Other Critical Reforms

1. Implementing Payment Reform

Changing how Pennsylvania pays for health care is critical to improve the quality and value of care and to bend the health care cost curve. The Commonwealth is one of the largest purchasers of health care in the state. By using an integrated set of payment reforms, the state can provide leadership that will result in more collaboration among health care providers, improve primary care, reward high performing providers, more efficiently use Commonwealth resources, bend the health care curve and promote the reorganization of the health care system in Pennsylvania.

Pennsylvania should reform how health care is paid for by the state (through PEBTF, Medicaid, CHIP, adultBasic, Corrections, etc.) so that it pays providers for efficient use of resources while providing high quality care. This approach should include and be applied to both physical and behavioral health care.

- **Paying for an entire episode of care.** Paying bundled payments for certain hospital stays, including a post-discharge period of time (e.g., 30-days) encourages health care providers to collaborate, eliminate avoidable complications and provide better care. Hospitals would be encouraged to coordinate care to minimize readmissions by arranging for home health care or other step down care.

  - The 2009 Pennsylvania Hospital Performance Report found 58,084 hospital readmissions in 2009 representing 343,000 hospital days for which hospitals charged $2.6 billion. The readmission rate for 15 commonly reported conditions was 19.2%, with congestive heart failure the highest, at 27%. By providing a bundled payment, Pennsylvania would be offering hospitals, physicians, home health agencies, etc., the opportunity to share the savings from reducing readmissions, including readmissions for complications from infections (21,688 in 2009 for Pennsylvania).

- **Linking payment to performance, with performance evaluated by evidence-based process and outcome measures, patient satisfaction measures and an assessment of organizational structures known to improve quality, such as electronic health records.** To achieve more affordable, better quality health care, we must pay for the evidenced-based care and outcomes we want.

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1 The federal health care reform law establishes a pilot program to start no later than January 1, 2013, to determine the most clinically appropriate way to bundle payments for 10 specific conditions. Payment for each episode of care will cover acute hospital care, physicians’ services, outpatient hospital care, services such as home health, skilled nursing, inpatient rehabilitation, care coordination, medication reconciliation and discharge planning for three days before the hospital admission and 30 days following discharge.
Paying fee-for-service encourages unnecessary volume of care, wastes resources, and results in unacceptably wide variations in safety and quality. Payment needs to encourage the kind of care we know helps keep people healthier and rewards high quality, efficient care and effectively controls cost. Pennsylvania should work with other payers to agree on uniform performance measures where appropriate and possible, to minimize distraction and administrative difficulty for health care providers. This should include consideration of federal performance measures as the basis for agreement.

- **Sharing cost savings achieved by improved health care quality and efficiency with the providers that made the savings possible.** Pennsylvania should gradually increase the percentage of revenue potentially available to health care providers from shared savings programs. It is important to require achievement of benchmarks for health outcomes, utilization and process criteria to qualify for shared savings, to guard against inappropriately limiting necessary access to care that has adverse health outcomes. Savings from avoidable hospitalizations, readmissions and emergency department visits should be an integral part of this effort and should optimally involve as many integrated providers as possible.

- **Paying providers more for efficiently and effectively treating sicker patients.** Any payment methodology needs to be risk-adjusted to acknowledge the extra effort needed to effectively and efficiently treat sicker patients.

- **Joining with other payers in a common risk adjusted payment methodology that could include the components listed above to help drive more efficient, quality care and encourage administrative efficiency.** All-payer initiatives have the advantage of aligning all payers and participating health care providers in a shared focus to improve health care quality and bend the cost curve. Multi-payer initiatives can be a much more powerful force to reorganize how health care is delivered and paid for. Wherever possible, use of national standards such as National Quality Forum-endorsed standards, National Guideline Clearinghouse, meaningful use standards, etc., should be used.

- **Exploring the use of Population Based Payment®, which is a payment methodology which compensates healthcare practitioners for providing an agreed-upon set of services for a specific population of covered beneficiaries for a specific period of time.** Using a county or a specific set of zip codes, historical (3-5 years) claim cost experience is actuarially determined. Performance targets (Clinical and Financial) are established and a provider network is engaged. Providers participating under this payment methodology are paid on a fee-for-service basis that is reconciled against established financial targets. If both clinical and financial targets are met, providers organized via clinically integrated panels share in the savings.

