Opportunities for Improved Health Service Delivery
Healthcare Commission Ideas for Governor Freudenthal
June 29, 2005

Develop a Healthcare Delivery System Plan to Meet Wyoming Citizens' Needs

1) What is the problem?

a) Wyoming does not have complete/accurate data on the number of health care providers in the state. Efforts to quantify the current Wyoming health care workforce have not met expectations. A new effort to create a provider database by the Health Professional Tracking System is underway, but the data *must* be used strategically if it is to make an impact—gathering it alone will not change anything.

b) Some areas of the state do not have appropriate access to healthcare services, physicians, nurses, and other providers. Wyoming ranks 47th out of 50 states in physician to population ratio.[1] The federal government has designated significant portions of the state as Health Professional Shortage Areas for both primary medical care and mental health services.

c) Regardless of federal designation, there are many areas of the state where a lack of primary care, acute and/or preventive services results in Wyoming citizens not being able to access the right care at the right place and time. This leads to a failure to receive services or the possibility of receiving inappropriate services.

d) The Wyoming health care system is a cottage industry dealing with ever more complex, highly specialized care. Because of technology advances and demographic trends, complexity will increase over the next decade

2) Describe your ideas.

a) Wyoming should expand data collection and analysis to understand current health resources and project future needs.

b) Using this data, Wyoming will have the tools to consider a range of options to respond quantitatively and objectively to healthcare work force, facility and equipment needs.

c) The outcome of a state health resource planning process would be identification and development of a delivery system that provides the *right care* at the *right place*. It is anticipated that the process will result in a reallocation and more creative need-responsive use of existing resources. For example, many of Wyoming's counties have Critical Access hospitals with federal staffing requirements. Could these facilities use that mandated staffing to provide off-peak primary care or immunization clinics?

d) The analysis and resulting recommendations should be presented in a State *Health Work Force and Delivery System Plan* that creates a blueprint for access to a continuum of affordable, quality, coordinated health care services. This plan should be updated every 4 years as the economy, demographics and delivery system changes.

e) Data collection and publication should be supervised by an independent Wyoming agency envisioned to function with the autonomy of a "Federal Reserve Board"- type entity for healthcare.

3) Who are your partners?

The following stakeholders will provide data, describe the current state of their local health delivery systems, help determine solutions, and create coalitions to address issues.

a) Public health departments
b) Hospitals/hospital association
c) Physicians, nurses and other professionals
d) Professional societies
e) Professional licensing boards
f) Professionals in other states
g) Health insurers
h) Health and medical education programs

   i) University of Wyoming College of Health Sciences
   ii) Community Colleges
i) Center for Rural Health Research and Education "Wyoming Health Scout"
j) Wyoming Department of Health
k) Wyoming Health Resources Network
l) Health Professional Tracking System
m) Employers
n) The public

4) Please provide supporting evidence and data for the proposal

a) Washington, Maryland, West Virginia and Maine have state health planning processes focused on improving the organization and cost-effectiveness of the health care delivery system. Successes cited by officials in these states include:
   i) Building movement around reform[2]
   ii) Community collaboration[3]
   iii) Significant gains in reducing tobacco consumption and improving diabetes care[3]
   iv) Recognition that health resource decision-making should be driven by data[4]

