DRAFT

Minutes of March 9, 2011 Advisory Body meeting

Department of Public Health, Office of Health Care Access
Statewide Health Care Facilities and Services Plan Advisory Body
Wednesday, March 9, 2011 at 9:00 AM

410 Capitol Avenue, Hartford, Connecticut
Commissioner Hearing Room
3rd Floor, OHCA Office

Attendance: Karen Buckley-Bates, Lisa Winkler, Kimberly Martone, Kaila Riggott, Paula Chenail, Karen Roberts, Stan Soby, Meg Hooper, Brian Carney, Al Bidorini, Wendy Furniss, Evelyn Barnum

Absent: Yvette Highsmith Francis, Ken Ferrucci, Lauren Siembab, Kennedy Hudner, Linda Kowalski, Laura Jordan, Melanie Dillon, Karen Goyette

Notes: Leslie Greer

Item I. Opening Remarks

Kimberly Martone, Director of Operations of the Office of Health Care Access at DPH welcomed everyone. She announced that Commissioner Mullen will be in attendance at next month's meeting. The presentation will be on Primary Care.

Item II. Approval of February 9th Minutes

The following information was provided to clarify why the Hispanic population has lower death rates in Connecticut.

Hispanics in CT (and the US) have lower all-cause mortality compared with white, non-Hispanic residents. This is considered a "paradox" because Hispanics have, on average, a lower socioeconomic position that would supposedly predispose them towards higher mortality rates. Various explanations have been advanced to account for this phenomenon, including better health practices and social support relative to white, non-Hispanics. But another explanation has been that this observation may be due to undercounting of Hispanics on death certificates. Although it cannot, at this time, be said exactly what the definitive explanation may be for this observation, it is important to continue to monitor these trends in Hispanic mortality, since Hispanics are the largest and growing ethnic minority subgroup in our state.

The February 9th meeting minutes will be changed to reflect this clarification.

Item III. Discussion of presentations at February 9th meeting: Chronic disease data and Unmet need of at-risk or vulnerable populations and Guiding Principles

Advisory body members were reminded to feel free to email Kim Martone with any comments they may have on the presentations or Guiding Principles.

Item IV. Discussion of Behavioral Health Dataset

Lauren Siembab from DMHAS presented an overview of Behavioral Health data availability. Two DMHAS databases, DDaP, which collects information about clients and facilities that DMHAS contracts with and Avatar, which collects information about clients and facilities that DMHAS operates. In addition, DMHAS is required by statute to collect information from all substance abuse facilities, whether or not DMHAS contracts with them. DMHAS does not have data for the private for-profit mental health treatment agencies or private non-profit agencies that do not contract with DMHAS. Within DMHAS data systems there are fields that indicate where the provider is located, what services are offered, and data that speaks to program utilization including admissions and discharges. Performance data is also collected. Providers have performance benchmarks within their contracts that they have to meet; the data providers submit to DMHAS is used, in part, to determine their success at meeting the benchmarks.

Lauren distributed a handout with a sample of a provider report card, which is still in development (although they have used them with providers over the past year). Report card major categories include: basic program data, utilization, consumer outcomes, data submission and system outcomes.

Also included in the handout was the front page of the Connecticut clearinghouse directory, which might be another resource for getting information. Questions were asked about the behavioral health partnership and if we need to know anything from them. It was indicated that we have access to specific data and will discuss further in subgroups. Questions were asked, when looking at the facility plan, if geographical, hospital needs and/or health care needs in certain regions will be looked at. Is this information available on the geographic breakdown that can be manipulated or established as one of the variables? It was indicated that it was available.

Item V. Update on Ambulatory Surgery and Imaging Surveys

Karen Roberts, Principal Health Care Analyst, at OHCA discussed that the link to survey monkey for Outpatient Surgery. Minor changes have been made to the ambulatory surgical and outpatient surgery survey documents. Karen informed the group that for the last few weeks they have taken into account the testing and some of the comments. She indicated that the focus has primarily been on the releasing the Outpatient Surgery survey. The link for the ambulatory surgery is available on the OHCA website.

Item VI. Update on Plan: Chapter 4 Acute Care Services

Kaila Riggott, Planning Specialist at OHCA, presented an overview of what OHCA intends to include in Chapter 4. Contents will include definitions, descriptions of services offered in Connecticut, maps of services, utilization metrics, comparisons to regional and national statistics, acute care inpatient bed need methodology and possibly a table of services offered at all acute care hospitals similar to the one

done in the annual AHA survey. She requested that members provide OHCA with any additional suggestions or recommendations for content.

Item VII. Presentation on Bed Need Methodologies

Brian Carney, Associate Research Analyst at OHCA, gave a presentation on Acute Care Hospital Bed Need Methodologies. As part of the Plan, OHCA is developing an acute care bed need model to serve as a guideline for CON applications seeking to increase licensed bed capacity. In addition, the model will help to assess acute care service availability, determine unmet need and project future demand for acute care beds. OHCA examined a number of other states' bed need methodologies. Many models use common elements and incorporate planning area, utilization, population changes, target occupancy rates and age groups. Methodologies from Alabama, North Carolina and South Carolina were used to illustrate differences. For purposes of this presentation, both counties and DEMHS (Department of Emergency Management and Homeland Security) regions were used. Surplus beds in Connecticut ranged from approximately 1,100 to 1,960, depending upon which state's methodology was used. Additional factors may need to be considered when evaluating bed need, for example, if a hospital is experiencing census levels over a certain percentage for a certain period of time.

When asked why length of stay was not factored into the methodologies, Brain explained that patient days were used in the calculations instead.

Adjournment

Kimberly Martone closed the meeting.