- **Driving delivery system reform through innovation, collaboration, and process improvement on the front lines of care.** Payment reform should drive delivery system reform by incentivizing innovations and best practices, promoting collaboration among front-line staff and managers, and reorganizing health
care services in ways that result in process improvement and better outcomes for patients. Payment systems should take account of the well documented link between adequate nurse staffing and quality of care.

The American health care system is the poster child for underachievement. The largest limiting factor is not a lack of money, technology, information, or even people, but rather a lack of an organizing principle that can link money, people, technology and ideas into a system that delivers more cost-effective care (meaning value) than current arrangements.2

There are many ways to organize to provide better quality, less expensive care. See, for instance, the discussion of the Patient-Centered Medical Home/Chronic Care initiative below. Another method, recognized in the federal health care reform legislation3, is Accountable Care Organizations (ACOs). ACOs are an organization of health care providers that agree to be accountable for the quality, cost and overall care of its patients and meet quality performance measures and are eligible to share realized savings. Normally, health care payers cannot get together to determine what they will pay health care providers because of anti trust laws. An exception to this is if the state convenes and supervises the discussions for the public good. The next Administration can play an important role in facilitating better organization and accountability for care by:

- **Convening interested multi-payers and providers interested in initiating accountable care organizations to provide the anti-trust protection necessary for those discussions and efforts.**
- **Establishing a multi-payer claims database to provide a better understanding of health care cost drivers and to assist in identifying costs in the system that are not medically effective and permit population-based payments. A number of states have created multi-payer claims databases to support quality improvement efforts and to reduce costs. These databases use readily available claims data and provide important information on utilization and cost. Details on who could access the data and for what purposes would need to be carefully determined.**
- **Exploring how to create a value-based ranking of health care providers on quality and efficiency that can be offered to the public and to payers. Such a ranking could be a tool for payers that wish to offer reduced cost sharing for enrollees who seek care from the highest rated providers. Pennsylvania should study the experience and lessons learned from other states (especially Minnesota and the Rand critique) to determine if this would be feasible in our state.**

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3 The federal legislation establishes the Medicare Shared Savings Program that will provide financial incentives to groups of physicians, hospitals, etc. to reduce the growth of Medicare expenditures.
• Creating a commission with representation from all appropriate stakeholders to recommend the best cost and quality measures to be provided by the Exchange to assist consumers in selecting health care plans and health care providers. PHC4 provides charge information but not actual cost. PHC4 provides very little information about the quality of outpatient providers. It is critical that Pennsylvania quickly determine how to produce quality and cost data needed to assist consumers using the Exchange to make informed choices of health care plans and to use market forces to help reduce health care costs and drive quality improvement. It is also critical to minimize the data reporting burden for providers and to simplify the information for optimum consumer use.

• Examining the impact of workforce changes on both cost and quality. The subcommittee strongly urges the next Administration to immediately form a time-limited taskforce made up of all appropriate stakeholders to develop a draft strategic plan to implement payment reform in Pennsylvania to bend the cost curve and significantly improve quality.

2. Transforming Primary Care and Improving Chronic Care and Transitions of Care

Everyone needs an accessible primary health care provider who knows the patient’s medical history and who works with the patient to ensure that care is timely, coordinated, appropriate and centered on the patient’s needs. This approach to primary care is called a “patient-centered medical home”. The Pennsylvania Governor’s Office of Health Care Reform has been working with 900 primary care practitioners and all major payers (except Medicare fee-for-service) to transform primary care in Pennsylvania in those practices to patient-centered medical homes for the 1.4 million patients they serve, and to change payments for primary care to encourage the use of interdisciplinary teams, patient registries, assistance with patient self-management and embedding care coordinators in the practice. The primary care practices are participating in nine learning collaboratives across the state, attending regular training sessions, submitting monthly health process and outcome data and participating in monthly conference calls with quality improvement experts who review their monthly data. This effort has resulted in a significant increase in delivery of evidence-based care to patients with chronic conditions keeping them healthier and out of the hospital, improving their blood pressure, blood sugar, cholesterol levels and engaging patients in doing what they can to improve their care. This initiative tests the ability of primary care practices to increase the quality of care while reducing costs, by preventing chronic disease complications and resulting hospitalizations. To build on this effort, Pennsylvania should:

• Continue the the Chronic Care/Patient-Centered Medical Home Initiative. There is no question that this initiative has significantly improved process and health outcome measures. The Commonwealth Fund is funding a study by Rand to also evaluate the impact of this initiative on bending the cost curve.
If the longer term results are promising, this initiative should be spread and sustained across the state.

