

DRAFT MINUTES

Health Care Planning and Accountability Advisory Council

Wednesday, September 10, 2008

4:30 – 6:00 pm

Department of Health, 3 Capitol Hill, Providence – Health Policy Forum (Lower Level)

David Gifford, Council Co-Chair opened the meeting at approximately 4:40 pm. D. Gifford explained that Co-Chair Adelita Orefice would be arriving late and that he would need to leave when she arrived.

D. Gifford asked for any revisions to the minutes. None were requested. Minutes were accepted as written.

D. Gifford opened floor to feedback on values since only two people had responded via email.

M. Reynolds said that the statement at bottom of agenda is effective and asked to start from there.

M. Montanaro said the statement gets at access and appropriate level of care. The problem is the approach to getting to a system or planning method to achieve desired outcomes. She hopes to get to deliverables, strategies and objectives.

R. Farias stated that committing to the need to gather information is critical and needs timelines.

T. Wetle requested clarification of the process. The Health Care Planning Advisory Committee (HCPAC) spent lots of time on values and thought this group would move to planning and operationalizing.

D. Gifford thought the values would be quickly agreed upon. Data analyses are beyond the scope of resources of the group but can aim to move forward with that. He wants to work through objectives and strategies with the group, however, he does not want to move to the next step until we have agreement on values as a foundational step.

M. Montanaro agreed with the values offered by the CHPAC.

K. Malcolm agreed with Maria and thought we should go forward with those.

[Distributed findings from Coordinated Health Planning Advisory Committee Report]

[A. Orefice entered, D. Gifford left]

S. Farrell asked what the end product of the group should be, how success would be defined.

A. Orefice put the question out to the group.

R. Farias offered that success would be measurable progress.

J. Purcell asked if that means the Council is writing a health plan and if that plan would be limited to certain available resources.

N. Tsiongas suggested the Council ought to write a plan specific enough to be able to write legislation to advance us toward objectives. Should commit to finding the funding and going before the legislature to see that this is a funded process. RIMS wants to this forum, at which everyone is represented, produce a plan. If issues are addressed here, we can be much more open to negotiating instead of arguing in front of legislature. Start with comprehensive services and how they're distributed. Don't need to start with access.

C. Koller offered two options- develop a defined health plan with a delivery system or suggest elements (from the Coordinated Health Planning Act) that should be reflected in existing or new regulations.

A. Orefice offered that the two options are not mutually exclusive but reflect a different prioritization. She would choose to do an interim plan while we look for funding to do a longer-term plan. However, we don't want to make decisions in a vacuum. She is looking for a product that would help OHHS and HEALTH make decisions in the

short term but that would also be useful to the whole group because all the parties are at the table

M. Montanaro recommends developing a set of strategies that if adopted would guide and inform the planning and regulatory process because the state does not have a broad strategy that everyone can refer to when making decisions. The ends are the principles but this group can devise the strategies. If a short-term plan is to be made, the Council should pick current problems and test them against the agreed upon principles.

N. Tsiongas suggested that the way to make a guiding document would be to consider existing problems in the state (e.g. community hospitals at risk, global Medicaid waiver) and compare them to principles.

R. Martinez suggested that there appears to be confusion in the language being used. Strategic planning principles (i.e. values, virtues, and obligations) are conditions that help to make decisions. What we have are goals, not principles. This Council can develop a strategy map that will visually depict the goals that will get us to principles. Staffers can use the map to create a strategic plan that names who is doing what, timelines, and accountability.

A. Orefice said she and D. Gifford spoke about defining the role of the advisory and how to use everyone's time and expertise effectively to

get a product. One option is for us to keep producing summary docs that everyone can react to but she's not sure that will be effective or keep everyone at the table. How do Council members want to contribute and/or interact with the process?

T. Wetle said the reason the CHPAC was able to do so much work and be effective is because it had great staff, a Chairwoman for whom this was a priority, and a 5-person Executive Committee whose focus was to move the process forward.

A. Orefice thought it may be good to task a group for this process.

K. Malcolm, in responding to whether she felt invested and involved in the CHPAC, said that a value of this council is that it can be a forum for negotiations on policy, legislation, and implementation. The reason other group worked is because it had a trusted executive committee that set agendas, structured meetings, generated products, and acted as a liaison to government. She also stated that a long-term, well-articulated state plan and a shorter-term issue specific plan are not mutually exclusive and we can get somewhere with both.

W. Johnson said that it is hard to add value to what was done in the previous report. We shouldn't ignore current crises in order to develop long-term plan. He would like to know the priorities currently being discussed because people here can advise and respond to

them. Advising councils work well when there is clear direction and goals.

A. Orefice, in response to the question of whom the Council advises, said the Council advises HEALTH, OHHS and the larger health care community that works with the state.

C. Koller suggested the Co-Chairs should ask Council for advice on specific issues.

S. Farrell offered that he participated in similar effort in Connecticut that produced a report, not an operational plan, that all could endorse and support in the end. They used a consultant that was not very expensive. He agreed to share that product with the Council.

L. Giancola offered that he would not find it useful to advise existing policies but rather, the group should take the opportunity to define how to advance critical issues like strengthening access to care, which he thinks should be a top priority.

D. Siedlecki agreed and is more interested in action, in the common-sense application of something principled. Council can work from the existing document but the only way to do it is to take specific problems and move.

N. Tsiongas recommended establishing an Executive Committee and

having everyone offer a few issues to address.

M. Montanaro stated that the Council has the opportunity to make recommendations regarding a strategic vision for reforming the health system. She suggested that the group agree to a vision and strategic goals before addressing hot button issues because one can then apply/test issues against the framework and make recommendations that may guide policies & legislation. She recommends hiring a facilitator to take group through process, identifying staff to develop policy recommendations, and holding shorter, full Council meetings.

A. Orefice stated that the Council/state agencies have good staff but don't have money for a facilitator and asked who the other owners/champions of this are.

K. Malcolm suggested identifying another Council Chair to help make sure the work of the group progresses. This may be accomplished through an Executive Committee. She also suggested that the Rhode Island Foundation may be able to pay for a facilitator.

R. Martinez clarified the distinction between strategic thinking/visioning and strategic planning. He suggested the Council do strategic visioning which starts with assessing where the system is now- faults, facilitators, etc.

L. Giancola requested that someone write that for the group to respond to and then move on to setting goals.

M. Reynolds felt that it makes sense for the State to be recipients of the guidance. There seems to be a lack of comprehensive health planning in the governmental sphere and the Council should identify what a public/private combination should do.

A. Orefice agreed to update D. Gifford and look for a facilitator. She will check in with people who may want to volunteer to help staff and direct the Council.

M. Montanaro, T. Wetle, K. Malcolm, and C. Koller volunteered to participate in a small group.

N. Tsiongas asked if it would be a priority for both Co-Chairs to find funding to support this.

L. Giancola requested that a small group move forward with the vision statement regardless of whether a facilitator is identified.

Meeting adjourned at approximately 6:15 pm.

Respectfully submitted,

Carrie Bridges