

**Coordinated Health Services Planning
Advisory Committee
November 9, 2006
RI Department of Administration, Conference Room A
3:30 – 5:00 p.m.**

Meeting minutes

Attendees (Committee members): Fox Wetle, Chair. Jeffrey Borkan, Jessica Buhler, Kathleen Connell, Lou Giancola, Bob Guneyi, Kathy Heron, Joan Kwiatkowski, Peter Oppenheimer, Donna Policastro, Mark Reynolds, Marti Rosenberg, Margaret Sun, Alan Tavares, Nick Tsiongas, Dawn Wardyga

Attendees (Dept. of Health Staff): Valentina Adamova, Jay Buechner, Stephanie Kissam, Jennifer Morgan, Bill Waters, Donald Williams

Attendees (Interested parties): Lauren Conway, Tish DiPrete, Rick Farias, Liz Gemski, Jason Martiesian, Craig O'Connor, Peter Porter, Ed Quinlan, Josie Santilli, Craig Syata

I. Health Data for Health Planning

Presentation by: Jay Buechner, Ph.D., Chief, Center for Health Data and Analysis (RI Dept. of Health)

Handout distributed that describes the data needs for 4 levels of health planning

Level 1 – CON/Tertiary Care Issues – focus on technology

- DOH looks at data for CON or Tertiary Care issues only when we have a need
- DOH tends to look at supply, demand, and geographic distribution of services.
- DOH has health care utilization data from some providers.
- DOH also does ad hoc surveys to determine supply and utilization of some services.

Level 2 – Health care system – focus on the costs and balance of supply across system

- DOH has some information (e.g., quality measures, structural features) on facility-based providers, hospitals, home care agencies, and nursing homes.
- New data collection needed for information on ambulatory care providers
- Used to do an aggregate funds flow analysis – who pays whom for health care.
- New data collection needed to understand out-of-pocket expenditures in health care system
- DOH does not have good data on all types of preventive services that drive utilization.

Level 3 – Health status – focus on characteristics that impact need for health services

- DOH has excellent mortality and life expectancy data
- DOH has some morbidity data – e.g., prevalence and incidence of injuries and communicable diseases.
- DOH does not have good information on some conditions, such as heart disease

- DOH has some disability data from health services.

Level 4 – Health risk behaviors

- Have good survey data on this – both surveys of adults and school-aged children
- Covers risk behaviors for injury, chronic disease, communicable disease.

Funding needs:

- Existing data sources would need to be upgraded for use in health planning
- New data collection where needed
- New data analysis, e.g., predictive modeling
- Surveillance and monitoring

Comments from Group:

In addition to data covered above, additional data needs would include information on practice patterns (comparing RI with national patterns), clinical outcomes, and medical error rates.

Quality is a critical part of health services planning – we should put data collection of outcomes and errors on the table.

Looking at past utilization is not a good indicator of need, because the underlying factors that drive utilization are rapidly changing (e.g., supply, financing structure, recommended treatments for certain conditions...)

Question: What access do state agencies have to each others' data?

Response:

- Data can go from Medicaid to DOH
- MHRH has utilization information on mental health / substance abuse treatment facilities
- These data sources are typically designed for management and or reimbursement, not data analysis
- These data sources are on limited populations – would have to be adjusted for use in total population planning

Question: Does public reporting on health care providers improve available data sources?

Response:

- Public reporting addresses some quality measures
- Public reporting is limited in breadth
- Publicly reported data not in format that fosters analysis

Comments from Group:

Why are we doing this planning? One reason is to increase coverage and access. An important piece of planning is who is insured, how well insurance works for people who have it.

Need to measure whether care is provided in the most appropriate place.

Question: Does DOH have ongoing data on tertiary care services or high-cost technology? Is there a basic level of monitoring?

Response:

- No, data collection on these issues is ad hoc. Not all technology is in licensed facilities.

Question: Is there data available on practice patterns?

- We have hospital inpatient data, but no outpatient data (except for some breast cancer screening data.)
- Insurers' data could help us, but health insurers don't usually collect data in the same way (makes it difficult to combine and analyze)

Comment from Group: Would it be valuable to identify expectations for data collection? Some ideal scenarios? In the report, we could do a gap analysis of what it would take to use existing and new data for health planning.

II. Current Health Services Regulation and Licensure Authority at Dept. of Health:

Certificate of Need and Licensure Requirements for Tertiary Care Services

Presentation by: Donald Williams, Associate Director for Health Services

Regulation (RI Dept. of Health)

Handout of information distributed.

In the early 1990s, the General Assembly decided that the Dept. of Health should look at how tertiary care services are provided in RI, and gave authority to the DOH to establish licensure standards where there is a volume-quality relationship for tertiary care services.

The Tertiary Care Advisory Committee has convened and is looking at 5 procedures to determine whether there is a volume-quality relationship that should be included in the list currently regulated in licensure.

Review of Certificate of Need program.

Health Services Council, which reviews Certificate of Need applications, wants to know what the plan for the health system is in the next 10-15 years. They are currently reviewing each application in isolation. They are most interested in a plan for facilities and for technology.

DOH currently has authority to do health planning, but is missing the linkage to the CON process.

Comments from Group:

Accountability is critical – a health plan needs to have authority behind it.

Enforcement of a health plan doesn't have to be through a regulatory process. Another approach is to make more information publicly available – e.g., error rates.

Today regulation has a narrow focus – that might be part of the problem.

Need to look at whether one does statewide planning or planning at a regional or local level.

The SHAPE study was the most comprehensive and current set of data, and it looked at health data at the statewide and service area level.

Current regulatory mechanisms focused on facilities – perhaps what is necessary is to regulate individuals where there is a volume-quality relationship in the services they perform.

III. Summary of comments from October 30th Community Forum

Presentation by: Stephanie Kissam (RI Dept. of Health)

See handout.

III. Introduction to Advisory Committee discussion of Scope of Health Planning -

Range of options for the scope of a coordinated health planning process?

Presentation by: Bill Waters, Ph.D., Deputy Director (RI Dept. of Health)

Presented range of elements that health planning could encompass. The ultimate goal should be to improve health status.

Comments from Group:

Primary care improves health status.

Could list steps in the report – propose an incremental approach to health planning.

Need to think broadly about health planning for the report – it is for ourselves and for the legislators. If we propose a plan for the widest scope of health planning, it will likely be narrowed.

Should think about how we incorporate measures of success for health planning that matter to consumers. We need to get the public behind us as part of this process.

Consumers should be involved in the health planning process.

Providers do what they're paid for – the system is not based on consumer need. It is hard to embark on a health planning process if it is disconnected from payment – so payment should be included in our plan.

There are a lot of elements of reimbursement that we can't control.

Concern raised about consumer-driven health system – have to plan for a system that is effective, not necessarily what makes consumers happy.

The health plan becomes an educational tool to consumers and providers.

The health plan should be detailed about how to control the introduction of technology – including pharmaceuticals.

Consumers want what doesn't exist now.

Insurers also struggle with balancing benefit design between what consumers want and what is effective. Blue Cross would be willing to bring data to the table.

Next steps

- Next meeting December 7, 3 – 5
- Follow up with suggestion to circulate most recent GACH (Governor's Advisory Council on Health) report that combined data and analysis of health supply and utilization.

Meeting adjourned at 5:00 p.m.

Respectfully submitted by:
Stephanie Kissam
RI Department of Health