- **Continue to work with payers to provide enhanced reimbursement to primary care practices to embed care managers in their practices to support the highest risk patients and to improve care transitions.** Eighty percent (80%) of all health care costs are for 20% of patients who have multiple chronic conditions. These patients often unsuccessfully try to navigate a very fragmented health system with only their family helping them coordinate care in a system they don’t understand. One of the most cost-effective investments for primary care is to fund a care manager located in the practice to work with patients at highest risk for hospitalization or readmission and to assist them with care transitions.

- **Explore the concept of using the community hospital as a Primary Care Support Center.** Community hospitals stand to lose admissions as chronic disease management reduces hospitalizations and readmissions. However, in other countries, there are successful models of Primary Care Support Centers that offer services that small PCP practices cannot. For example: clinical pharmacy, behavioral health screenings, team interventions, care management, etc. Both community hospitals and FQHCs offer promising venues for providing these critical support services to the small practices in which the majority of our PCPs practice. This would also be a means to maintain the community hospitals whose financial situations are often precarious and will continue to decline if admissions are significantly reduced.

- **If the results are promising, work with medical schools, residency programs and other health professional schools in the Commonwealth to include teaching and training in PCMH/Chronic Care in their curricula.** In addition to retraining interdisciplinary primary care staff in the field, Pennsylvania should do what it can to assure that newly graduated primary care providers are trained in the PCMH/Chronic Care models.

- **Encourage, as quality of care and cost reduction information indicates, all plans/insurers under contract with the Commonwealth to fully participate in the PCMH/Chronic Care initiative.** Although an excellent beginning has been made with the 800 primary care providers involved to date, Pennsylvania should encourage further involvement so that PCMH is the norm in Pennsylvania and not the exception.

- **Facilitate ways for hospitals, psychiatric facilities, long-term care facilities, pharmacies, pharmacy benefit managers, etc., to electronically send or fax discharge summaries to the patient’s primary care practitioner/behavioral health care provider at time of discharge to facilitate better transitions in care.** Significant and costly readmissions can be avoided if primary health care and behavioral health care providers are promptly notified of a discharge and contact the patient within 24-48 hours of discharge to do medication reconciliation and arrange for follow up care. Similarly, information from primary care physicians about a patient at time of hospital admission will result in better care.

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• Examine and eliminate barriers to appropriate integration of behavioral and physical health, consistent with patients’ rights to confidentiality.
• Take advantage of the new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing a second, or at least one serious and persistent mental health condition, to designate a provider, including the behavioral health providers as the patient’s medical home. This initiative provides 90% federal matching money for several years and would be a way to stretch limited state funds, while improving care for the most vulnerable Medicaid enrollees.
• To address the high readmissions rate of recurrent hospitalizations among HIV/AIDS patients activate the state funded CBOs with Ryan White funds to form a learning collaborative to address this issue.

3. Supporting Safety Net Providers

The Institute of Medicine defines safety net providers as: "Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." In particular, they define a group of "core safety net providers":

"These providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."

Safety net providers can be the only point of access to primary care for the uninsured, underinsured, or those in medically underserved areas. The present economic situation and the increasing cost for employers to provide employer-based health care coverage, has led to a sizable increase in the number of uninsured in Pennsylvania. With the extension of coverage in 2014, the number of uninsured will be significantly reduced, but not eliminated, and the many Pennsylvanians who are newly covered will continue to rely on safety net providers, especially FQHCs, for access to primary care.

Pennsylvania should use the next three years to fortify its safety net providers, including maximizing resources for FQHCs in Pennsylvania, by:

• Providing planning grants and technical assistance to existing FQHCs that want to expand into other areas, and to communities in seriously underserved or under resourced areas that need and want to have an FQHC. There is $9.5 billion in federal money available to double the number of FQHC’s, but planning money and technical assistance is needed to ensure that Pennsylvania can leverage as much of that funding as possible.
• Working with the Pennsylvania Association of Community Health Care Providers to identify access problems with dental, behavioral health,
diagnostic testing, and hospital services that clinics are having for their patients and to remedy these problems. Several states have been successful in working with professional health care organizations to get their members to agree to take a “fair share” of appointments for the uninsured, underinsured or those on Medicaid fee-for-service. Scheduling software, used by Connecticut and Wisconsin, allows FQHC’s to make limited appointments with participating specialists for the uninsured.

