DRAFT Meeting Notes

State-Wide Health Care Facilities and Services Plan Advisory Body

July 31, 2014

9:00 a.m.

Agenda Item	Discussion	Action/Results
Welcome and Introductions	Kim opened up the meeting and welcomed everyone. Since the kick-off meeting in December the consultants (HRiA) have gone through the survey and assessment process. The 2014 plan is a supplement to the 2012 Plan; it is not a new plan. The 2014 Plan focuses on certain requirements in the state statute not addressed in the last plan. The CON standards in the last plan are now being put into regulations. OHCA staff attorney Kevin Hansted has met with the subcommittees; the review process is ongoing and is separate from the supplemental plan activities. There will be a public hearing for comments on the CON standards, which are in the plan and posted on OHCA's website. The regulations process will take about a year and half.	.
Health Care Facilities and Services Survey: Overview of Methodology and Key Findings	Discussion involved an update on methodology, status report, key highlights and next steps in the process and the recommendations. The 2012 Plan was a very comprehensive effort. As previously stated, the 2014 Plan will build off of that work, focusing on inventory, unmet health care needs, at-risk and vulnerable populations, future demand, capacity, need for acute care hospital inpatient services and looking at the recommendations. Looking at what has changed from the first report; the current health care landscape in CT; and the impact of changes. There will be greater focus on at-risk and vulnerable populations; the State Innovation Model (SIM) Grant and State Health Improvement Plan aligning those efforts with the 2014 Plan. The timeline for data collection and inventory survey took a little bit longer than expected. From July through September we will be working on recommendations and the planning process, aiming towards October for the final report. The mandate requires an inventory on the availability and accessibility of outpatient surgical, imaging, and hospital based primary care services; facility location and type, hours of operations, services provided, number of clients, treatment, and scan and other indicators. The Survey piece used some of in the 2012 questions and a few new ones. There were four surveys on Acute Care hospital based service lines and primary care services and imaging and outpatient surgery services were streamlined into one big survey and placed on-line. Survey respondents were automatically directed to the part that reflected what services they provided. Thanks to the association the survey was pilot tested with a sample of the facilities.0% completed the survey by link provided and the rest were by email or hardcopies. April through June was the time for data collection. Since then it has been ongoing follow-ups on survey responses, data quality and accuracy checking. Once cleaned, the results of the survey will be formatted for publication. Data on non-survey facilities are being compiled using the e-	Currently in the process of cleaning the data and making sure it is accurate and ready for publication. Looking to feed the data to the work groups to help them in thinking about the recommendations

	licensure files. A question came up regarding hospital facilities that have merged, "Are you asking the facility or the system?" Response is that it is facility focused. Some facilities have merged into larger systems and services may have changed. If there is a large change then there was a call back to see if it was an error or what caused the change. Another issue was that there were duplicate responses from the same facility but with different answers. Also, some of the facilities did not know that this survey was a mandate, although it was discussed in the instructions but maybe needs to be clearer next time. There were some concerns about the information being public. Specifically in the areas of number of scans and patient visits. With the competitive environment, the facilities did not want to have this information made public. There was a separate link on the survey that the facility could use to look at their 2012 data. Most questions were asking about the current calendar year. 2012 report used 2010 data so it was a bit cumbersome for some to gather all the information. The consultants are looking to streamline the process for the next time. Participants noted that it would have been helpful if there were some definitions around service lines (CPT, ICD9 or DRG) for more clarity.	
Bed Need Projections: Overview of Methodology and Key Findings	Brian Carney spoke about the bed need projections. He gave an overall picture of utilization trends within the state. Two measures of inpatient utilization data are discharge and patient days. Discharges have fallen about 4% since 2009 and patient days are on a downward trend as well. The past three years of historical utilization data by major service category was presented. The data showed declines in all of the service categories, except psychiatric services. A question came up regarding rehab. "It seems rehab has declined significantly. It is a small percentage of the total volume, but a significant percent reduction. " Brian indicated OHCA will try and identify the reason for the rehab decline. OHCA will examine psych by age group and by hospital. Brian than presented the future need for licensed beds in the state using the three most current utilization data. The bed need was completed by DMHAS regions to compare with the results from the last plan. However, there has been some internal discussion that would change the model to use county as the planning region, instead of DMHAS in order to align better with the State Health Assessment and State Health Improvement Plans. The results should be similar as only the individual hospitals would be grouped by county and use population growth/attrition factors for the individual counties. Brian went over how the bed need was calculated. A question was asked regarding observation stays and whether they were accounted for in the model. The response was that observation stays were not currently included. At present, the data is not available to OHCA.OHCA will evaluate how to include observation stays once the data can be obtained and reviewed. A question came up in the analysis of bed need in relation to the reduction in health care services. "How much is the decrease related to the economy and how much is related to changes in the health care environment?" It was noted that CHIME data is now capturing observation stays data. Jim Iacobellis will check and see if this information can be provided to OHCA.	Jim Iacobellis will check on the availability of observation day data being submitted to CHA.

