

Health Care Planning And Accountability Advisory Council
Tuesday, June 24, 2008
4:30 – 6:00
Department of Administration, 1 Capitol Hill, Providence - Conference Room A

Draft Meeting Notes

Dr. David R. Gifford, co-chair of the Council, welcomed the Council members and led introductions.

One member asked for clarifications on the hospital and nursing home representatives on the Council. Dr. Gifford clarified that Lou Giancola is the hospital CEO representative and Hugh Hall is the nursing home administrator representative.

Dr. Gifford began with initial remarks that the members of the Council are not representing their own organizations, but are bringing different perspectives to a statewide planning process. This Council is analogous to a Board rather than a coalition.

Dr. Gifford reviewed the materials handed out at the meeting and committed to making materials available to the Council ahead of time, with the expectation that Council members will read them ahead of time.

He further stated that the goal is to have a health plan that doesn't sit on a shelf, but rather drives decision-making in state government and the private sector.

Dr. Gifford transitioned to the next part of the agenda by asking Council members to each spend a few minutes answer the question of what their opinion is on what a health plan is and how it would be used. He prefaced their answers by saying that one concern is that a health plan that could answer all questions would be too long and detailed.

Dr. Gifford stated that the plan for the Council is to take this meeting to hear ideas, and then synthesize those ideas and come back at a future meeting to start to put something in writing.

Terrie Fox Wetle began her remarks. She stated that a plan should outline the principles and primary goals of a health system, identify targeted questions to address, have a data analysis component, and include strategies and recommendations. She said that health planning should be staged. She also said that it could inform several aspects of policy, for example, Certificate of Need processes.

William Johnson agreed that health planning should start with principles, priorities of the population, and consider support systems needed to support those principles and priorities – for example, what is needed to provide a medical home or access to care. It should address integration of behavioral and physical health. A health plan would guide policies and prioritize expenditures.

Dr. Gifford addressed the group again, asking them to think about the level of specificity a health plan would have.

Maria Montanaro stated that a health plan needs to be strategic – it will point to the ultimate goal. Goals need to be commonly held and understood. The health plan should look at the health system and what it should accomplish – what’s the appropriate use of public funds – for example, should they support private entrepreneurship. The health plan needs to point to aims for the health system. It could guide regulation, policy, and resource allocation.

Lou Giancola agreed with what had been stated. He said that the plan should be embedded with values that the health care system should have. Right now, there is no document that says that the system will rely on competition vs. collaboration, for example. He stated that the health plan should not be static, but a point of reference – meaning, it would be looked at to see if it could inform any decision. The health plan could shape the payment system, organizational behavior, how the Health Services Council would respond to applications. It should try to integrate the data we have – a lot is available, but it is not all analyzed and utilized to inform decisions.

Rick Brooks stated that the planning process shouldn’t address specific issues, but would hopefully look at current decision-making processes and assess the efficacy of what we have currently. It should spell out priorities for spending. It should address principles and the allocation of resources. It should make some decisions about whether we manage changes or be laissez-faire.

Dawn Wardyga stated that the end-product of planning will always change. Speaking as a consumer advocate, she said that the state needs a plan that doesn’t discriminate based on health status or race. If we say that health care is a basic human right, then we make certain decisions about a healthy Rhode Island. For example, a pilot program that targets a specific population isn’t equitable. The health care system should blend public and private funding. It can deliver services in a more comprehensive and responsible way. The health care system shouldn’t be split according to the haves and have-nots. We should have a seamless system with intense accountability to make sure that people are treated fairly. We had a healthy debate on values in last advisory committee – this is important. The discrimination factor is big. Healthy people impact the economic status of the state.

Stephen Farrell commented on the structure of the Council. The topic of health planning could be broad, and the group shouldn’t try to boil the ocean. He noted the Council’s lack of funding. He suggested that the Council needs to stick to basics – that is, look at the need that is in the state, incorporate the initiatives that are underway such as the Health Information Exchange and CSI [Chronic Care Sustainability Initiative.] These elements should be folded into a health plan. The Council should delineate the outcomes that it wants from a plan, develop a baseline and ongoing reporting, and perhaps use existing reporting. It may be possible to choose one theme like obesity, and determine some critical success factors. The Council should identify action steps, but also allow for some flexibility and be given the opportunity to revise any plan.

