

Coordinated Health Planning in Rhode Island

A report submitted to:

The Rhode Island General Assembly
Joint legislative committee on health care oversight
House committee on finance
Senate committee on finance

Submitted by:

The Director of the Department of Health
in consultation with
The Coordinated Health Planning Advisory Committee



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Executive Summary

The Coordinated Health Planning Act of 2006 charged the Director of the Rhode Island Department of Health (HEALTH), in consultation with an advisory committee, to develop this report, which assesses existing state capacity and authority to perform coordinated statewide health planning. This report also includes a plan to develop and revise health planning documents to improve the state's health care system.

Health planning describes an iterative process that uses an assessment of current and projected health needs to set goals for the most effective and efficient allocation of future health resources. It describes the current system, goals for the future, options for achieving those goals, and whether those goals were achieved.

Findings

In the course of six meetings between October 2006 and March 2007, the Director of HEALTH and the Coordinated Health Planning Advisory Committee (Advisory Committee) found the following:

- The health care system has not and will not transform optimally or effectively without a robust health planning process that features collaboration and coordination across all public and private sector participants.
- The state does have the authority to establish a health planning process; however, additional authority is recommended to implement the health planning process as envisioned in the report.
- The state does not have sufficient capacity to establish this health planning process. Existing capacity is limited to conducting isolated health planning studies that are single-issue and uncoordinated with a comprehensive plan.

Recommendations

The Director and Advisory Committee recommend the following plan for conducting coordinated health planning to improve Rhode Island's health care system:

- **Objectives.** Rhode Island's coordinated health planning process should have the following objectives:
 1. Conduct ongoing assessments of the state's health care needs and health care system capacity. These assessments should be used to determine the most efficient and affordable capacity and allocation of providers, services, and equipment that will best serve the health of Rhode Islanders;
 2. Review and recommend innovative models of health care delivery that should be encouraged in Rhode Island;
 3. Review and recommend health care payment that rewards improved health outcomes;
 4. Evaluate the impact of the health planning process through measurements of quality and appropriate use of health care services;

5. Promote the adoption of technology that improves the availability of health information across the health care system; and
 6. Recommend legislation and other actions that achieve accountability and adherence in the health care community to health planning directives.
- **Infrastructure.** An Office of Health Care Planning and Accountability should be created within HEALTH and funded with an annual budget of \$1–1.25 million to establish a health planning process that responds dynamically to an ever-changing health care landscape. This new work requires new resources to coordinate data analysis, system-wide goal development, planning, and plan implementation on behalf of all Rhode Islanders – health care consumers, providers, and payers.
 - **Governance.** The Director of HEALTH should appoint a Health Care Planning and Accountability Council that would oversee the health planning process. The Council would be co-chaired by the Secretary of OHHS and the Director of HEALTH, and be advisory to both OHHS and HEALTH. Other members of the Council would include consumers, providers, purchasers, and the major insurers.
 - **Public accountability.** Rhode Island’s health planning process must publicly report, on an annual basis, the current health care system status, health care system goals, and any progress or barriers to achieving those goals. This report will provide the basis for holding health care system participants accountable for developing policies that are consistent with achieving health system goals.

Conclusion

The U.S. health care system – and Rhode Island’s health care system – are notoriously fragmented. One consequence of this is that the system costs more without better results in terms of population health. As the Coordinated Health Planning Act of 2006 stated in its legislative findings, a robust health planning process in Rhode Island should lead to improvements in the health care delivery system through the creation of a unified health care system planned and coordinated in public-private partnership. The health care system must transition from one based on competition to one that is rewarded for collaboration and coordination. A coordinated health planning process that values both public and private input is the first step.

The Director and the Advisory Committee struggled to plan for a health planning process that would be used by multiple parties in the state and revised often. Thus, the recommendations in this report favor the infrastructure, governance, and public accountability mechanisms designed to get traction for health planning reports in health care policy-making, instead of leaving those health plans to gather dust on a shelf.

The development of this report garnered a high level of community interest and participation. Importantly, it demonstrated that a public-private collaboration can set forth goals and direction for Rhode Island’s health care system that a broad array of stakeholders will support. The objectives for the health planning process are ambitious, but feasible, given the appropriate commitment from the public and private sector.

I. Background

The Coordinated Health Planning Act of 2006 charged the Director of the Rhode Island Department of Health (HEALTH), in consultation with and an advisory committee, to develop this report to assess existing state capacity and authority to perform coordinated statewide health planning, including a plan to develop and revise health planning documents to improve the state's health care system. In the Act's legislative findings, the General Assembly recognized that a robust health planning process in Rhode Island should lead to improvements in the health care delivery system through the creation of a unified health care system planned and coordinated in public-private partnership.

What is health planning?

A simple description of planning is “making current decisions in light of their future effects.”¹ Health planning refers to a process that determines the criteria for making health care investment decisions. Given that health care services exist in an ever-changing environment, health planning is an iterative process that uses an assessment of current and projected health needs to recommend a most effective allocation of future health resources.²

Developing this report

To provide broad community input to this report, the Director of HEALTH appointed an Advisory Committee. Participants on this Advisory Committee included health care insurers, consumers, and providers. The list of invited members to the Advisory Committee and their record of attendance, as well as the meeting schedule, agendas, and meeting minutes, appear in Appendix A.

Additionally, the Advisory Committee held two community forums. At the October 30th Community Forum, members of the community expressed their interest in participating in a health planning process and made suggestions as to the elements of the structure and process to conduct health planning. At the February 12th Community Forum, members of the community made comments on an early draft of this Advisory Committee report to the General Assembly. Appendix B contains a summary of testimony given at both community forums.

HEALTH staff also conducted research on the history of health planning in Rhode Island and in the U.S., as well as current health planning activities in other states. A summary of this background information is available in Appendix C.

¹ Bergwall DF, Reeves PN, Woodside NB. 1973. Introduction to Health Planning. Information Resources Press: Washington D.C.

² Thomas, RK. 2003. Health Services Planning, Second Edition. Kluwer Academic/Plenum Publishers: New York.

II. Findings

II.a. Vision for Rhode Island's health care system

The Director of HEALTH and the Advisory Committee agreed upon this vision for Rhode Island's health care system to guide their discussion:

Every Rhode Islander should have access to high quality, affordable health care, delivered at the most appropriate time and place.

Together, the Director and the Advisory Committee identified the following characteristics of Rhode Island's health care delivery system that are necessary to achieve this vision. To meet the community's expectations for high quality, affordable health care, the delivery system must:

- Deliver health care according to latest scientific evidence, using current evidence-based guidelines where available;
- Improve the quality, efficiency, and accessibility of health care services;
- Improve affordability by ensuring efficient utilization of health care providers and services;
- Partner with the consumer in his/her health care;
- Orient the system towards person-centered care, with family involvement as appropriate;
- Respond to the health care needs of the community, in terms of access and cultural and linguistic competence;
- Improve the health status of the population.

Additionally, the Office of the Health Insurance Commissioner uses "affordability principles" as defined in state statute (Rhode Island General Laws 27-50-10) to describe an affordable health care delivery system that is consistent with the Advisory Committee's vision. The health care delivery system should have:

- Emphasis on primary care, prevention and wellness;
- Use of least cost most effective setting for care;
- Use of evidence-based medicine;
- Active management of chronic diseases.

