

Health Care Planning and Accountability Council
Comments on Workplan and Research Questions

Proposed Research Questions for Comment

- 1.) How do the different ways of organizing our primary care infrastructure drive Rhode Island's need for hospital services?
- 2.) What is the ideal number, location, and type of hospital beds that yields the best outcomes at the lowest cost? What is the cost of excess capacity?

COUNCIL COMMENTS

Blue Cross Blue Shield of Rhode Island

Thank you for the opportunity to provide feedback concerning the research questions that consultants will answer for upcoming Coordinated Health Planning Council meetings. Blue Cross & Blue Shield of Rhode Island believes strongly in this comprehensive, coordinated, statewide health care planning effort and wants to do everything we can to support positive and productive outcomes as a result of this work.

In no particular order, we suggest several other questions might be considered:

- How are clinical service lines currently provided in the state? In other words, at how many hospitals do we perform cardiology, obstetrics, cancer care, etc? Should there be some coordination of service line provision across hospital facilities in the state in such a way that we could essentially create statewide centers of excellence?
- What is the percentage of services (by service line) received by RI residents out of state? Could the state plan for and coordinate its health care services in a way that we might repatriate these services back into RI facilities with RI providers?
- While this is both an inpatient and outpatient issue, we believe we should address the appropriateness of the number of imaging machines and locations (MRI/CT/PET) for a state of this size with its population.

Donald Williams

As you know, PL 12-259 requires an assessment of hospital services and the development of recommendations about changes (if any) to HCA and CON. The related report to the General Assembly is due 1 March 2013. This is clearly an exceedingly tight time frame for completing the Council's work. While the proposed research questions seem to address an "assessment of hospital services", the proposed work plan for the development of recommendations about changes (if any) to HCA and CON seems to initiate this aspect with a discussion at the Council's January 14, 2013 meeting.

Accordingly, it would seem prudent to initiate staff or consultant work forthwith on the range of options for changes (if any) to HCA and CON that may be necessary/appropriate, in the Council's judgment, as a result of the assessment of hospital services. The Council's January 14th meeting and consideration of the assessment of hospital services and the development of recommendations about changes (if any) to HCA and CON should be informed both by the hospital bed need study and by a presentation on the range of options for amending the HCA and CON statutes.

Dr. Patricia Flanagan

I am struggling to understand how Children's Health Services (Hospital beds in particular) fit into this conversation. Not all beds are equivalent so thinking about # and distribution must also consider the patient characteristic/needs (such as age, behavior health etc).

Dr. Eve Keenan

1. Are we asking to have an informed opinion on the number of primary care providers in relation to their need as dictated by current population and future growth?

2. What components of infrastructure will we look at for primary care? IT communication, places of employment and the incentive packages; relationships with specialty medicine groups and how they interact? All of these issues and others (insurance policies) need to be discussed to have a "big picture" for RI's future health management and primary care's role in this system.

3. When we ask about hospital beds, somehow we need to look at the institution called a "hospital." As you know inpatient beds are only a small indicator of the role hospitals play in a community. All the outpatient services are equally important and are vital to the continuum of care that patients need. To me this begs the question of the ancillary services we find in many stand-alone practices/ entrepreneurial health care initiatives throughout the state. We need to be sure that this discussion is part of the "bed" question. I agree that there are too many beds, but a plan for allocating them for appropriate patient care with the hospital services required to provide the care is a very complicated question.

I would ask how does a "hospital" fit in a system to take care of a population?

Needless to say these issues are very complicated and need a strong vision of what we think will provide safe, cost effective care for our state's population.

Jodi Bourque

Thank you for the opportunity to provide comment to the Work Plan, as I stated in our recent meeting, I feel that the work of this Council is vital. I am concerned that up until now, much of the work and direction of this Council have been done without direct

input of the Council. The Council members represent a truly committed group of people from a variety of backgrounds and have much to offer in this process. With that said, I would like to suggest that discussion on the HCA be moved forward on the agenda if they are to have any impact in this legislative session. I understand that our role is advisory, but it is advisory to the Governor and the Legislature and the date our report is due is on or before March 1, 2013. I think that the thoughtful input of the Council on this topic in this year is important and does not need to wait until a final report. This is especially true as the Governor has indicated that he would like to revisit the HCA this year to fix issues with the previous legislation. More than one meeting should be afforded even if additional meetings are necessary. Further regarding meetings in general, I am not sure how we will be in a position to sign off on a final report of this Council with only 4 meetings regarding its content. With regard to the questions for the experts that you have decided to engage, I leave it to the others on the Council who work in this arena to make suggestions regarding specific research questions. It is difficult to suggest questions at this point without discussion with other members as to the goal of the research.

Dennis Keefe

Thank you for this opportunity to review and comment on the research questions the consultants will address as they assist with the creation of a coordinated state-wide health plan.

We believe that this report will be tremendously useful as we pioneer new wellness and disease management models that promote health and explore new ways to improve the continuum of care within our organization and as members of the Rhode Island care community.