- Working collaboratively with adultBasic, COMPASS, PA Fair Care, etc., to refer those on the waiting list or who do not qualify for coverage, to the FQHC’s toll free number. No one in Pennsylvania should go without primary care.
- Staying competitive with other states, by increasing the amount available and the number of slots for the health care professional loan repayment programs for all needed providers that work in medically underserved areas and providing enhanced repayments for those graduates trained in Pennsylvania schools. Students graduating from health professional schools are doing so with increasingly large student loans. The only way they can even consider working for a safety net provider or in a medically underserved area with lower revenue potential is to receive help paying for their student loans. Every state around us has these programs and has increased both the amount of loan eligible for repayment and the number of slots, making it difficult for Pennsylvania to compete. It is important that Pennsylvania stay competitive with other states’ loan repayment programs and significantly increase the number of slots funded, so we can attract health care providers in anticipation of the large increase of people seeking health care in 2014.
- Creating a technical assistance center for FQHC and other safety net providers that provides assistance with business operations and financial management. Many safety net providers are in fragile financial shape, often lacking the financial and business skills to improve their position. As we move towards the influx of the newly insured in 2014, it is critical that assistance be given to financially fragile safety net providers to improve their ability to manage and maximize their resources.
- Applying for a federal waiver, as Montana has done, that permits FQHCs to provide ancillary services to small primary care practices. FQHCs can provide services beyond the reach of small primary care practices, because their staff includes social workers, care managers, dental hygienists, behavioral health providers, etc. Practices in Montana are able to refer their patients to the FQHC for these ancillary services without losing their patient for other primary care needs which the practice can meet.

4. Fostering Consumer Engagement and Compliance

Informed and engaged consumers can play a vital role in improving the quality of health care in our Commonwealth and in improving their own health. To do so consumers must make decisions about their choice of health plan, choice of health care provider, choice of treatment and choice of whether to actively
participate in the management of their own health. The Chasm Report of the Institute of Medicine in the United States contains the following two passages:

“Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the decisions that affect them. The health care system should be able to accommodate differences in patients’ preferences and encourage shared decision making.”

“The health care system should make information available to patients and their families that allow them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.”

Pennsylvania should:
- Assist consumers to make an informed choice of plan through the Exchange. The information provided must allow easy comparison of plans based on cost and quality.
- Determine the best means of providing easy-to-use information to consumers, so they can pick their health care providers using timely cost and quality information. This information is currently unavailable.
- Develop pilots on shared decision making. The Dartmouth Atlas has documented unjustified variation in medical practice and use of medical resources in the United States. There is too little use of proven, effective care, overuse of supply-sensitive care (where there are more hospital beds, surgeons, specialists, etc., than may be needed) and misuse of preference-sensitive care (where there are significant tradeoffs among various options, that are not adequately explained to the patient). This problem leads to significant additional costs and outcomes that are unwanted by the patient. The use of impartial, medically accurate materials and counseling has been proven to reduce costs and to result in outcomes consistent with the patient’s values.
- Continue to train primary care provider teams to help patients set and achieve goals (e.g., medication compliance, weight loss, exercise, nutrition) that will lead to improved health.

5. Reducing Medical Errors and Other Means of Improving Health Care

- Eliminate perverse payment incentives: Pennsylvania should stop paying for any care related to health-acquired infections or other medical errors, aligned with the federal initiatives. It is critical that Pennsylvania eliminate the perverse financial incentives of paying more money for care due to medical errors.
- Improve performance through data and evidence: Pennsylvania should foster and build data collection and reporting capabilities with analytics to be able to rapidly determine and share the impact of reforms on cost and
quality, first by using existing data sources and improving and supplementing the data as it becomes available.

- **Revise and update the Department of Health’s Hospital Regulations.** For the most part, Pennsylvania’s hospital regulations are over two decades old and do not reflect current hospital quality requirements. Pennsylvania should develop model regulations to improve the quality of care in the hospital, including consideration of requiring hospitals to institute checklists modeled on the aviation industry to improve quality and requirements to eliminate medication errors.

