SECTION 4 CHAPTER 10
NEXT STEPS/RECOMMENDATIONS

10.0 NEXT STEPS/RECOMMENDATIONS

As planning is a dynamic process, and planning for the rapidly changing health care environment covered by the CON program is especially so, planning practices and the standards used by OHCA should reflect and incorporate current best practices, whenever possible. OHCA will be continuously attentive to technological advances, research findings, demographic changes, shifting economic incentives, and significant changes in the organization and delivery of health care and planning and quality standards.

Next steps and recommendations had several sources; they were either suggested directly by subcommittee and advisory body members, evolved from subcommittee and advisory body discussions, or were suggested by reviewers of the Plan.

10.1 ACUTE CARE/AMBULATORY SURGERY

The next steps/recommendations on acute care/ambulatory surgery are intended to build upon the first Plan's efforts.

- Explore whether and how data on observation days should be collected and submitted to OHCA and determine how the inclusion of bed days would affect the bed need methodology.
- Examine service type by region to determine if gaps in service exist on a regional basis.
- 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.
- Explore the formation of a statewide task force comprising key industry stakeholders to further examine action steps and solutions needed to address the concerns identified by the ED Focus Groups about inappropriate use of the ED.
- Evaluate ED capacity issues on an on-going basis.
- Examine availability of on-call specialty physicians to EDs.
- Further study Behavioral Health/ED Focus Group findings with the Connecticut Hospital Association (CHA)/ Department of Mental Health and Addiction Services (DMHAS) to determine if access to behavioral health services is a significant problem at Connecticut's EDs and if there are any opportunities to help improve access.
- Examine the effect on hospital EDs of increasing reimbursement for outpatient behavioral health programs.
- Examine the benefits of increasing the number of intermediate care center (ICC) beds.
- Examine cardiac program quality measures, including risk-adjusted outcomes, institutional and operator performance.
- Continue to review and update Connecticut's cardiac guidelines to reflect current information and recommendations provided by professional societies and organizations with expert knowledge of cardiac care.
- Encourage the adherence to national cancer clinical practice guidelines and investigate the inclusion of standards and guidelines in future Plans.
- Consider adopting the following surgical facility classes as defined by the American College of Surgeons:

  Class A: Provides for minor surgical procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. These procedures are also appropriately performed in Class B and C facilities.

  Class B: Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs. These procedures are also appropriately performed in Class C facilities.

  Class C: Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

- Consider amending the definition of "operating room" as follows: "Operating Room" means a room with a fully controlled sterile environment that meets either (i) the standard for a Class B or Class C operating room as set forth

in the 2006 edition of the American Institute of Architects (AIA) Guidelines for the Design and Construction of Health Care Facilities or (ii) the standards for an operating room as forth in the R.C.S.A. § 19-13-D56, to the extent consistent with section 19a-493b.

- Include treatment rooms in future Plan discussions related to ambulatory surgery capacity.
- 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; and the quality of care at other facilities as additional factors for consideration in the next Plan.

10.2 BEHAVIORAL HEALTH

The next steps/recommendations on behavioral health are intended to build upon the efforts of and discussions held by the behavioral health subcommittee.

- Explore ways that Connecticut's behavioral health service system can measure or determine capacity as it relates to need and access to care.
- Inventory and discuss behavioral health care services provided by private practitioners and include how the provision of services in private practice contributes to the overall provision of behavioral health care in the state.
- Further advance the discussion of additional types of providers (e.g., private practitioners, Veterans Administration) and the availability of clinical level services in the state and seek and provide more information on recovery supports available to residents in the state.
- Inventory distinct service levels.
- Enhance OHCA's Hospital Reporting System (HRS) reporting mechanisms to capture accurate, usable data from short term general and children's general hospitals on hospital-based or hospital-affiliated behavioral health care services (such as a revamped Report 450[218] or a new schedule).
- Provide more focus on the provision and interrelation or co-location of mental health, primary care and/or oral health services within the various settings and provide further discussion as to the concept of "no wrong door" to accessing these services at any location.
- Further consider how health care reform and a possible blended behavioral health license might change the landscape for both behavioral health finance and delivery of care in the future.

[218]Hospital Report 450 (Hospital Inpatient and Outpatient Other Services Utilization and FTE Employees) is the form into which hospitals electronically report utilization data to OHCA, annually.

10.3 PRIMARY CARE

The Primary Care Subcommittee's next steps/recommendations are intended to assure and enhance the quality of care provided by primary care providers in all settings by eliminating health disparities and barriers to access, and tracking and evaluation of health outcomes and patient satisfaction.

- Utilize the results of the DPH Primary Care Office survey of primary care providers to report on and highlight access issues related to primary care facilities and services to better identify practitioners' places of practice, affiliations or relationships with institutions (such as hospitals, FQHCs, multi-specialty practices) and to illustrate any primary care workforce needs, size, and distribution issues which the Primary Care Office identifies.
- Consider adjusting future Behavioral Risk Factor Surveillance System questionnaires so large enough samples are drawn in each county so that results for the questions related to health care access may be used for county level assessment and solutions.
- Consider mandating responses on all license renewal applications to certain survey questions on whether practitioners are actively practicing in the state; the primary location of practice; if the respondent is currently actively treating patients; and if he/she had ever been convicted of a felony.
- Improve OHCA's Hospital Reporting System's reporting mechanisms to capture accurate, usable data from hospitals on hospital-based primary care services (such as a revamped Report 450 or a new schedule) and to collect primary care data on all providers of primary care services.
- Consider more comprehensively primary care provided by hospital-affiliated entities, which are expanding rapidly throughout the state.
- 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.