Gap between current system and the vision for RI's health care system

At monthly meetings, members of the Advisory Committee discussed how our health care system falls short on each of these expectations. In the absence of a planning process, other factors have influenced the shape of the health care system. For example:

- The prevailing financing system rewards individual practitioners or organizations for services provided, rather than rewarding teamwork across providers in the health care system for delivering recommended care in the right place at the right time.

- The health care system rewards services provided in the short-term, but does not provide incentives for delivering services that improve health status in the long-term.
- Health care providers compete by developing lucrative lines of service, which leads to an overall community investment in fixed-cost technology and equipment and capacity that exceeds community need. A combination of competition between providers and perception among consumers that “more is better” has led to a proliferation of services, technology, and equipment that are dispersed across health care organizations with insufficient regard to the appropriateness of setting or quality of services delivered.

Potential results of establishing a health planning process

A health care system that overcomes the current challenges to achieving quality, accessibility, and affordability in health care will necessarily change some aspects of the current system.

Primary care

Greater priority must be placed on addressing the challenges of the primary care practitioner. A health planning process that identifies the expectations for services provided by the primary care practitioner (e.g., coordination and collaboration with specialty providers), and pays accordingly, will increase the quality of primary care services and preserve an appropriate capacity of primary care in Rhode Island. Excess capacity of specialty services, technology, and equipment, which are needed less often, should be reduced so as to decrease unnecessary expenditures in the system.

Integrating physical health care and mental health care

The integration of physical and mental health care is an important, if often overlooked, strategy for improving health care delivery overall. Mental health status can affect physical health and use of health care services, but because mental and physical health care provider systems operate largely independently from each other, individuals often do not receive “whole person” care and treatment. A unified health planning process that considers both systems at once can help to plan for integrating these systems.

Community hospitals

Attention must also be given to the struggles of the community hospitals. The financial future of community hospitals will be imperiled if the collective efficiency of their operations does not improve. Furthermore, the role of these hospitals must change if the future context of the health care system is one that rewards improved health outcomes as well as pays for individual episodes of acute and specialty care. A health planning process that addresses these changes will strengthen community institutions while at the same time reducing redundancy in the current system.

Long-term care

As Rhode Island's population ages, the quality and capacity of the long-term care system will have major impacts on the health care system, and vice versa. Planning for long-term care services, including both institution-based and community-based care, is best done in conjunction with planning for other aspects of the health care system.

Shaping the health care system today and in the future

Rhode Island currently has a regulatory process in place that reviews the placement and development of specialty services and large capital investments through Certificate of Need applications, initial licensure requests, and "change in effective control" requests. This process involves the Health Services Council, an advisory body to the Director of HEALTH. However, continuing solely with a regulatory strategy to shape the health care system is not sufficient for achieving the objectives identified in a health planning process.

In order to change fundamentally the health care system today, the underlying factors that contribute to its current features must change. A health planning process should establish the direction for Rhode Island's health care system so that public and private sector entities will align all of the incentives that they control in the health care system – namely, financing, public reporting, regulation, and consumer incentives – to drive towards the same vision for improvement in health care.

II.b. Vision for Rhode Island's health planning process

The Director and the Advisory Committee recommend that a comprehensive, coordinated health planning process is necessary to design a health care delivery system that meets the community's expectations and to maintain and improve the health of the population. In fact, the health care system has not and will not transform optimally or effectively without a robust health planning process that is defined by its successful coordination of data analysis, system-wide goal development, planning, and plan implementation.

Objectives of a health planning process

To meet community expectations, a health planning process should be collaborative and coordinated across all public and private sector participants in the health care delivery system, and be informed by a consumer perspective. The planning process should be dynamic and should continuously work towards implementation in the health care system in accordance with health planning studies.

The Director and the Advisory Committee recommend six objectives of the health planning process. These are:

1. Ongoing assessments of RI's health care needs and health care system capacity. These assessments should be used to determine the most efficient and affordable capacity and allocation of providers, services, and equipment that will best serve the health of Rhode Islanders. An appropriate capacity and allocation should be

identified based on population health needs, rather than through the competitive strategies of providers. A range of demand scenarios should be considered in determining the appropriate capacity and allocation of health care, from lower long-term utilization (e.g., as health status improves) to higher short-term utilization (e.g., as in a public health emergency.)

2. Development of innovative models of health care delivery. The health planning process should identify successful models of health care delivery that could be implemented broadly to improve the health care system. These innovative models may be developed in demonstration projects led by private groups or state agencies in Rhode Island or nationally. Of particular interest to the Rhode Island community are models of health care delivery that successfully integrate physical and behavioral health care; encourage home and community based long-term care services; and address end-of-life care appropriately.
3. Payment that rewards improved health outcomes. The methods and levels of payment to health care providers have historically been among the strongest determinants of the supply of health care providers, services, and equipment. The health planning process should result in a change in payment to health care providers that is consistent with the priorities for supply, allocation, quality, and health status improvement developed in the health planning process.
4. Measurements of quality and appropriate use of health care services. Health planning decisions should be informed by ongoing measurement of health care quality and use. A health planning process would coordinate with current and planned efforts to use public reporting to provide information to consumers and providers in order to drive improvement in the health care system. These measures should also be used to evaluate the impact of the health planning process on the health care system.
5. Adoption of technology to improve the availability of health information across the health care system. The health planning process should promote the adoption of health information technology in a manner coordinated with other efforts to increase HIT adoption for the sake of improved patient care. HIT adoption should contribute to measurement and reporting of information about health care providers, too.
6. Legislation and other actions that achieve accountability and adherence in the health care community to health planning directives. Because a major focus of the health planning process will be on finding ways to implement health planning outcomes, legislation or other actions may be necessary to ensure implementation. Participants in the health planning process should be involved in identifying appropriate actions to secure implementation.

Strategies to achieve health planning objectives

The Director and the Advisory Committee also recommend that participants in the health planning process harness the same strategies that currently shape the health care system to implement coordinated health planning objectives. These include:

- Purchasing: Employers and insurers in the public and private sectors shape payment to health care providers and other financial incentives according to health planning objectives.
- Public reporting: Publicly-available reports on health care quality are designed to provide a non-financial incentive to drive health planning objectives.
- Regulation of licensed health care entities: All state agencies consider the direction of health care system established by health planning process when carrying out their regulatory activities.
- Consumer incentives: Health insurance products and health providers include incentives for consumers to use the health care system in a manner consistent with health system objectives.

Table 1 summarizes the recommended objectives of the health planning process and implementation strategies. The table also illustrates the strength that each strategy has in implementing each deliverable, as indicated by a diamond rating where three diamonds indicates that the strategy is most likely to be used in implementation. For example, purchasing is the most likely strategy to be used to implement new payment mechanisms and to achieve an appropriate health care supply. Regulation will be a less likely strategy for driving the adoption of innovative models of health care.

Table 1. Recommended objectives of the health planning process and strategies for implementation (◆ = less likely; ◆◆◆ = most likely).