Karen Malcolm referenced the original Coordinated Health Planning Advisory Committee report. She said that we should have a plan so that the state can make current decisions in light of future effects. She stated that the plan should have criteria for decision-making based on values. It should examine priority needs to improvements in health. It should focus our public and private resources to meet immediate needs, even as they change. The plan should be the starting point for decision-making. For example, when a request is made for an expensive addition, the question should become whether it is addressed in the plan or not. The plan is the

framework for shaping the system. The plan should get us to planned investments to help all Rhode Islanders – medical students, providers, consumers. Any decisions outside of this framework are problematic.

Nicholas Tsiongas began by stating that the plan should be clear about the distribution of services within and across institutions – what is the capacity and utilization. It should inform the Health Services Council, the Office of the Health Insurance Commissioner, insurers, and regulatory bodies in the future. We have a funding problem. It makes sense to make decisions in democratic small groups than in legislation. From a physician’s perspective, everything is on the table. Disagreements should be aired in a democratic forum. The Council is an opportunity to get beyond the usual decision-making process.

Rick Farias stated that ideally, we would be starting with a clean slate and then decide how many hospitals, physicians, etc. we would need to accomplish our health goals. We could plan for Electronic Health Records and how they could be used. However, we don’t have the luxury of starting from scratch. The plan should answer the questions of whether services are necessary, and if there is excess capacity in the system. The plan should identify one or two areas to take on and agree on the priorities for those areas.

Don Nokes said that he found himself agreeing with everyone. The plan should take an inventory of capacity and needs of population. Guidelines are there to help make decisions. We should look at what’s available regionally – do we really need capacity here? To meet Rhode Islanders’ needs? We should match need and capacity. If this group can continue with funding, its work will be impressive.

Ramon Martinez stated that he has the perspective of the military mind. A plan should be a roadmap to a destination. What are the current and emerging conditions that influence our goals? What are the underlying assumptions? For example, how do we create a resilient state and community? Another assumption – that we are in a democratic, capitalist society and we abide by the Constitution. What are the conditions? Some include: demographics, health needs, built environment, capabilities, knowledge level, natural environments (what contaminants), specific illnesses (e.g., Human Papilloma Virus.) There are emerging and immediate conditions, and financial conditions. Then, we need to look at what capabilities do we need to create to get the health care system we want. How do we connect caregivers to provide reliable services? What kind of capital do we need to raise? According to Maslow, we need to satisfy basics first – health, education, shelter. If we talk about a health care plan – how do we integrate with other services required (e.g., workforce.) How do you work in a system of both for-profits and non-profits? If we can export health – we should consider if this is possible, and make a profit from it. We must execute this plan to make it worthwhile – how do you train people to do that?

Maureen Glynn stated that she thinks about this with regard to the Attorney General’s role. The Attorney General has a role in the Hospital Conversions Act, oversight of charitable donations, statutory and common law authority over anti-trust (compares what is the product and what is the geographic area), and represents consumers in insurance rate hearings. Health care is not an unlimited resource – what services are there and how do we deliver them? The free marketplace is not the model – it allows duplications of services. Competition is not driving value or pricing. A health plan should look at data for what services are needed and where should they be. It should look at institutions and individual practitioners. It should look to the future – the system is not functioning now. We have the opportunity to be pro-active about the aging population,

and the most common conditions. We need to look at primary care, community-based care, and hospitals. The role of the AG is to examine how we get value from the health care system.

Christopher Koller stated that the Office of the Health Insurance Commissioner looks at how the concept of “affordability” gets interpreted. It would be helpful to have some guidance on priorities for affordability. The health plan should provide a collectively defined set of priorities. The alternative is that the regulator defines it based in the regulatory agency’s interpretation. Planning is a value-neutral word. Planning can be comprehensive or not so comprehensive – which do we want? There is a growing sense of wanting something that is more comprehensive. Where do we do more comprehensive planning? In the environment, or Department of Transportation. We should look to those models. The components of planning are the values, data and analysis, leadership and structure, authority that is tied to the plan. For example, the military’s base realignment commission had teeth to implement its plan. Chris concluded that a comprehensive plan would be great, but that he would also take a set of values to do things such as justify the Medicaid budget or a set of regulations.

Rick Harris stated that the original legislation said that everyone should have health care. The health plan needs to look at our current crisis, and address system fragmentation, resource allocation, collection of data. It should be dynamic guidance to improve the health care system. We need to look at accountability. Rick stated that he hoped this would be a successful effort. The Council is here to support the Department of Health’s primary function – public health.

