

VALUE OF COMMUNITY HEALTH PLANNING

Planning and Consulting Services
for Community Health Improvement

The legislature finds that a return of health planning and decision-making to the regional level is vital to the creation of an overall system to properly meet individual and community health care needs.

New York State Legislature, 1993

Regional Healthcare Advisory Groups should be formed. Membership...would be voluntary and be comprised of independent business and community leaders with institutional and individual providers of health care as well as payers...The Advisory Group's goal would be to: (1) develop healthcare policy for the region and (2) promote the improvement of the region's health care delivery system.

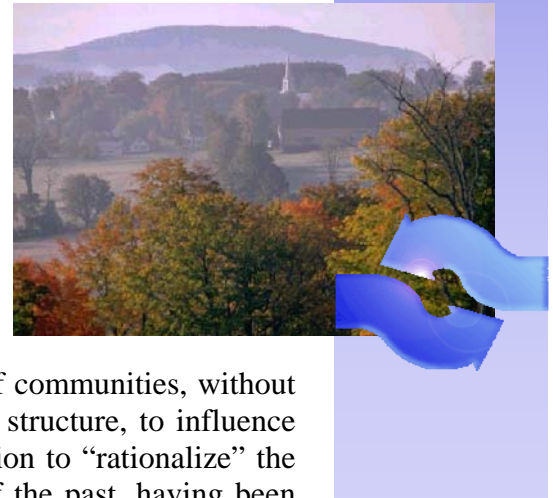
Healthcare Issues Discussion Group, 2003

Structured decisions about health care resource allocations must be continuous rather than a one-shot phenomenon. Issues of the uninsured, mental health, and primary care development should be at the forefront of an ongoing reform agenda.

*New York State Commission on Health Care
Facilities in the 21st Century, December, 2006*

The common thread of the above assessments by three distinct “blue-ribbon” entities speaks to the value of local health planning which has been neglected in New York State over the past fifteen years, in favor of a market driven system. The following set of statements represents a composite of testimony presented by staff leadership of the Central New York Health Systems Agency .¹

While health care competition has contributed to institutional and health care practice efficiencies, it has also been inadequate in several respects. The most glaring inadequacies have been **the failure of the market to develop efficient systems of care and respond effectively to community-wide issues** of access, cost, and availability of care. A further dimension of this problem is the inability of communities, without some form of independently-supported process or planning structure, to influence the future configuration of health care services. Collaboration to “rationalize” the community’s investment in health care is largely a thing of the past, having been replaced by a combination of competition and random or evolutionary development, often at the expense of the community. **Major decisions on capital investment in health care have been ceded to Albany which often has little understanding of the regional implications of its decisions.**



¹ Taken from testimony presented before the Commission on Health Care Facilities in the 21st Century, Regional Advisory Committee, February 24, 2006; New York State Assembly, Health Committee, December 6, 2006; and New York State Hospital Review and Planning Council, July 23, 2008.

Other local concerns which have not been addressed in this environment include: the **affordability of care**; the **burden of county Medicaid expenses**; **provider financial distress** and the need for investment in modernization of hospital physical plants; the **cost impact of excess capacity** and duplication; **trust issues** among insurers, employers, and providers; **workforce shortages**; the **number of uninsured**; and the persistence of **health care disparities** and **inability of minority and low income populations to gain access** to services such as dental care.