Unmet Need and Gaps in Services: Overview of Methodology and Key Findings	Part of OHCA's statutory mandate is to look at the availability of health care services and to try to identify any unmet need for inpatient services. Psych was the only area that showed growth in services (using a target occupancy rate of 80%). A question was asked to break it down by age, which can be done. The analysis did show that there is a need for additional psych. beds. Maternity utilization is decreasing and birthrates are decreasing. The target occupancy for maternity 50% (which skews the results significantly). A question was to have a break down by age for maternity results. A question came up about licensed beds and staffed beds, where there may be licensed beds that show capacity but there might not be staffed beds available and the distribution of beds was also at question.	
Planning Process for Developing the 2014 Recommendations: Next Steps	Lisa Wolff noted that one of the specific focus areas of the 2014 Plan is looking at vulnerable and at-risk populations: elderly, disabled, less educated, uninsured, immigrant populations. Looking at the distribution of these populations in the state-- what do we know about the health status of these populations, are some more disproportionately affected? We have data tables and narrative to provide context on this. Looked at the geographic area of focus (wide variations using regions or counties.) The Plan will provide maps on mortality of different chronic diseases by towns/city level to see geographic patterns. This will show some of the variations in stark terms and the plan will have accompanying narrative. The Plan will also examine hospitals' Community Health Needs Assessments and strategic implementation plans to see if there are some patterns around issues identified in those assessments. What are those needs and are there unique issues in communities or regions? Are there some strategies that hospitals are discussing that are consistent across the state in addressing these needs/issues? A number of hospitals did the assessments collaboratively so 21 health needs assessments are being viewed. It is not surprising that an overwhelming majority of CHNAs identified chronic disease, specifically, heart disease, cancer and diabetes as critical health needs in the community and some of the risk factors such as obesity, nutrition and physical inactivity. 13 of 21 looked at gaps in primary care and identified that issue as one of their top needs in the community. Gaps in mental health care were treated as a separate issue. Mental health was related to health status and issues related to inaccessibility or unavailability of services and so this was treated as a separate category because this was talking about the care environment and not necessarily about the status. Other issues - a few of community health needs (CHNA) gave a social determinant of health perspective and identified a number of issues related to social and economic factors as their primary issues of concern. Many cited housing and others had financial instability and other issues related to vulnerable populations as a critical need in the community. The strategies that the hospitals are discussing are varied. They ranged from systems level change to community outreach to very specific individual level focused or participating in health fairs and having support groups in the hospitals.	

	Bed need is one indicator but there are a multitude of factors such as access issues and population and community characteristics. HRiA and OHCA are currently discussing how to examine this in a systematic way. We are hoping to look at these issues across the state utilizing and index we are developing that would include a number of socioeconomic factors such as: poverty, unemployment, education, transportation access and health status indicators at geographic level. We will use the index scoring to make some comparisons to estimate unmet need. A question came up about town scoring and unmet need. According to Olga Armah the indexing is mostly to compare with the state in general, to determine if a town is worse or better off and to aid in decision making on a services going to be terminated or added vis-à-vis the health care needs of residents of the town. Other factors that affect access and availability to be included in the index are census data on: the percent of population that speaks English but not well; the share of population that is below the federal poverty level; the percentage of the population 25+ who have less than high school education or are without a high school diploma. Census data is preferred because it is available and is reliable. Indicators on the town level will be used to determine the need for primary care. With respect to availability of primary care physicians it is not just the number of active licenses, but what percentage of the time the physicians are actually seeing and treating patients. A question came up about capturing community resources. OHCA responded that we would have to use information that is currently readily available. Because the timeframe for the Plan, which is due in November, does not allow us to access other state efforts such as the State Innovation Model and All Payer Claims Data. Everyone who is reviewing the Plan needs to comment on the Plan and provide OHCA with relevant information to which they have access. A question came up about including urgent care and minute clinic visits and readmission with 30 days of discharge. OHCA responded that the data is unavailable at the moment but may be when claims data becomes accessible. The issue with readmission data is OHCA in unable to differentiate between utilization data that might be helpful to use in the Plan. The unmet need index is expected to be in the 2014 Plan. The factors to calculate the index will be shared with the entire group, along with a deadline to respond.	
Next Steps	Amanda Ayers (HRiA) discussed next steps. Three Subcommittee meetings are being planned. There will be conference calls for the first two meetings and then meet collectively in person for the third meeting with the first two calls with all the groups in August. We will be reviewing the recommendations from the 2012 Plan and see if recommendations are still relevant. Would like to know from the subcommittee members if things are being covered because of new programs and services that are being offered and looking at changes in the environment and what's happening right now. Based on the recommendations on 2012 and data that we have now and based on changes in the environment we will decide where we want to go. Looking at acute care, behavioral health and primary care. Email will be sent out regarding the meetings. If	A

	unable to participate in the meetings, minutes will be provided. Feedback and suggestions are welcome. First conference call has already been made. There was a suggestion that questions be sent out prior to the meetings in preparation for them or as a result of the meeting. A suggestion was made to reconvene the focus group and therefore the focus group will reconvene. The timeframe will be short (one to two weeks) in reviewing the draft supplemental Plan (70 to 80 pages expected without tables and inventory). The publish date for the 2014 Plan is November 2014. Kimberly informed the group that the regulations are still moving forward and a hearing will be scheduled. Meeting was adjourned.	

Attending in person: Andrew Lawson, Carl Schiessl, Marc Camardo, Matthew Katz, Barbara Bunk, Jim Iacobellis, Lisa Winkler, Barbara Durdy, Lori Anne Russo, Pat Charmal, Brad Weeks, Wendy Furniss; Lisa Wolff and Amanda Ayers from HRiA; Kimberly Martone, Kaila Riggott, Karen Roberts, Brian Carney and Olga Armah from OHCA.
Conference call-in: Sally Herlihy, Robert Smanik, Steven Cowherd, Matt McKennan, Kara Koss, Yvette Highsmith Francis