That being said, we have created a few areas that we think should be considered by the consultants during their review. (See below.) The overarching theme of our comments relates to the changing mix of services and sites for care in the hospital environment of today. By focusing on traditional measures of hospital activity such as discharges and length-of-stay, some fundamental shifts may be missed, thereby creating a distorted view of activity on hospital campuses. In other words, hospitals are still very busy places, although the focus away from inpatient care is a clear trend and should be a focus of planning.

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1. How do the different ways of organizing primary care infrastructure impact Rhode Island's need for hospital services?

Areas for Consideration

The utilization of hospital services is more complex than the organization of primary care. Provider access/availability and the public's willingness to participate in disease management initiatives are crucial to the success of any primary care initiative. Health Plan alternatives must stress and incentivize a commitment to primary care through their design rather than the current proliferation of PPO plans offered and in place throughout Rhode Island. Additionally, many new physicians are continuing to choose specialization over primary care, and/or elect to leave Rhode Island based on payment structures. When reviewing primary care infrastructure, it should also be considered that medical home models can handle an average panel size of 1800-2000 patients per primary care physician, while traditional models average 2000-2500 patients per primary care physician. Also, existing emergency department visit increases may indicate a shortage of available primary care at convenient times and locations. In short, one cannot move quickly to a primary care based system if there is a fundamental shortage of primary care providers.

2. What is the ideal number, location, and type of hospital beds that yields the best outcomes at the lowest cost? What is the cost of excess capacity?

Areas for Consideration

While Observation stays are not considered admissions, they are inpatient day stays requiring intense utilization of hospital resources for up to 72 hours. However, these "days" are not included in occupancy figures which relate only to discharges and related inpatient days. The growth in Observation "visits" is increasing exponentially, particularly through the Medicare Program.

Additionally, day surgeries have likewise increased substantially over the past 5-10 years. Hospital operating rooms are busier than ever for these surgeries, which require much the same resources as when they had been performed on an inpatient basis. So, when one looks at inpatient surgical volume over time, this huge shift to outpatient care must be taken into account. There has also been a shift of less complicated patients to freestanding private ambulatory surgery centers; albeit with the more complicated procedures still being performed in hospital settings for reasons of risk and patient safety.

Discharges FY 2000-2007 reflected increases but have since that time (FY 2007-2011) demonstrated decreases; while the number of staffed beds has remained relatively unchanged. This may question the assumption that bed size drives usage. The Observation day phenomena referenced above explains some of this impact (or lack there-of), as these "visits" aren't reflected as either discharges or patient days.

Also, Rhode Island's increasingly aging population will require a greater need for services, especially so in specific areas of the State. This growing segment of our

population may also contribute to potential issues with access, complexity of care and multiple chronic health conditions. Efforts to negate these increases by decreasing readmissions and length-of-stay through expanded primary care must include hospital, physician (primary and secondary) and post- acute care alignment to ensure success.

While many challenges are ahead, we are optimistic about the changes taking place toward creating a high performing health care system and are grateful for the opportunity to be a part of this review. It is in the spirit of developing the best possible plan that we offer these comments on the information presented so far.

HealthRight

1. HealthRight anticipates that the Council will play a critical role in improving our statewide health care system. However, HealthRight feels strongly that:
 - a. The Council should have a community-appointed co-chair. We recommend Fox Wetle.
 - b. The Council should have more funding to enable a more comprehensive research scope and a faster timeframe for designing a coordinated statewide health care plan. We know that it might not be possible to get more state funding for this goal – but we would urge the council to continue to raise foundation dollars to make this happen.
2. HealthRight would like to see the Council take a more strategic approach to managing the research they have asked the consultants to undertake. Specifically, as the consultants carry out their research, we would like them to be guided by the following kinds of strategic questions (rather than just a numerically based set of questions):
 - a. Instead of the question being only about hospital beds, what are the ideal *bed and service* configurations that would yield the best outcomes at the lowest cost? This study should also include an analysis of hospital capacity during peak demand and on a per-hospital basis, and clearly define what is meant by “excess capacity”.
 - b. Behavioral health should be included in these analyses. What are the ideal kinds of behavioral health services that would yield the best behavioral health and medical outcomes at the lowest cost? How should behavioral health be reimbursed (and at what levels) on its own and as part of broader payment models?
 - c. What is the economic impact of the proposed primary care providers plan? Is this model in use anywhere else in the country? If so, what has the impact been?
 - d. Are the hospitals appropriately staffed in terms of quantity *and* quality? Or do they need to reallocate or retrain staff?

- e. What is the economic impact on hospitals and premiums of the spun-off independent specialty service centers?
 - f. For recommended cost containment strategies, is it possible to see the proof of their effectiveness?
 - g. In ten years, what will the health care demands of the population be, and how well positioned is our system to manage those demands?
3. HealthRight would like the council to clarify what is meant by “best outcomes” since there are varying definitions of what constitutes a good health outcome. Ideally, we would like the members of the council to be able to determine the definition of “best outcomes” themselves, in a facilitated process.
 4. HealthRight would like the Council to create specific opportunities for public participation, including a public hearing or public input session.