<i>Objectives</i>	<i>Implementation strategies</i>			
	Purchasing Self-insured employers Commercial insurers Government-sponsored insurance	Public reporting Commercial insurers HEALTH reports	Regulation All state agencies E.g.,: CON, licensing	Consumer incentives Health plan design (commercial and public) Health care providers
1. Continual assessment of RI's health care needs that is used to determine and achieve the appropriate capacity and allocation of providers, services, and equipment to meet Rhode Island's health care needs efficiently and affordably.	◆◆◆	◆	◆◆◆	◆◆
2. Development of innovative models of health care delivery.	◆◆◆	◆◆	◆	◆◆
3. Payment that rewards improved health outcomes.	◆◆◆	◆	◆	◆◆
4. Measurements of quality and appropriate use of health care services.	◆◆	◆◆◆	◆	◆◆
5. Adoption of technology to improve the availability of health information across the health care system.	◆◆◆	◆◆	◆◆◆	◆◆
6. Legislation and other activities that achieve accountability and adherence in the health care community to health planning directives.	◆	◆◆	◆◆◆	◆◆

II.c. Assessment of current state authority and capacity to perform coordinated health planning

Findings

In the Coordinated Health Planning Act of 2006, the Rhode Island General Assembly specifically requested that the Director of HEALTH, in consultation with an Advisory Committee, conduct an assessment of the state authority and capacity to perform coordinated statewide health planning. The Director and Advisory Committee find that:

- The state does have the authority to establish a health planning process; however, additional authority is recommended to implement the health planning process as envisioned in the report.
- The state does not have sufficient capacity to establish this health planning process. Existing capacity is limited to conducting isolated health planning studies that are single-purpose and uncoordinated

State authority to conduct coordinated health planning

With regard to authority, HEALTH is the state agency with the specified authority “to conduct health planning studies and to develop health plan documents.” The Director of HEALTH, with approval of the Governor, also has the authority to “appoint various committees and task forces as appropriate to assist and advise the department of health in the conduct of its health planning responsibilities.” Sections 23-1-1.1 and 23-1-1.2 of the Rhode Island General Laws state:

23-1-1.1 Health planning – Findings. – It is found and determined that health planning is essential to promote appropriate access to high quality health services at a reasonable cost and is a precondition to effective public health practice by the department of health; and that health planning is a prerequisite to the effective discharge of the department of health's certificate of need responsibilities.

23-1-1.2 Health planning process. – The department of health is authorized to conduct health planning studies and to develop health plan documents to assist the department of health, the director of health, and the health services council in the conduct of their public health responsibilities. The director of health, with the approval of the governor, may appoint various committees and task forces as appropriate to assist and advise the department of health in the conduct of its health planning responsibilities, provided that the director of health may appoint ad hoc short-term committees or task forces to advise and assist the director on technical issues.

Additionally, Section 23-15-4(e) requires the Health Services Council, which advises the Director of HEALTH on licensing reviews and Certificate of Need applications, to consider any state health plans conducting those reviews and in determining need.

The Executive Office of Health and Human Services (EOHHS) also has a directive to improve health planning and implement best practices for access, safety, and positive outcomes. Section 42-7.2-2 of the Rhode Island General Laws states:

42-7.2-2 - Executive office of health and human services. – There is hereby established within the executive branch of state government an executive office of health and human services. This office shall lead the state's five health and human services departments in order to:

- (a) Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing.
- (b) Design strategies and implement best practices that foster service access, consumer safety and positive outcomes.
- (c) Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards.
- (d) Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments.
- (e) Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf.

Additionally, Section 42-7.2-5 authorizes the Secretary of EOHHS to do the following, both of which could contribute to the state's authority to conduct coordinated health planning:

- (h) Improve the ability of departments to utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development; and
- (i) Foster the establishment of an integrated approach to interdepartmental information and data management that will facilitate the transition to consumer-centered system of state administered health and human services.

The Office of the Health Insurance Commissioner (OHIC) is directed by statute to accomplish similar objectives to those proposed for a health planning process. Specifically, Section 42-14.5-2 of the Rhode Island General Laws states:

42-14.5-2 Purpose. – With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:

- (a) Guard the solvency of health insurers;
- (b) Protect the interests of consumers;
- (c) Encourage fair treatment of health care providers;
- (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

In summary, there are three public entities - HEALTH, EOHHS, and OHIC – that have broad authority to conduct health planning and influence the development of the health care system. In particular, HEALTH has the authority to create advisory bodies to assist in health planning.

State authority to implement health planning guidance

There is little authority to implement health planning guidance developed by HEALTH or by an advisory body beyond regulation through licensing and Certificate of Need. For example, neither EOHHS nor OHIC have the statutory mandate to consider statewide health planning activities in health care purchasing or regulation. This proposal recommends that one objective of the health planning process be the identification of additional authorities as needed. Specifically, these authorities may include legislation and other activities that achieve accountability and adherence in the health care community to health planning guidance.

State capacity to conduct coordinated health planning

With regard to capacity, there are currently numerous health planning activities that occur around the state, but with inadequate coordination. Table 2 describes the current status of health planning studies as a proxy for the current or recent capacity that the state has to conduct limited health planning. Most health planning studies and reports, if conducted at all, are completed for a single purpose. This approach to health planning does not provide for the coordinated development of strategic plans to improve the quality, accessibility, or affordability of the state's health care system.

Thus, the Director and Advisory Committee find that the state has very limited capacity to perform coordinated statewide health planning. Capacity can be measured in three ways:

- 1) Ability and authority to convene public and private participants and facilitate adoption of a single coordinated state wide health planning process;
- 2) Staff resources to organize public and private participants and produce analyses to inform the products of the health planning process; and
- 3) Budgetary resources to collect data, maintain databases, and hire technical consultants for analyses of specific components of health planning.

There is no health planning body in Rhode Island that has all three measures of capacity. The Secretary of EOHHS, Health Insurance Commissioner, or the Director of a state agency (such as HEALTH) may convene private sector entities and various state agencies to participate in a health planning process, but does not have staff or budgetary resources to conduct or coordinate health planning activities statewide. As demonstrated by the SHAPE Foundation's health planning studies (SHAPE studies) financed by Blue Cross Blue Shield of RI³, the private sector has the budgetary resources to conduct health planning studies and to convene community partners, but is not viewed as a neutral player in the health care sector and does not have direct public accountability, including required compliance with open meeting or public record laws.

Current health planning activities in Rhode Island

As described below in Table 2, some infrastructure exists to conduct health planning studies within state agencies such as HEALTH, the Department of Human Services (DHS), and EOHHS. For example, Healthy Rhode Island 2010 planning at HEALTH sets goals for risk

³ Available at: www.shaperi.org

reduction to improve population health, and goals for Medicaid spending at DHS often shape purchasing policies that affect the health services delivery system. Private sector-led health planning activities have also occurred. However, these planning activities do not always result in directives that may be readily implemented to shape the health care system.

