Connecticut Department
of Public Health

Statewide Health Care Facilities and Services Plan

2014 Supplement

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STATEWIDE HEALTH CARE FACILITIES AND SERVICES PLAN

2014 SUPPLEMENT

Connecticut Department of Public Health
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LETTER FROM THE COMMISSIONER

Dear Friends of Public Health,

I am pleased to present to you the *Statewide Health Care Facilities and Services Plan 2014 Supplement*. This document aims to align with *Healthy Connecticut 2020* by focusing on implications of the health care environment and availability of and access to health care facilities and services for at-risk and vulnerable populations.

The supplemental plan builds upon the 2012 Plan by updating previous information and discussing how the health care environment has changed in the past two years with the implementation of the Patient Protection and Affordable Care Act. It provides an updated analysis of inpatient bed need, an equitable measure to determine how the state's inpatient acute care hospital beds are distributed and is helpful in identifying areas with unmet need.

The supplemental plan considers multiple determinants of health when examining unmet health care need. This planning effort uses hospital community health needs assessments (CHNAs) to identify geographic areas and population subgroups with potential unmet health care need and, using indices developed from outcomes and health status data, provides a standard for assessing need. Additionally, it presents an overview of current initiatives addressing prevention, reducing health inequities, improving access to primary care and enhancing care coordination.

I thank the many individuals and organizations that participated in this planning process. I encourage you to integrate this document into your organization's or community's ongoing planning activities to improve the health of all Connecticut residents.

Sincerely,

Jewel Mullen, MD, MPH, MPA
Commissioner

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EXECUTIVE SUMMARY

OVERVIEW

The Department of Public Health (DPH) Office of Health Care Access' (OHCA) planning and regulatory activities are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources and provide financial stability and cost containment of health care services. Section 19a-634 of the Connecticut General Statutes (CGS) charges OHCA with the responsibility of developing and maintaining a *Statewide Health Care Facilities and Services Plan (the Plan)*, along with establishing and maintaining an inventory of all Connecticut health care facilities and services and conducting a biennial utilization study.

The supplemental plan, like the 2012 Statewide Health Care Facilities and Services Plan, is intended to be a resource for policymakers and those involved in the CON process. It presents information, policies and projections of need to guide planning for specific health care facilities and services. The primary focus of this supplement is to identify at-risk and vulnerable populations and to uncover areas of unmet health care need. It provides an updated analysis of inpatient bed need, an equitable measure to determine how the state's inpatient acute care hospital beds are distributed and is helpful in identifying areas with unmet need.

The Plan incorporates available health care facilities and services utilization, outcomes and health status data and community health needs assessments (CHNAs) to identify geographic areas and population subgroups with potential unmet health care need. These data serve as a foundation for projecting future health care needs.

KEY ISSUES

The Plan identifies key issues surrounding the delivery of health care in Connecticut:

- Connecticut's health care system landscape continues to transform under the Patient Protection and Affordable Care Act (PPACA). The transformation can be seen in the regulatory arena via Certificate of Need (CON) applications received by OHCA, as providers focus on creating new models of care that bring higher quality at a lower cost, thus delivering greater value in health care.

- Increasingly, Connecticut's hospitals are applying for regulatory approval to become members of larger umbrella corporate health care systems. These affiliations or mergers may be attributed to several factors, including the economic downturn, health care market competition, PPACA requirements and the need to achieve efficiencies in health care administration and delivery.

- Some Connecticut hospitals are pursuing strategies to remain financially viable and independent of large health care systems through the creation of alliances. These alliances seek to enhance purchasing power to extend the economies of scale enjoyed by larger systems and to share best practices and strategies to adapt to the evolving health care environment.

- Based on acute care bed need projections for 2020, Connecticut has an adequate supply of acute care inpatient beds statewide.

- In 2013, the largest proportion of emergency department (ED) visits was among patients with Medicaid (38%).

- From 2009 to 2013, there were almost 8 million visits made to an ED in Connecticut by state residents. Of these visits, one million were for psychiatric, drug or alcohol-related mental disorders

- Of the children visiting the ED for issues relating to behavioral health, nine out of ten were treated for a psychiatric-related disorder.

