary care services related to their life-time condition.
- Providing primary care physicians in offices, outpatient departments and free-standing clinics with the appropriate support and incentives to undertake the requisite changes and investments needed to re-design their care models, collect patient data and use new technology – all part of creating a chronic care system.
- Aligning the insurance plans so that they – and Medicaid – offer a coordinated set of incentives and proposed changes to physicians.
- Changing hospital clinical and data-collection practices to improve the delivery and coordination of diabetic care among settings.
- Identifying the various provider and state priorities, next steps, investment needs and barriers toward creating a statewide information technology plan.

The alignment process doesn't end there. It also includes more day-to-day issues such as: creating enough meeting time to coordinate plans and efforts, communicating our progress and plans clearly, ensuring that strategies make economic and operational sense for all those involved, and keeping everyone – from the clinical leaders to the CEO – engaged, committed and moving in an aligned direction. On a broader scale, making systemic improvements in health care will also require specific alignment with current payment methods, regulatory rules, legislative health care priorities, provider changes and consumer expectations.

Rome wasn't built in a day. To date, reforming our health care system has been like trying to create an orchestral symphony without sheet music or a conductor. By aligning our aims, strategies, and day-to-day efforts, health care leaders – particularly through the Vermont Blueprint – can create a reform process that composes "system-ness" step by step. It will take hard work, perseverance, unfailing focus and of course, alignment.

LEGISLATIVE OVERVIEW: MID SESSION REPORT

Since returning from Town Meeting recess, the Vermont General Assembly has made progress on the "must pass" bills of the session. The House passed the FY05 Budget Bill, a $41 million Capital Construction Bill and a Transportation Capital Bill authorizing about $350 million in transportation fund spending, paving the way for final adjournment by late May. But the fate of other high profile bills, such as permit reform, agricultural issues, health care reform, and the governor's so called "tax equity proposal" – revising the way capital gains are taxed and redistributing the resulting additional state tax revenue to other taxpayers – remain uncertain at this time. A bill to reform the workers' compensation system to control escalating insurance rates, including imposing a fee schedule on hospitals, is one bill that appears likely to be enacted into law this year as it passed the House and is before the Senate at this time.

Meanwhile, several important health care issues will continue to receive attention this session. The last few weeks of the session will see significant discussion, but uncertain action, on a Senate-passed bill designed to control prescription drug costs, the Governor's proposal to begin reforming the health insurance market by making it more attractive for commercial insurance carriers to do business in the hard-to-serve individual and small group markets in Vermont, a bill related to advance directives and pain management, and a bill that provides whistleblower protections for hospital workers. The House is also exploring what action can be taken to reform Vermont's mental health system as a result of the problems at the Vermont State Hospital, but it is unclear at this time what will come out of this discussion.

The possibility of gridlock on some of the major issues facing the General Assembly this session is real as both parties jockey for position for the upcoming fall elections. The political challenge at this time is for lawmakers to put aside politics and see if common ground can be found on key issues.

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