- **Aligning Pennsylvania’s Reforms with the Institute of Healthcare Improvement’s Triple Aim**

  The Institute for Healthcare Improvement (IHI) urges health care reform efforts to simultaneously accomplish three key objectives (thus the “Triple Aim”):
  
  - Improve the health of the population;
  - Enhance the patient experience of care (including quality, access, and reliability); and
  - Reduce, or at least control, the per capita cost of care.

IHI identified five components for a system that would meet the Triple Aim: focus on individuals and families, redesign of primary care services and structures, prevention and health promotion, cost control platform and system integration.

- **Pennsylvania’s health care reform efforts should be crafted to build these necessary components for achieving the Triple Aim into all segments of the health care delivery system as follows:**

  1) **Focus on Individuals and Families**
     - For medically and socially complex patients, establish partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among multiple providers of care.
     - Jointly plan and customize care at the level of the individual.
     - Actively learn from the patient and family to inform work for the population.
     - Enable individuals and families to better manage their own health.

  2) **Redesign of “Primary Care” Services and Structures**
     - Basic health care services are provided by a variety of professions: doctors, nurses, mental health clinicians, nutritionists, pharmacists, and others.
     - Have a team for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
     - Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
- Cooperate and coordinate with other specialties, hospitals, and community services related to health.

3) **Prevention and Health Promotion**
   - Work with the community to advocate and provide incentives for smoking prevention, healthy eating, exercise, and reduction of substance abuse.
   - Develop multi-sector partnerships, utilize key stakeholder resources (worksites, schools, etc.) and align policies to provide community-based support for all who wish to make health-related behavior change.
   - Integrate healthcare and publicly available community-level data utilizing GIS mapping to understand local context to determine where and for whom health-related strategic community-level prevention, health promotion and disease-management support interventions would be most useful.

4) **Cost Control Platform**
   - Achieve an inflation rate of less than 3% yearly for per capita cost by developing cooperative relationships with physician groups and other health care organizations committed to reducing the waste of health care resources.
   - Achieve lowest decile performance in the Dartmouth Atlas measures by breaking or countering incentives for supply-driven care.
   - Reward health care providers, hospitals, and health care systems for their contribution to producing better health for the population and not just producing more health care.
   - Orient care over time - the “patient journey” - targeted to the best feasible outcomes.

5) **System Integration**
   - If the experience of the individual is the primary driver of the Triple Aim system, the health of the population and the per capita cost become constraints. Individuals cannot get all the services that they might want or perhaps even need.
   - Match capacity and demand for health care and social services across suppliers.
   - Insure that strategic planning and execution with all suppliers including hospitals and physician practices are informed by the needs of the population.
   - Develop a system for ongoing learning and improvement.
   - Institute a sustainable governance and financial structure for the Triple Aim system.
   - Efficiently customize services based on appropriate segmentation of the population.
   - Use predictive models and health risk assessments that take into account situational factors, medical history, and prior resource utilization to deploy resources to high-risk individuals.
   - Set and execute strategic initiatives related to reducing inequitable
variation in outcomes or undesirable variation in clinical practice.

- Encourage/require/reward frontline staff for taking a basic web based course on safety science and quality improvement techniques. Courses exist that are certified, interactive, and appropriate for frontline staff and will help reduce the high cost and human cost of preventable errors.

7. Patient-Sensitive End of Life Care

Pennsylvania should create a more positive environment for better pain management for persons at the end of life by:

- Creating pain-management standards for nursing facilities, quality indicators for end-of-life care and, in cooperation with the two nursing home associations, training for staff on palliative/hospice care. Too often, nursing home residents at the end-of-life suffer in pain or are transferred to a hospital because the staff has not been adequately trained in palliative/hospice care.
  - Ensuring Medicaid and other state-funded health care payment for palliative/hospice care in a variety of settings. Pennsylvania should support payment to make patients as comfortable as possible at the end of life in all appropriate settings.
  - Reviewing and revising laws and regulations, which put undue restrictions on medical decision-making regarding palliative/hospice care. Well meaning laws to prevent prescription abuse can keep patients at end-of-life from getting needed pain relief.
  - Making Education on Palliative/Hospice and End-of-Life Care (EPEC) Project training on palliative/hospice care widely available and eligible for CME credits. EPEC training is online training for health care providers to increase competency in providing palliative care.
  - Explore opportunities to educate patients, families and providers on palliative/hospice care end of life and make this information widely available.