- The growth of urgent care settings has contributed to some concern that this type of care setting may contribute to fragmentation of care, inadequate follow-up and preventive care, and misdiagnoses, particularly for clinics that are not affiliated with a health care system.

- While Connecticut has an overall favorable health profile compared to the rest of the U.S., the health of Connecticut's residents is not equally distributed across population groups or geographic regions.

- In general, at-risk and vulnerable populations have a higher prevalence of chronic disease than the overall population.

- The Socioeconomic Status Index identifies 20 Connecticut towns as at-risk for unmet health care need.

- Black non-Hispanics and Hispanics were more likely than White non-Hispanics to have a potentially preventable hospitalization, avoidable ED visit or to visit the ED more than ten times within a year.

- One hundred forty Connecticut towns have better health outcomes than the state. Twenty-three of the remaining twenty-nine were urban core or urban periphery towns.

- Nearly all the CHNAs identified chronic disease, overweight, obesity, nutrition and physical activity as overlapping and major health issues regardless of socioeconomic status.

- More than one-half of the assessments identified substance abuse and mental health care as priority health needs in the community.

- A reconvened ED focus group identified the need for the coordination of mental health and substance abuse care.

RECOMMENDATIONS

Recommendations are intended to build upon the efforts and discussions conducted during the initial 2011-2012 planning process and reflect additional discussions held during the planning process for the 2014 supplemental plan.

Behavioral Health

1) Determine the resources available and options and approaches for further exploration of ways that Connecticut's behavioral health service delivery system can be measured to determine capacity as it relates to need and access to care;
2) Develop further understanding of recovery supports and how they relate to the overall care for behavioral health clients across all age groups;
3) Determine the feasibility of and resources available for a future inventory of distinct service levels as opposed to broad categorization of facilities using behavioral health licensure categories;
4) Provide more focus in future plans which specifically discuss the coordination, interrelation, provision or co-location of mental health, primary care and/or oral health services within the various settings and how such interrelationship will benefit the behavioral health patient population.

Acute Care/Ambulatory Surgery

5) Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas;
6) Research, investigate and quantify the use of observation stays in Connecticut hospitals and determine how these data can be standardized in a way that would allow them to be incorporated in the acute care bed need model;
7) With respect to ambulatory surgery standards and guidelines, discuss and consider including backlogs in the service area, ability of physicians to schedule block times, patient throughput at other facilities, the quality of care at other facilities as additional factors for consideration in the next Plan, if such data is available to OHCA to verify and analyze.

Primary Care

8) The DPH Primary Care Office will collect and report real-time health workforce data and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs;[1]
9) Utilize data from Behavioral Risk Factor Surveillance System and/or other surveys which have large enough samples so that results for questions related to health care access may be used for town, city or county level assessment and solutions;
10) Consider assessing/evaluating primary care provided by hospital-affiliated entities (e.g., urgent care centers) and determine if beneficial to patients;

11) Provide additional Plan focus on the provision of mental health and oral health services in primary care settings and assess the interrelation of these services with primary care.
12) Align OHCA planning efforts with SIM Grant activities (e.g., physician data collection, goals and objectives, etc.) and other relevant State planning efforts.

NEXT STEPS

As providers continue to assess their organizations, service array and delivery structures, OHCA's planning efforts will focus on the evolving health care system and available data to determine how best to meet the unmet need of residents in ways that benefit the community and assist providers in transforming to meet those needs. Future OHCA planning activities will include:

- Analyzing health care service specific data by health care systems, utilization and physician referral patterns to determine if there could be logical regionalization of certain services;
- Evaluating patient data and provider revenue patterns to identify shifts in demand for inpatient to outpatient services and between types of services for geographic regions;
- Identifying modalities through which the state may direct and/or assist providers to be more responsive to health care needs of communities;
- Analyzing all payer claims data to identify availability of and access to health care services, utilization patterns and the impact of expanded health insurance coverage through the PPACA.
- Monitoring the various settings where health care is now being delivered as additional data sources become available to OHCA.
- Reviewing CON statutes and regulations to ensure they are responsive to the evolving health care environment and make recommendations to better align the process with health care reform.
- Providing consumers with access to all available data.