Table 2. Current and recent past health planning activities in the state of Rhode Island

Health planning activity	Purpose	Lead agency / organization	Status
<i>Population health</i>			
Healthy Rhode Island 2010	Identify current and target measures for risk reduction in the population (leading health indicators) & highlight priority areas for improvement	HEALTH	Funded by federal Preventive Block Grant. Completed mid-course review in 2006. Anticipate Healthy RI 2020 planning process.
Disease- or condition-specific state plans for improvement (e.g., asthma, diabetes, tobacco control, etc.)	Identify goals and intervention plans to improve disease prevention and control.	HEALTH	Funded by federal grants from CDC for specific programs. In various stages of development.
State partnership for minority health	Identify current and target measures of population health (leading health indicators) & highlight priority areas for improvement	HEALTH	State and federal funding.
State plan for improving health of persons with disabilities	Identify opportunities and strategies to improve health of persons with disabilities.	HEALTH	Federal funding.
<i>Health care professions</i>			
Designation of Health Professional Shortage Area (HPSAs) and Medically Underserved Areas (MUAs)	Identify shortage/ underserved areas and bring resources to those areas, e.g., state loan repayment program, National Health Service Corps, Medicare Incentive Program, etc.	HEALTH	Statewide surveys of all Rhode Island licensed primary care physicians, psychiatrists, and dentists conducted every 3 years. Funded through federal grant for specific program.
SHAPE studies –	Identify capacity health care	BCBSRI	Last study published

Health planning activity	Purpose	Lead agency / organization	Status
Nurse, Physician, Behavioral Health Workforce	professionals and project future capacity		in 2005.
<i>Health care equipment and technology</i>			
Ad hoc studies on equipment / technology reviewable by Certificate of Need (CON): cardiac catheterization, PET, linear accelerators.	Statewide surveys on current supply and capacity of equipment and technology conducted for Health Services Council in the course of reviewing specific CON applications.	HEALTH	Studies are re-active, not pro-active, and limited to informing the review of current CON applications.
<i>Health care services</i>			
Ad hoc studies on specialty care services reviewable by CON: open heart surgery, organ transplantation, neo-natal intensive care.	Statewide surveys on current supply and capacity of specialty care services conducted for Health Services Council in the course of reviewing specific CON applications.	HEALTH	Studies are re-active, not pro-active, and limited to informing the review of current CON applications.
Reports developed by the Tertiary Care Committee	Licensing regulations for health care facilities may set minimum volume standards for tertiary care services where a volume-quality relationship is indicated. Reports on volume for various services produced for Committee's consideration.	HEALTH	No specific funding source.
<i>Health care facilities</i>			
Ad hoc studies on health care facility capital investment reviewable by Certificate of Need (CON).	Statewide surveys on current supply and capacity of specific health care facilities conducted for Health Services Council in the course of reviewing specific CON applications.	HEALTH	Studies are re-active, not pro-active, and limited to informing the review of current CON applications.
SHAPE studies – Health care facilities	Identify capacity of health care facilities and project future capacity	BCBSRI	Last study published in 2005.

Health planning activity	Purpose	Lead agency / organization	Status
<i>Health care delivery system</i>			
Plan for alternative financing and deliverables for chronic care in the ambulatory care setting	Identify innovative practices and payment mechanisms in primary care delivery system that improve chronic care conditions for patients in that system.	Office of Health Insurance Commissioner (OHIC)	2-year funding from private foundation.
Future of Medicaid study	Identify optimal expenditure and utilization of health care services in Medicaid.	EOHHS	No direct funding.
“Lively Experiment”	Identify universal health care mechanisms.	Health Care Organizing Project and Ocean State Action	Occurred November 2005.
RI Public Expenditure Council (RIPEC) Medicaid study	Identify optimal expenditure and utilization of health care services in Medicaid.	RIPEC and state agencies	No direct funding.
State Rehabilitation Plan	Plan for providing rehabilitation services	Department of Human Services – Office of Rehabilitation Services & Rehabilitation Services Council HEALTH	
State Independent Living Plan	Promote independent living through implementation of financing strategies, collaboration, and development of service providers.	Department of Human Services – Office of Rehabilitation Services & Independent Living Council	Federal funding.
Plan to implement transparency legislation (RIGL 42-14.5-3 (d)(iv))	Report to the legislature on proposed methods for HMOs and nonprofit hospital or medical service corporations to make facility-specific data and other medical service-specific data available in reasonably consistent formats to patients regarding	OHIC	Report due March 15, 2007

Health planning activity	Purpose	Lead agency / organization	Status
	quality and costs.		
<i>Health care quality</i>			
Health plan performance reports	Report on the clinical care and customer satisfaction of health plan members.	HEALTH	No specific funding source.
Public reporting on hospital, nursing home, and home health agencies	Provide clinical and patient satisfaction measures of quality to the public.	HEALTH	Funding source is state revenue and in-kind contribution of data from providers.

III. Recommendations

The Director and the Advisory Committee recommend that the state implement a coordinated health planning process as soon as possible. This health planning process, as well as accountability mechanisms to ensure the implementation of health planning directives that have been adopted in a collaborative forum, should be established as soon as possible. The state's existing capacity to conduct health planning is insufficient to achieve the objectives of the recommended health planning process. For example, resources are required to create the capacity within the state to coordinate the data analysis and system-wide goal development necessary for a health planning process. The state's existing authority is sufficient to establish a health planning process, but new authorities may be developed to ensure implementation of health planning guidance through health care purchasing, public reporting, regulation, and/or the design of consumer incentives. New authorities are also recommended in order to achieve the level of accountability for the planning process as envisioned by this report.

III.a. Structure of health planning entity

Members of the Rhode Island community expressed their views on the structure for a health planning process through participation on the Advisory Committee and in testimony at the Community Forums (see Appendix B).

Considering those perspectives, the Director and Advisory Committee recommend the establishment of a coordinated health planning process with the following structure.

- **Infrastructure.** An Office of Health Care Planning and Accountability at HEALTH should serve as the principal staff agency of the health planning process. The responsibility of this office would be to develop analyses of the health care system, including health planning studies and health plan documents; recommend guidance for stakeholders to consider for adoption, modification, and promotion; and ensure the continuous and efficient functioning of stakeholder input in the health planning process. This office should coordinate closely with other state agencies' planning efforts, both within EOHHS and other state agencies.

In making a recommendation about creating an office within state government for the health planning process, members of the Advisory Committee weighed the relative advantages of having a private-sector entity, quasi-public agency, HEALTH, or EOHHS serve as the principal staff agency. The Advisory Committee recommends that a public agency should serve in this role so as to enhance its accountability and ties to regulatory and public purchasing activities. For example, HEALTH has existing regulatory processes to implement health planning recommendations and EOHHS has broad authority to coordinate planning activities across the state's health and human service agencies. Additionally, it may have greater influence over public sector health care purchasing decisions (i.e., Medicaid).

In the end, the Advisory Committee identified HEALTH as the most appropriate location because it has the programmatic capacity to contribute to this office. It has direct statutory authority to create health plans and to collect data from licensed providers. It is also the locus of ongoing planning activities related to population health, as well as ad hoc planning studies used in review of Certificate of Need applications.

- **Governance.** The coordinated health planning process should be overseen by a Health Care Planning and Accountability Council composed of individuals who represent a broad array of stakeholders. The Council should be co-chaired by the Secretary of EOHHS and the Director of HEALTH. Other members of the Council would include consumers, providers, purchasers, and the major insurers appointed by the Director of HEALTH with approval of the Governor.

Members of this Council would serve a defined term of 3 years, with the option to renew for one year. The Council would be responsible for overseeing the health planning process, including the coordination of health planning activities in Rhode Island and the development of guidance on the shape of the health care system for public and private sector entities to consider when creating health care policies. This body would adopt, modify, and promote guidance to meet the objectives of the health planning process (outlined above.)

Members of this Council would include individuals from the following positions or categories. Designees should not be permitted.