8. Ensuring the Workforce Can Meet Emerging Health Care Needs

Although the federal government is providing significant funding to address current and future health care workforce issues, much of the leadership, analysis and planning will need to be done by the state. Pennsylvania should:

- Quickly determine what additional health care providers by category and location will be needed to meet the increased demand due to an aging population, increased prevalence of chronic conditions, and extension of coverage to the uninsured starting in 2014, and develop a plan to meet those needs. Where appropriate consider expanding the scope of practice of health care providers to meet these needs.
• **Revise scope of practice laws and regulations to ensure that health care providers can practice to the extent of their education and training.** Although Pennsylvania’s scope-of-practice laws have recently been revised, more work is needed to maximize the skills and deployment of every member of the current health care workforce to the fullest extent of their training and individual capabilities.
  - Encourage the growth of family practice, internal medicine, pediatric, psychiatry, OB/GYN, geriatric and adolescent medicine programs in Pennsylvania’s medical schools. Pennsylvania must proactively determine the steps that must be taken to address these shortages, as it did with the nursing shortage.
  - Foster development of additional interdisciplinary primary care providers focused on disease prevention and care coordination for chronic illness with specialists.
  - Promote medical malpractice liability reform.
  - Provide medical malpractice liability relief for critical providers in short supply, such as OB/GYNs.
  - Address pay and benefit issues for direct care workers and personal care assistants. To avoid expensive and unwanted nursing facility care, Pennsylvania must work with others to address pay and benefit issues that help in the retention and recruitment efforts for these critical health care providers.
  - Support efforts to improve performance of skilled nursing facilities, including efficiency, safety and clinical care, productivity, etc. This involves using successful models for transforming care that include training and coaching, and which would yield better care at lower cost.

• **Leverage all opportunities for grants and federal assistance to recruit, retain and train health care workers.** There are not only opportunities for the state, but also opportunities for health care professional schools to apply. Pennsylvania should work with Pennsylvania schools labor-management training partnerships, and other training organizations to maximize federal funding.

• **Promote and support labor-management partnerships to ensure that workers who directly serve patients have a voice in delivery innovations, worker training and quality improvement strategies.** Such collaborations can lower cost and improve quality by driving process improvement, increasing patient satisfaction, promoting workforce stabilization, and reducing workplace injuries.

• **Update existing provisions prohibiting the use of public funds by employers to oppose, support, or otherwise influence union organizing efforts to ensure that these funds are used in the provision of quality health care services.**
  - Support transition to electronic health records and prepare health care workers to make the best use of new technologies. As health care systems transition to electronic health records and the health information exchange, a growing workforce of information technology workers with working knowledge of the health industry will be needed. Frontline workers from
doctors to home health attendants will need support and training to effectively use the new technologies.

- Create strategies to address public and private health care worker shortages in rural and urban areas.
- Increase training capacity for allied health occupations where shortages currently exist.
- Assist employers in developing initiatives that create an environment of learning for organizational boards, administrators and clinical staff in regard to embracing principles that transform organizational cultures to incorporate employee retention principles.
- Reinstitute grant programs for nurses seeking advanced degrees to become nurse practitioners, nurse faculty and nurse researchers to meet projected shortages by 2013. This is consistent with recent recommendations from the Institute of Medicine Report and supported by data from the PA Center for Health Careers, state should
- Change training requirements so that home health aides/nurse aides working in acute care, home health care and long term care have the same curriculum for entry into the healthcare system. This will allow mobility within the system and address one of the primary retention issues related to direct care workers.

9. **Health Information Exchange and Electronic Health Records (EHRs)**

Clinicians need up to date clinical information to treat their patients. Pennsylvania has been awarded $17.1 million for the creation of the Pennsylvania Health Exchange (PHIX) that will provide the electronic highway that will allow clinicians to share information to improve health care and lower costs. PHIX needs to be governed by a public-private Board, including representative stakeholders who use PHIX. It needs to be in an authority that has the power to assess subscription fees to pay for its operation.

- The General Assembly should pass legislation creating an Authority for the operation of the Pennsylvania Health Information Exchange.