Additionally, as more information becomes available to OHCA, the next plan will attempt to:

- Address the impact that technology may have on the demand, capacity or need for health care services;
- Facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning.

DATA AVAILABILITY AND CHALLENGES

- Data-related challenges and gaps are important considerations when planning for appropriate allocation of health care facilities and services. The success of such planning is dependent upon the availability of comprehensive data spanning numerous service delivery settings. Discussion of data gaps and efforts to resolve them will help to build the foundation for better planning and greater understanding of the evolving health care system.

INTRODUCTION

LEGAL MANDATE AND PURPOSE

Section 19a-634 of the Connecticut General Statutes (see Appendix A) requires the Department of Public Health (DPH) Office of Health Care Access (OHCA) to conduct an annual statewide health care facility utilization study, establish and maintain an inventory of all Connecticut health care facilities, and services and certain equipment and to develop and maintain a Statewide Health Care Facilities and Services Plan. The Plan is intended to be a blueprint for health care delivery in Connecticut, serving as a resource guide for planning for specific health care facilities and services. In 2012, OHCA issued its first Statewide Health Care Facilities and Services Plan (Plan). This publication is a supplement to the 2012 Plan. It includes an updated discussion of the current health care environment in Connecticut and adds a "population health" and "health equity" perspective, focusing on those who have experienced social or economic disadvantages. While the 2012 Plan focused on standards, guidelines and methodologies, which will be codified into regulation for use in the Certificate of Need (CON) review process, this Plan focuses on the unmet health care need of vulnerable and at-risk populations and the alignment of public health and health care initiatives that aim to address these needs. The 2014 planning process also involved updating the 2012 inventory of health care facilities, services and equipment, available at http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557564.

RELATIONSHIP TO THE CONNECTICUT STATE HEALTH ASSESSMENT AND IMPROVEMENT PLAN

Section 19a-7 of the Connecticut General Statutes (see Appendix B) establishes DPH as the "lead agency for public health planning," and charges the department with "assist[ing] communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance." DPH is required to prepare a multiyear assessment of the health of Connecticut's population and the availability of health facilities and a plan that includes: (1) policy recommendations regarding allocation of resources; (2) public health priorities; (3) quantitative goals and objectives with respect to the appropriate supply, distribution and organization of public health resources; and (4) evaluation of the implications of new technology for the organization, delivery and equitable distribution of services.

Healthy Connecticut 2020, available at http://www.ct.gov/dph/hct2020, includes the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP), which were developed in 2013-2014 to identify priority public health needs and facilitate public health planning for residents of Connecticut.

Key findings from the SHA include:

- Chronic diseases and injuries are the leading causes of premature death and morbidity;
- Racial/ethnic minority groups suffer from many conditions at disproportionately higher rates;
- Specific age groups such as youth/young adults and older adults are more at risk for certain conditions;
- Unhealthy behaviors such as binge drinking and prescription drug misuse have increased over the last decade; and
- HIV, smoking and teen pregnancy rates have declined over the last decade.

The SHIP provides an integrating framework for agencies, coalitions, individuals and groups to use in leveraging resources, coordinating and aligning efforts at the community and state levels and sharing data and best practices to improve the health of the citizens of Connecticut in a focused and purposeful way. *Healthy Connecticut 2020* was shaped by the national framework of "Healthy People 2020" initiative, particularly in targeted health-related outcomes for 2020 and the evidence-based and informed strategies that can be implemented to reach these targets.

The 2014 Statewide Health Care Facilities and Services Plan aims to align with *Healthy Connecticut 2020* by taking a population health approach to how access and services within the health care system affect a community's health, particularly among vulnerable and at-risk populations. *Healthy Connecticut 2020* provides the overarching frame for discussion of the intersection of public health and health care and how change within the health care system can help achieve the triple aim of improving the individual experience of care, improving the health of populations and reducing the per capita costs of care for populations.