Katherine Graziano introduced herself as a representative from the Rhode Island State Nurses, but is also a member of AARP and has served on the national health policy committee. She said their goal this year is to address every political candidate to work with them on health care reform. The Rhode Island delegation has signed on to the pledge. There has been no mention this evening of universal access or universal payer – this will be a significant issue of reform. Over 50% of health care is paid by the government. She warned the Council to keep in mind that Rhode Island is not isolated – we need to look at how these national efforts impact planning. She also commented that the Health Services Council gets competing applications – and are in a bind. She said that they don’t apply conditions consistently. Changing that won’t happen overnight.

Lita Orefice said that the role of OHHS is to better help its agencies to collaborate (DEA, DHS, MHRH, DOH, and DCYF.) From that perspective, planning is important to what we do across all departments. We don’t want to add to the pile of plans, but rather want a community-based tool to use. The alternative is that state officials make decisions without that tool. She stated that her bias is to do something good and fast rather than slow and perfect. She asked what can we afford to do, and what can we use practically? She foresees something that could be done in 12-18 months. The concern is accountability – accountability is what would keep the plan from just sitting on the shelf. Whatever the plan is should have some teeth. And advisory council or an individual can’t compel use of a plan, but there are some opportunities if it is useful.

Dr. Gifford summarized the comments by saying that there are some differences, but more consensus or agreement than he expected. There is agreement that we needed values and principles to guide each decision that comes up across the state. There was a good discussion on the criteria and process for how to evaluate those decisions – not only values, but how do we approach a decision. For example, should it be data-driven and evidence-based?

The discussion of values, principles, and process is something that could be accomplished in a short time with few resources, and is worth investing in.

Dr. Gifford commented that a more resource-intensive or comprehensive agenda would be to have data sources developed, and then to answer the question of how resources should be distributed or the health conditions that should become priorities. Additionally, the analyses to answer the questions that have not even been asked yet will take longer.

Maria Montanaro commented that what is missing from Dr. Gifford's summary is the need for strategic goals to use as a yardstick, and Dr. Gifford suggested that those goals are in a category similar to values.

Dr. Gifford commented that the amount of funding that other states have to do health planning varies a great deal, and data analysis takes a lot of funding. He then introduced Dr. Quigley, chair of the Health Services Council, to describe the application that was submitted to Representative Kennedy's office for an appropriation to fund health planning.

Dr. Quigley described the criteria that the Health Services Council uses to evaluate applications, and suggested that they were not strong enough. He said that in November, Rep. Kennedy met with him to discuss health issues. Dr. Quigley made the request for \$1,000,000 over two years to test a model of health planning in Rhode Island that could be used elsewhere. Dr. Quigley suggested that several people could write letters of support for this application, and asked who could get together to plan for that.

Fox Wetle suggested that if the Department of Health received the appropriation, it would be most useful to employ a Request for Proposals from potential consultants that would describe the characteristics of plan development that would be desirable. She also suggested that the final proposal submitted to Representative Kennedy be circulated.

Karen Malcolm stated that the Council should be more aggressive in seeking funding even before the appropriations money flows. She suggested that the Rhode Island Foundation be approached for funds resulting from the settlement with Blue Cross Blue Shield of Rhode Island, as well as use the funds from the merger application. She suggested that a subcommittee form to proactively seek these funds.

Subcommittee volunteers included: Nick Tsiongas, Fox Wetle, Karen Malcolm, Rick Brooks, and Rick Harris.

Dr. Gifford suggested that before the next session, the Council members read the Coordinated Health Planning Advisory Committee report, especially the principles, values, and strategic goals listed on page 6. He stated that we would email additional principles, goals, and values out to the group to try to reach agreement on a common set. This is a valuable activity regardless of funding available.

Chris Koller asked where the levers were within state government to apply these values – we need to address this at some point, after determining the principles.

Lou Giancola said that there is a potential change in the system (alluding to a potential hospital merger), and some will be in the middle of this. The goals and values should guide those decisions – so is there an urgency to our efforts?

Lita responded that there is an urgency to these efforts. She said that these Council meetings won't be the only place where values get set, but to the extent that this is an overarching statement of values, it can be powerful.

Dr. Gifford stated that we can't stop changes in the health care environment to work out these issues.

Dr. Gifford asked for comments from public members and heard none.

The meeting concluded with the agreement to meet again this summer and in September.

Respectfully submitted,

Stephanie Kissam