- 1) Five consumer representatives. A consumer is defined as someone who does not – directly or through spouse/partner - receive any of his/her livelihood from the health care system. Consumers may be nominated from among the labor unions in Rhode Island; the health care consumer advocacy organizations in Rhode Island; the business community; and organizations representing the minority community who have an understanding of the linguistic and cultural barriers to accessing health care in Rhode Island;
- 2) One hospital CEO nominated from among the hospitals in Rhode Island;
- 3) One physician nominated from among the primary care specialty societies in Rhode Island;
- 4) One physician nominated from among specialty physician organizations in Rhode Island;
- 5) One nurse or allied professional nominated from among their organizations in Rhode Island;

- 6) One practicing long-term care administrator, nominated from among the long-term care provider organizations in Rhode Island.
- 7) One provider from among the community mental health centers in Rhode Island;
- 8) One provider from among the community health centers in Rhode Island;
- 9) One person from a school or program for health professionals in Rhode Island.

The following members would be ex officio members with voting privileges. They are ex officio because the members would serve for as long as they held these positions, and would not be bound by term limits:

- 10) Health Insurance Commissioner;
- 11) Director of the Department of Human Services;
- 12) CEOs of each health insurance company that administers the health insurance of 10% or more of insured lives in Rhode Island;

- **Advisory Committees.** Advisory committees should be appointed by the Health Care Planning and Accountability Council as needed to advise on aspects of the state health planning documents considered for adoption.
- **Public input.** Council meetings should allot dedicated time for public testimony.
- **Transparency.** All planning studies and documents should be publicly available.

III.b. Elements of health planning process

Scope

Members of the Rhode Island community also expressed their views on the scope of activity that a health planning process should undertake.

Long-term: Planning process should meet all six objectives.

Short-term: Planning process should focus on assessing Rhode Island's health care needs that can be used to develop guidance on the appropriate capacity of and allocation of health care providers, services, and equipment. Health planning studies could be used immediately by the Health Services Council in their review of applications for Certificate of Need, initial licensure, and effective change of control of licensed facilities.

Public accountability

The Director and the Advisory Committee recommend that the Governor's Office and the General Assembly hold members of the Health Care Planning and Accountability Council accountable for making progress towards achieving the recommended objectives of the health planning process. The Council should provide an annual report to the Governor's Office and General Assembly, in particular the House Committee on Health, Education and Welfare; the Senate Committee on Health and Human Services; and the Joint Committee on Health Care Oversight.

This report should describe:

- The current status of RI's health care system;
- Health care system goals as set forth by the Health Care Planning and Accountability Council; and
- Any progress towards or barriers to achieving those goals.

This report will provide the basis for holding health system participants accountable for developing policies that are consistent with achieving health system goals. For example, as public and private entities pursue health care purchasing, public reporting, regulatory, and health benefit design activities, this annual report will identify the extent to which they support or impede progress toward RI's health care system goals. This annual report will be the primary mechanism for monitoring the impact of the health planning process. This monitoring mechanism will contribute to the dynamism of a health planning process that is continually assessing its progress and adjusting its strategies in response to an ever-changing health care landscape.

Implementation of health planning

One of the most important outcomes of the health planning process will be the ongoing creation and refinement of mechanisms that ensure the implementation of the health planning guidance. While existing regulatory authorities, such as the Certificate of Need process at HEALTH, could be used to implement health planning directives immediately, other implementation strategies such as public reporting, regulation, consumer incentives, and health care purchasing (and payment policies) may need to be further developed.

The Director and the Advisory Committee recognize that payment is one of the greatest drivers of the health care system. Therefore, if the health planning process is to be effective, public and private payers would ideally use payment to health care providers to drive implementation. Changes in payment can be implemented voluntarily, or be influenced through regulatory oversight. Through public monitoring of the actions taken to implement the health planning guidance, the Health Care Planning and Accountability Council and its interested parties are better positioned to propose additional authorities where needed to strengthen or accelerate effective health care system change based on the health planning process.

III.c. Resources needed for implementation of a health planning process

The Director and the Advisory Committee recognize that the establishment of a coordinated statewide health planning process requires an investment of resources that is substantial. If this planning process is effective, the potential savings of in the health care system will far outweigh the expenditure suggested here. Additionally, the investment in the staff and structure for a health planning process will leverage in-kind donations from state agencies and the private sector in their effort to implement coordinated plans for Rhode Island's health care delivery system.

Health care expenditures in Rhode Island every year total about \$6 billion. The Director and the Advisory Committee recommend that the state invest between \$1 million and \$1.25 million annually in a health planning process that meets all of the objectives outlined above. This

amount is consistent with past levels of spending on health planning in the public and private sector.

Broadly, an allocation of \$1 million or greater would fund a small staff to the Office of Health Care Planning and Accountability, a cadre of technical consultants with specialty in the various aspects of the health care system, and importantly, the aggregating, linking, and mining of existing data systems currently held by state agencies. Much of the state's potential for doing robust health data analysis and health needs planning is lost because the resources used to build those systems are only sufficient to build them for isolated objectives, and not for collaboration. The technical expertise to work with existing data, and the staff oversight of the use of that data in the planning process, would be a valuable contribution to Rhode Island's health care system.

In addition to data analysis functions, a fully-funded Office of Health Planning and Accountability would:

- Convene the Health Care Planning and Accountability Council and appropriate advisory committees.
- Provide health planning studies and staff support to assist the decisions of the Health Care Planning and Accountability Council.
- Prepare data for public presentation.
- Coordinate planning activities across state agencies to ensure consistency.
- Identify additional authorities to implement guidance adopted by Health Care Planning and Accountability Council, as needed.
- Develop annual report to Governor and General Assembly on the strategies and effectiveness of the implementation of health planning guidance.
- Ensure that the Health Planning and Accountability Council meets its annual objectives.

IV. Conclusions

The U.S. health care system – and Rhode Island's health care system – are notoriously fragmented. One consequence of this is that the system costs more without better results in terms of population health. As the Coordinated Health Planning Act of 2006 stated in its legislative findings, a robust health planning process in Rhode Island should lead to improvements in the health care delivery system through the creation of a unified health care system planned and coordinated in public-private partnership. The health care system must transition from one based on competition to one that is rewarded for collaboration and coordination. A coordinated health planning process that values both public and private input is the first step.

This proposal for a coordinated health planning process in Rhode Island improves upon past efforts to conduct health planning in two important ways. First, it includes a process for formulating strategies to implement the plan – that is, a process to identify the authorities needed to make guidance become reality. Second, it includes a monitoring mechanism to hold the Office of Health Planning and Accountability, the Health Planning and Accountability Council, and the participants in the planning process accountable for progress made in making guidance become a reality.

The development of this report garnered a high level of community interest and participation. Importantly, it demonstrated that a public-private collaboration can set forth goals and direction for Rhode Island's health care system that a broad array of stakeholders will support. The objectives for the health planning process are ambitious, but feasible, given the appropriate commitment from the public and private sector.

Appendix A. Invited members of the Coordinated Health Planning Advisory Committee and record of attendance.