GUIDING FRAMEWORKS: POPULATION HEALTH AND HEALTH EQUITY

The Plan's "population health" approach examines the health of a group of individuals and variations in the patterning of health outcomes within and across groups.[2] In considering the health of populations, it is critical to understand the determinants of these health patterns, variations in the patterning of these factors across and within groups and over the life course and why some populations have better health outcomes than others.[3] This framework considers the influence of multiple determinants of health outcomes. These determinants include the social, physical, economic and political context in which persons and groups live, work and age; access to and quality of health care; individual behaviors and the complex relationship between these factors.[4]

Health--and opportunities to promote health--are not equally distributed across populations or across the life course. Racial or ethnic minorities, low-income populations, residents of urban or rural regions, homeless persons, persons with disabilities, veterans and sexual minorities may experience barriers to the opportunities to live a healthy life.[5] The social, physical and economic environments in which Connecticut's residents are embedded often influence access to resources such as money, knowledge, power, social relationships and health-promoting advancements.[6] The relationships between race, ethnicity, geography and socioeconomic status are often interconnected.[7] It is important to consider the complex relationships between these factors and their impact on the determinants of health patterns of at-risk populations.

In this report, health and health care patterns are presented for Connecticut and for particular population groups. An examination of these patterns is important for facilities and services planning and for developing data-driven, evidence-based approaches used to formulate equitable public health policies and programs.

The 2012 Plan identified the following key issues pertaining to the delivery of health care in Connecticut:

- Major changes to Connecticut's health care system to improve health care efficiency, integration and quality in response to the 2010 Patient Protection and Affordable Care Act (PPACA);

- A need to continue to assess whether the clinician mix, size and distribution of the health care workforce meets the demand across the State following changes to Connecticut's health care system under the PPACA;
- A need to investigate whether there are unmet bed needs in particular regions of the State and an adequate supply of inpatient beds in the aggregate;
- A need to determine whether care is coordinated effectively between EDs and community-based behavioral health services as behavioral health needs are increasingly being treated in EDs due to a limited access to these services;
- A growing number of hospitals acquiring imaging equipment from free-standing imaging centers; and
- A shift in behavioral health care to focus on treatment, recovery assistance and resilience enabling:
    a) the provision of some behavioral health services by primary care providers and some primary care services by behavioral health providers; and
    b) an assessment of the demand for primary care services following changes from the PPACA, which are expected to increase demand for primary care.

In response to these findings, the Advisory Body, subcommittees and reviewers of the 2012 Plan provided numerous recommendations focusing on developing more robust data systems, evaluating health care capacity in the state around emergency services and behavioral health, examining health care access at a more local geographic area and enhancing outpatient behavioral health services and coordination of care. A discussion of the full list of recommendations from the 2012 plan can be found at http://www.ct.gov/dph/lib/dph/ohca/hc_facilities_advisory_body/ohcastatewide_facilities_and_services_chapter_10next_steps-recommendations.pdf.

The goal of the 2014 Plan supplement is to build on the 2012 plan by updating information when appropriate, discussing how the health care environment has changed in the past two years and revisiting and developing recommendations for the future. Moving forward, OHCA will develop supplemental updates every two years.

ADVISORY BODY AND STRUCTURE

Since the 2012 Plan was published, the Advisory Body and subcommittees have engaged in discussions on the drafting of CON standards and regulations. During that time, the Behavioral Health and Primary Care subcommittees also worked to develop action plans for implementing the 2012 Facilities Plan recommendations.

In December 2013, the Advisory Body met to discuss the methodology and approach for the 2014 Plan. Members provided feedback and guidance on steps to move forward. An additional meeting was held in July 2014 to discuss preliminary findings of the Plan and elicit feedback. A focus group was held in August 2014 with representatives involved in the 2012 Plan to discuss the relationship between emergency department utilization and the limited availability of mental health and substance abuse treatment.

In addition, each subcommittee (Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care) met in a virtual manner from June to September 2014 to discuss the development of future recommendations. These meetings were facilitated by Health Resources in Action (HRiA), a non-profit

public health organization and consultant for the 2014 Plan.

The Advisory Body have provided OHCA with valuable insight about the operation and delivery of health care facilities and services and assisted in addressing a number of complex issues, including the unmet health need of vulnerable and at-risk populations. Advisory Body and subcommittee participants can be found in Appendix C.