b) Each of these states has concluded that reliable data about the current workforce and facilities is critical to the process of creating rational delivery systems. However, as Wyoming has already discovered, this data is not always readily available.
   i) State of Washington began its State Health Work Force and Delivery System Planning process by identifying essential health care services and gaps in these services across their state, then engaging community partners in closing the gaps. The Washington State Board of Health (SBOH) determined that reliable local data about access to critical services do not exist. Recommendations for their 2005-2007 plan include promoting integration and availability of data across programs. The SBOH has created a website (www.assessnow.info) to provide an opportunity to present data, analysis, and studies on-line, making them accessible to local health jurisdictions and others.[3]
   ii) The Maryland Healthcare Commission relies on quantitative methodologies to forecast need, based on discussion about indicators like length of stay and discharge rates with the health care industry. This forecast is critical for dealing not only with requests for new facilities and beds, but also with closures and realignments of services. While access issues are local, the solutions can often include statewide or state-level resources. For instance, many local health departments lack data analysis and planning resources, so having this capacity at the state and providing technical assistance locally is the best way to create appropriate solutions[5].
   iii) The West Virginia Health Care Authority has recently changed the state planning process to give it a firm basis in data. Previously they started with industry stakeholders around a table; now they have committed all of their planning resources to putting available health care data into commercial software (Solucient) that will describe disease prevalence and demographics along with available health care delivery resources by health market. By law, all hospitals send claims data to the state. The outpatient care has been modeled based on state employees' outpatient claims and Medicaid data.[4] The West Virginia Health Care Authority has ensured that business and labor leaders buy into the process and are willing to make hard decisions. The business community understands that state staff can write a plan, but those same staff will change with the next administration. Business and labor leaders can have input and drive a process that spans administrations.[4]
   iv) Maine has an epidemiological study that divides the state into four regions, highlighting the specific challenges in each. In spite of the state level data gathering and analysis, communities still choose their own priority areas for collaboration, such as teen pregnancy. Across the state, an important goal of the health planning process in Maine is shifting the focus of the current delivery system from acute care to a chronic care orientation.[2] This is evidenced by the Maine Quality Forum, a state sponsored group working with a consultant to develop a request for proposal for a pilot project in the Medicaid program to demonstrate the value of the chronic care model.[2]

5) Funding/Staffing needs.

a) Other states staff this function with 2 to 6 FTEs, sharing resources from state agencies, departments, partners and consultants. Total annual budgets have ranged from 400,000 to $750,000.

b) In West Virginia, the employees supporting the current effort include 3 data analysts, who are also responsible for rate review and CON. To maximize resources, the State has partnered with the health policy think tank at the University, sharing a Research Director position with them.[4]

c) Maine has two FTEs staffing the health planning process.[2]

d) Pennsylvania spends roughly $200,000 per year on mini-grants to communities.[6]

6) Who is better off and how could you measure the improvement?

a) All Wyoming communities should experience increased access to affordable, appropriate care as a result of a state *Health Work Force and Delivery System Plan* if the process yields its intended result – a more coordinated healthcare delivery system.

b) A component of the Plan will be an ongoing monitoring of capacity in Wyoming. If the initial plan indicates shortages in some areas and excess capacity in others, the Plan will track progress toward balancing resources to need.

7) Could this proposal be included in the Children and Families Initiative?

a) The resulting delivery system should address many of the indicators included in the Children and Families Initiative.

8) Potential drawbacks and political considerations.

a) Previous efforts to quantify the health care workforce have failed.

b) The planning process may create fears among providers and the public that the state wants to create a single-payer or "socialized" medical system or a certificate of need-type program.

c) Providers may feel proprietary about their current role and may not want to shift their focus. For example, an acute care, critical access hospital may have a hard time embracing the notion that it can also play a role in preventive care.

d) We'll have to examine and perhaps significantly alter traditional reimbursement mechanisms to make some of the shifts in categories work. These current reimbursement systems cannot be roadblocks to needed change.

9) Alternative possibilities.

a) A full-blown certificate of need process.

10) How does this recommendation relate to other recommendations?

a) This issue could be studied together with the impact of physician-owned ambulatory surgery centers (ASCs) and specialty hospitals.

b) This recommendation could be carried out by the independent entity envisioned by the Wyoming Healthcare Commission to function as a Federal Reserve Board for healthcare.

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[1] "Patient Information about Medical Liability Reform," Wyoming Medical Society, April 18, 2005 http://www.wyomed.org/pli%20patient%20info.htm.

[2] Ellen Schneiter, Deputy Director, Governor's Office of Health Policy and Finance, Maine. Phone interview May 11, 2005.

[3] Joan Brewster, Director, Public Health System Planning and Development, Washing State Department of Health. Phone interview May 16, 2005.

[4] Sonia Chambers, Chair, West Virginia Health Care Authority. Phone interview May 10, 2005.

[5] Pam Barclay, Deputy Director, Health Resources, Maryland Health Care Commission. Phone interview April 27, 2005.

[6] Joseph May, e-mail June 8, 2005.