3/12/2007

Coordinated Health Planning Advisory Committee

2006/2007 Attendance

NAME	ORGANIZATION	Community Forum					Community Forum		
		10/3/2006	10/30/2006	11/9/2006	12/7/2006	1/4/2007	2/8/2007	2/12/2007	3/12/2007
Kyle Adamonis	TACO; RIBGH								
Jeffrey Borkan, MD, Ph.D.	PCPAC			X					
Richard Brooks	UNAP	X			X				
Jessica Lee Buhler	Senior Agenda Coalition		X	X			X		
Kerrie Jones Clark	RIHCA	X				S	X		
Kathleen Connell	AARP	X		X		X		X	
Stephen Farrell	UnitedHealthcare					S			
Kathleen Fitzgerald, MD	RIMS	X			X	X			X
Louis Giancola	South County Hospital	X		X		X	X		
David Gifford, MD	HEALTH	X					X		
Robert Guneyi, MD	Progreso Latino			X	X	X	X		
Richard Harris	NASW/RI Chapter	X			X				
Roberta Hawkins	ABLTC	X		S	S	S	S		S
James Hennessey, MD	United Medicine Foundation								
Donna Huntley-Newby, Ph.D.	Rhode Island College	X			X	X	X		X
Christopher Koller	DBR	X					X		
Joan Kwiatkowski	CareLink	X		X	X	X	X		
Dennis Langley	Urban League of RI	S		S	X	S			
Tricia Leddy	MHRH	X							
Yvette Mendez	Northern RI AHEC	NA	NA	NA	NA	X	X		X
Craig O'Connor	Ocean State Action	X	X	X		X	X	X	
Peter Oppenheimer, Ph.D.	RI Psychological Assoc	X		X	X	X	X		
Donna Policastro	RISNA	X		X					
James Purcell	BCBSRI	X	X			X	X		X
Robert Quigley	Health Services Council	X			X	X	X		
Mark Reynolds	NHPRI	X		X	S		S	S	
Marti Rosenberg	U.S. Action	X		X	X				
Alfred Santos	RIHCA	X							
Andrew Snyder, MD	Academy of Pediatrics								
Frank Spinelli	DHS	X				X			
Margaret Sun, MD	RIAFP	X		X	X	X	X		X
Alan Tavares	RI Partners for Home Care	X	X	X		X	X		X
K. Nicholas Tsiongas, MD	RIMS	X	X	X	X	X	X		X
Dawn Wardyga	Family Voices of RI	X	X		X		X		
Terrie Fox Wetle, Ph.D.	Brown University	X	X	X	X	X	X	X	X
Bill Waters	HEALTH	X	X	X	X		X	X	X
Stephanie Kissam	HEALTH	X	X	X	X	X	X	X	X

NA: Not Applicable - not a member at that time

S: Substitute

X: Attended Meeting

Appendix B. Summary of Community Forum testimony

Summary of comments from Community Forum

Date of Community Forum: October 30, 2006

Time: 3:00 – 4:00 p.m.

Location: RI Department of Health, Health Policy Forum (Lower Level)

Individuals who spoke at the Community Forum:

Jessica Buhler, Senior Agenda Consortium

Nick Tsiongas, MD, MPH

Craig O'Connor, Health Care Organizing Project

Ted Almon Jr. (reading the statement of Edward F. Almon, Sr., Member, Health Services Council)

Individuals who sent written comments:

John X. Donahue

Fred Sneesby, Supportive Services Manager, Providence Housing Authority

Karlo Berger, President, Whole Health Solutions, LLC

The Coordinated Health Planning Advisory Committee requested that members of the community present their views on the following issues:

- The structure for coordinated statewide health planning in Rhode Island.
- The elements of a sustainable, coordinated statewide health planning process.

Overall

Community members favored the concept of health planning.

Community members also issued these caveats:

- Health planning should take a limited scope, at least at first.
- Health planning should not be entirely performed by government.

Structure for coordinated statewide health planning

Auspice: Two models were proposed – a) an “Authority” or “Board” with representatives from providers, government, and the community, or b) the Department of Health.

Examples:

- A Health Planning Oversight Board or Authority must be politically independent, serve a defined term, and represent stakeholders and the community (e.g., providers, business, labor, education, the elderly, minority communities, state agencies, social programs).
- An oversight board like the Federal Reserve Board, with the Director of Health or Health Insurance Commissioner as Chairperson.
- Board of Governors (9-11 representatives of interest groups) that oversees committees that are also representatives of various interest groups.
- State government should just be one player in a “hybrid” planning process.
- The Department of Health should have a strong planning role.

Participants: Two components of successful planning were identified as a) multi-stakeholder involvement, and b) participants who can be independent, objective, and knowledgeable.

- A variety of stakeholders must be involved in developing policy options and strategic plans, and then enforcing them either through their own policies (e.g., providers, health insurers) or other authorities.
- Providers should include complementary/alternative healthcare providers.
- Individuals involved in setting policy direction must be politically independent, honest, trustworthy, objective, knowledgeable about health care system, and follow ethical guidelines.

Source(s) Of Funds: Federal government, private foundations, state government, health insurers, and health providers were all suggested as sources.

Funding Level: Substantial funding will be required to address the findings of the Coordinated Health Planning Act of 2006.

Elements of health planning

Goals: Community members identified a wide range of goals for a health planning process.

Examples:

- Increase access to health care and coverage.
- Control and contain health care costs.
- Increase health care quality.
- Increase use of health information technology.
- Balance community needs with assuring the economic survival of provider organizations.

Relationship To Certificate of Need process: There was support for using the health planning process to inform Certificate of Need decisions in one of two ways – a) requiring that CON decisions are consistent with a health plan, or b) using a health plan to assist in evaluating CON applications.

Other recommendations include:

- Use state government mechanisms to support health planning.
- Use moratoria for specialty care services or technology pending strategic planning.

Scope: Recommendations ranged from comprehensive to limited scope.

Recommendations included:

- Focus on health service delivery system.
- Focus on health system infrastructure.
- Focus on medical technology.
- Focus on one aspect of health care delivery where planning “can be managed and accepted”.
- Use a planning horizon of 3-5 years.

- Include long-term care facilities and services.
- Include complementary/alternative healthcare providers.

Examples given of how health planning could have made a difference in cost of health care:

- MRI and CT scans
- Placement of coronary angioplasty services
- High-tech screening services

Potential outcomes: Health planning should provide advice to public sector and private sector entities that make decisions regarding health care investment.

Examples:

- Grant awards and government funds expended should be consistent with strategic plans, policies, priorities.
- Reimbursement policies should be supportive of strategic plans.
- Global budgeting should be a part of the health planning process.
- Rate-setting should fall either within the scope of a health planning authority or under different auspices that the health planning authority would coordinate.

Other comments

Request to add member of the Latino community to Advisory Committee.

- Update: Dr. Bob Guneyi, Medical Director at Progreso Latino, was invited to serve on Advisory Committee

Comment that there are health care resources at the Department of Human Services and Medicare – should coordinate with those entities.

Comment that health care technology vendors should be included in health planning process.

Summary of comments from Community Forum

Date of Community Forum: February 12, 2006

Time: 3:00 – 4:00 p.m.

Location: RI Department of Administration, Conference Room A

Individuals who spoke at the Community Forum:

- Annalee Wulfkuhle
- Lisa Smolski
- Greg Mercurio
- Liz Gemski, American Cancer Society – RI Chapter

Individuals who sent written comments:

- Edward F. Almon, Sr., Member, Health Services Council
- Kathleen Connell, AARP – RI Chapter

The Coordinated Health Planning Advisory Committee requested that members of the community present their views on the draft report titled “A Proposal: Coordinated Health Planning in Rhode Island” distributed February 5, 2007.

Summary

Annalee Wulfkuhle:

- Commented that it seems that the Coordinated Health Planning Advisory Committee is thinking of health planning as most appropriate for aggressive acute care services.
- Asked the Coordinated Health Planning Advisory Committee consider planning for end-of-life needs as well.
- Commented that planning is important from a cost standpoint – i.e., millions of dollars are going towards health treatment that could go to a non-traditional health care setting.
- Planning for end-of-life care would include planning for access, affordability, and quality of those services.

Members of the Advisory Committee asked Ms. Wulfkuhle asked:

Q: Of all the people who would benefit from hospice care, how many people receive hospice care?

A: 35-40%. Most people get additional care first, and then get hospice care. If we could add more palliative care services, we could increase quality and decrease cost of health care.

Q: What is the main barrier to accessing hospice care?

A: Nationwide, physician referral patterns do not advantage hospice care. Physicians are more inclined to different treatment, and might not have the relationship with their patients that makes them comfortable to suggest hospice care. In Rhode Island, people think of it as inpatient care.

Q: If there is greater demand, could workforce respond?

A: Yes. Even though there is a health care worker shortage overall, home and hospice care is growing.

Lisa Smolski:

- Applauded the work of the Coordinated Health Planning Advisory Committee.
- Stated that the Committee’s stated expectations for the health care system are consistent with all the things that the Rhode Island Free Clinic wants to do for the adult uninsured population.
- Asked the Committee to be mindful of the 120,000 uninsured individuals in Rhode Island, who are often overlooked in planning. The Emergency Rooms of our hospitals are not the place for them to receive care.
- Asked that the uninsured be heard in this process.

Comment from the group: One of the reasons to do health planning is to reallocate resources and make health insurance more affordable.

Greg Mercurio:

- Thanked the Committee for their work.
- Commented that he thought more people should know about this process.
- Presented his concerns both as a citizen and as a developer of high-technology radiation therapy center at Roger Williams Hospital, the founder/developer of PET/CT company that offers shared utilization of equipment that brings cutting edge technology to Rhode Island providers. He is a proponent of the Certificate of Need process.
- Pointed out the following:
 1. Absent from the report was a discussion of the need for parity between mental health services and physical health services. Suggested that the Committee include mention of the necessity for achieving parity for coverage between mental and physical health care services.
 2. There must be coordination between the Dept. of Health activities and other state activities. For example, believes that the 2% surcharge on diagnostic imaging services was inconsistent with this planning process. This surcharge applies to obstetricians and gynecologists and the gross revenues of all providers who do follow-up x-rays. This surcharge penalizes for-profit providers who bring a high standard of technology and services to the state by updating outdated equipment. For-profit providers have the expertise and resources to bring in technology, but they face barriers of higher taxes and the Certificate of Need process. As a result, Rhode Island physicians are building technological services in Massachusetts, and are still being reimbursed by Rhode Island's payers for the procedures they do. This undermines the planning process and shifts the beneficiary of tax revenue from these for-profit businesses from Rhode Island to Massachusetts. The Advisory Committee should be cognizant of this pattern.
 3. Currently, there is no incentive for providers to share the use of health care technology and equipment. For example, the MRI Network went out of business. Asked the Committee to think of ways to reward providers who are willing to set up the logistics of a shared utilization network (like PET/CT network). For example, community hospitals that need PET/CT services could benefit from the existence of mobile networks, but these networks are not rewarded.

Q: With regard to the providers who move out of state, is it due to the 2% surcharge or the Certificate of Need process?

A: Some people don't understand the Certificate of Need process, so it unnecessarily scares them away. However, it has more to do with the payers. For example, you get paid more to do surgery in Massachusetts than in RI.

Liz Gemski:

- Stated that she has been monitoring the Coordinated Health Planning process.
- Commented that goals for prevention are not stated in the plan.
- Commented that preventing disease or catching it early decreases the cost of treatment of the disease, so this point should be highlighted in the plan.

Written comments submitted:

From Ted Almon, President, CEO, Claflin Co. (Feb. 11th 2007 email)

My congratulations to the committee and its leadership on a fair, balanced and insightful plan to implement a much needed planning process for our State's Health care delivery system. It is apparent from the report that the advisory panel had an understanding of the function of our complex network of purchasers, payers, providers, and consumers, as well as the profoundly dysfunctional aspects of its operation and imminence of crisis.

One can only hope that its recommendations and their implementation come soon enough to avert the failure of the most threatened stakeholders.

Finding little in the substance of the report with which to take issue, one is left to speculate on whether the "solution" proposed to resolve a well-defined problem is optimum. In essence this involves the makeup of the "Health Care Planning and Accountability Council". Such a body will need to be broad enough to allow participation by a truly representative group of stakeholders without becoming too cumbersome to enact decisive action on issues sure to lack complete consensus. Remediation of the current crisis is certain to require an "omelet" of a plan involving the breaking of more than a few eggs, which may well represent the interests of some at the table. My personal observation is that these are most likely to be held by the insurers, who are perhaps over-represented, as compared for example to the hospitals. Clearly the community hospitals have interests disparate from the academic medical centers, which would suggest two CEO's, and why are insurers allowed "designees" when hospitals are not? Perhaps neither should be. Businesses too are insufficiently homogeneous to be represented by a single position. Small business clearly has interests in healthcare financing significantly different from large, self insured firms. For governance purposes, an "Executive Committee" of perhaps five might provide the most nimble and decisive structure. Such a body could be elected, at least partially, by the group itself.

These observations are merely suggestions, and certainly not criticisms of the report, although at the risk of one too many clichés, the "devil" will most definitely be in the details of the plan, and since the "Council" will hold ultimate accountability for the success of the process, its structure, autonomy, authority, and governance should be most carefully considered as the enabling legislation is conceived.

From Kathleen Connell, State Director, AARP (Feb. 13th 2007 email)

First----kudos all around on the process and the draft.

AARP strongly urges a re balancing of the recommendation to provide more consumer representation on the HCP&A Council.

The point raised by the gentleman at the Forum to incorporate a parity provision for mental health and physical manifestations of mental illness is worthy of consideration.

Thank you for the opportunity to give some input.

Appendix C. Health planning in Rhode Island and in the U.S.

History of health planning in Rhode Island and the U.S.

Health planning at the State and local levels received Federal direction and support in the forty-year period from 1946 to 1986. Four different Federal programs with slightly different emphases provided Federal funding and technical assistance to State and regional health planning agencies during this period:

1. The Hill-Burton Program (P.L. 79-725, 1946) emphasized planning for and expanding the supply of hospital facilities in the United States.
2. The Regional Medical Program (RMP) (P.L. 89-239, 1965) concentrated on the dissemination of new medical knowledge about heart, cancer and stroke from medical centers out to their natural catchment areas.
3. The Comprehensive Health Planning Program (CHP) (P.L. 89-749, 1966), as the name indicates, fostered a comprehensive approach to health planning encompassing health status, health services, health care facilities and the health professions. Its hallmark was requiring consumer majorities on State and regional health planning councils.
4. The Health Planning & Resources Development Act (P.L. 93-641, 1975) created Statewide Health Coordinating Councils (SHCC) at the State level and Health System Agencies (HSA) at the regional level. The thrust of this program was to link health planning to Federal funding and Certificate-of-Need (CON) regulation.
5. The “Healthy People” program (1979) began to set health objectives for the years 1990, 2000, and 2010. Unlike the other programs described above, this federal program did not provide no federal funding for States and localities.

The State of Rhode Island participated in all of the above Federal health planning initiatives. With the exception of the RMP Program, the Rhode Island Department of Health was the main locus of these health planning activities. Continuous health planning for personal health services and facilities was practically eliminated at the Rhode Island Department of Health when the Federal financial support was repealed in the mid-1980s.

Over the past twenty years, the main Federal/State health planning initiative has been the Healthy People program. Health objectives have been established at the national level for three decades now: 1990, 2000, and 2010. Most all of the States have followed suit and developed State level health objectives for their respective States. These health objectives have focused mainly on the reduction of behavioral risks such as tobacco use and sedentary lifestyle. However, unlike the previous four programs, the Healthy People program provides the States and regions with no Federal financial support.

In addition to these official Federal/State health planning efforts that have operated over the past sixty years, there have been a number of State-only health planning initiatives that have contributed to the winding path of health planning in Rhode Island. These efforts can be divided into three main categories:

1. Gubernatorial Commissions – The 1989/1990 Governor’s Steering Committee, the 1993/1994 Health Care Reform Commission, and the 1998-2002 Governor’s Advisory Council On Health were all initiated by the Governor and they all performed tasks that

could be considered parts of the health planning process: data collection & analysis, and/or establishing goals & objectives, and/or recommending strategies & interventions.

2. Private Sector Health Planning – The Health Planning Council, Inc. (1960s-1980s) and SHAPE (2002-2005) had different foci (the former health services & facilities planning, the later baseline measurement and projection of demand & supply of health care services and resources) but they were both conducted in the private, not-for-profit sector largely with funding from Blue Cross Blue Shield of Rhode Island.
3. Certificate-Of-Need (CON) Process – Following the Brosco Commission Report of the General Assembly, Rhode Island was the second State in the nation to establish a CON process to approve health care facility capital and new service proposals. From the beginning, the Health Services Council has served as an advisory body to the Department of Health in this process. Over the years, the Department of Health has commissioned a significant number of categorical health planning studies (e.g., diagnostic and interventional cardiac services) to assist in the CON review process.

A chronology of Rhode Island-specific health planning activities is presented in Table 1.

Table 1. Chronology of Rhode Island Specific Health Planning Organizations

1966 thru 1980s - Health Planning Council Inc.: Funded by Blue Cross Blue Shield of Rhode Island to conduct health care facility and services planning with advisories to the State Health Services Council for Certificate-Of-Need.

1968 - present – State Health Services Council: Appointed Council set in Rhode Island General Law to provide review and advisories to the Director of Health on Certificate-Of-Need applications for expansions of health facilities and services.

1989/1990 – The Governor’s Steering Committee on the Year of Family Health: Conducted recommendations related to cost control, health insurance coverage and health care financing.

1993/1994 – Rhode Island Health Care Reform Commission: Assessed five major national health care reform proposals and a number of their likely impacts on Rhode Island.

1998 - 2002 – Governor’s Advisory Council On Health: Tracked key health care industry characteristics in Rhode Island.

2002 - 2005 – The Rhode Island SHAPE Foundation: Funded by Blue Cross Blue Shield of Rhode Island to conduct studies and projections of the supply and demand for health care facilities, services, and professions.

Current health planning activities in the U.S.

Background

In the Spring of 2006, the Rhode Island General Assembly passed the “Coordinated Health Planning Act” calling upon the Director of Health in consultation with a representative advisory committee “to develop an assessment of the existing state capacity and authority to perform coordinated statewide health planning” and to study “an expanded role for the department of health in health care planning, including capital investment expansion and introduction of technology.”¹

Methods

In the fall of 2006, the Rhode Island Department of Health in conjunction with the American Health Planning Association conducted a web-based survey of all 50 states to determine the current organization and practice of health planning in the states.

Findings

19 (38%) of the States responded to this survey. 11 (22%) of the States indicated that they have a single state agency that is responsible for producing a statewide health services plan. All of these 11 States report to the American Health Planning Association that they have a “Statewide Health Plan” and/or a “Health/Medical Plan”, and that they do have active Certificate Of Need programs as well.² Based on the modal response of these 11 States (the actual response rate ranges from 6 to 10 on specific questions), the highlights of this survey are as follows:

- 5 state health-planning agencies are located in Departments of Health or Public Health;
- 7 state health-planning agencies had budgets in the range of \$250,000 to \$750,000 for a limited set of health planning activities that have “some impact” (see below);
- State revenue is the main source of revenue (54% of the revenue) for these states;
- Most of the revenue (73%) is used for State employee staff;
- 4 of the states have health planning advisory bodies, 4 do not;
- 7 states have state statutes mandating the scope of the statewide health services plan;
- 5 states do not address health care professionals in their state’s health services plan;
- 6 states address nursing homes and 5 states address hospitals in their state’s health services plan;
- 4 states address gamma knives and 4 states address PET scanners in their state’s health services plan;
- 5 states address cardiac catheterization and 5 states address open-heart surgery in their state’s health services plan;
- 4 states coordinate other state agencies’ plans to develop health care services;
- In 5 states the health services planning staff also undertake Certificate Of Need activities;
- 6 states indicate that the main customers of their state’s health services plan are health care facilities;
- None of the states indicate a “high impact” of health services planning on health care cost trends in their state, 4 states indicate “some impact”.

Conclusions

Given the low response rates to this survey, it is not possible to draw any definitive conclusions. However, the following insights seem justified.

There has been a substantial diminution in health services planning at the state level since the demise of federal funding for state health planning in the 1980's. Under three successive programs of federal financial support of health planning (Hill-Burton, Comprehensive Health Planning, National Health Planning & Resources Development Act) from 1945 to the mid 1980s, virtually all of the states had significant health services planning operations.³ It would appear the most states have not sustained health services planning in the absence of federal financial support. However, at least 10 states have sustained a health services planning operation at the state level. These states appear to be concentrating on traditional health care facilities and equipment issues directly related to the Certificate Of Need (CON) process.

While this survey did not directly address it, it is known that almost all of the states produce Healthy People/Health Improvement plans in conjunction with the national Healthy People initiative.⁴ The Healthy People planning process concentrates on the reduction of risk factors adverse to positive health outcomes. Thus, it would appear that health planning for health promotion is stronger at the state level than health planning for personal health services delivery. This observation seems consistent with the findings of the American Health Planning Association that reported in 2006 that 33 States had a "Statewide Health Plan", 11 States had a "Health/Medical Plan", 12 States had a "Specific Service Plan" and 15 States had none of these plan types.⁵

References:

1. Rhode Island Coordinated Health Planning Act of 2006, S 2757 Substitute A As Amended, H 7424 Substitute A As Amended.
2. American Health Planning Association, National Directory State Certificate of Need Programs Health Planning Agencies, 2006.
3. Hospital Survey & Construction Act, PL 79-725, 1946; Comprehensive Health Planning Act, PL89-749, 1966; National Health Planning & Resources Development Act, PL 93-641, 1975, as amended.
4. Healthy People, www.healthypeople.gov
5. Ibid, American Health Planning Association.