- **We Should Plan “For” or “From” the Future.** This means we should **begin with an understanding of the needs of patients rather than facilities.**
 - This is **especially true in long term care where we need an “operational blue print”** that outlines settings, care formats, and residential environments that patients will want. The blue print should also permit innovation, experimentation, and continuous learning. Rightsizing is not the most critical issue in long term care. While excess capacity may be a concern in select markets, the general decline in occupancy is due, in part, to management problems at certain facilities and to modest over-expansion. Lower occupancy is not all bad as evidenced by the fact we no longer experience hospital back-ups that prevent patients from getting appropriate care.
 - **It is also true for acute care where we need models for services, hospitals, and systems of care** that can provide guidance and direction for the future. We need models that address the needs and choices faced by the majority of Upstate NY counties. These typically have: 50,000-120,000 residents, one or more hospitals each with primary care and surgical specialists, and nursing homes run by hospitals. We also need models which address the needs of larger communities like Syracuse, Rochester, Utica, and Binghamton that serve as regional referral centers and support medical training and education needs.
 - **Such models should be flexible in their application.** The Commission is to be commended for recognizing the importance of flexibility in its recent White Paper. **Planning for or from the future is a learning process likely to result in adaptations from the field.** One example of this was the development of the Critical Access Hospital which changed from an inflexible 6-12 bed option designed for the West and Midwest where 12-25 bed hospitals were often the norm into a 25 bed option much more suitable for New York State.
 - **Such models should define and promote roles for local delivery systems that will make them attractive to providers**—to make providers say “this is where I want to be” or “wouldn’t it be nice if my child became a doctor.”
- **We need reimbursement which supports the way we think the health system should be,** i.e. one that directs appropriate funds to meet the medical needs of the elderly rather than give undue weight to lucrative, high tech surgery.
- **We need real protection from anti-trust** and regulatory changes that allow for or encourage joint ventures between facilities and with private practitioners.

- We need regulatory reform and new **standards that will support or enable innovative approaches to care** that could be used, for example, to provide maternity care in rural areas.
- We **need criteria for need that have broad acceptance and legitimacy**. Current methodologies used by state agencies are frequently provider-based or have not had their underlying assumptions examined for many years. What is often presented as new is only seems new because it was rerun with new population numbers and capacity data.
 - Planning "from the needs of patients" requires use of population-based, as opposed to, provider-based approaches to understanding of need.
 - Local decision making processes provide opportunities for methodological innovation and experimentation and can result in meaningful dialogue and debate between state and local planners about the best way to measure need.
 - Recent examples where CNYHSA has had this dialogue have included:
 - Radiation oncology where a multi-source database for Upstate New York was created to better understand regional trends and variations in service delivery
 - Cardiac catheterization where a statewide database was developed to understand the impact of hospital size and location. We discovered that technology diffusion had reached the point where the hospital being reviewed was one of few in the state with 200+ beds without the service and that many smaller hospitals did have the service.
 - Chronic dialysis where quality monitoring data, national survey data on age and race, and local service shift data were combined to develop a new approach to need
 - Hospice Residences where hospital, nursing home, and hospice census and discharge data were combined to develop a new methodology that accounted for all hospice settings and a significant new role played by hospices (care of terminal patients with chronic conditions) that existing methods did not take into consideration.
- **The Certificate of Need (CON) process can be a significant state and local planning tool** to the extent that it contributes to improved health care and health care outcomes, access, and quality and at the same time results in cost-effective investment decisions and cost-savings.
 - CON processes **need not be global and all encompassing**, especially at the local level. Our experience suggests the local processes can, and should be, focused, selective, and concentrate on proposals that have high impact on the community, relate to technology diffusion or specialty care, are political sensitive or controversial, represent obvious duplication, are based on poor or inflated documentation of need, or may be inappropriate for the type of facility.
 - The goal of CON should be to promote more proactive, rather than reactive outcomes, ones that are less institution-based and more reflective of collaborative efforts on a community-wide basis.

- The value of local CON continues to be confirmed by our experience in recent years:
 - In dialysis, where hospital and private practice applications were clearly duplicative, the local review process was a major factor that led to a partnership approach.
 - A “community dialogue” component of our review of the Upstate Medical Children’s Hospital proposal dealt with concerns of outlying hospitals for more active participation in a collaborative regional approach to pediatric services.
 - A Cayuga Medical Center Radiation Oncology review brought out the dynamics between hospital and private practice approaches and the need for a single integrated solution focused on the continuum of cancer treatment services.
 - One hospital cardiac catheterization review documented hospital size and utilization as a major factor for approval. Another review highlighted the need for cooperation with neighboring hospitals and physicians.

- **Community Planning in the Future should be Local and Continuous.**
 - The mechanism for this continuity **should involve community-based entities** such as health systems agencies and other regional health care coalitions and consortiums. It should **have sufficient resources** to engender community support, **be empowered to assist with implementation**, and be **able to exercise discretion and flexibility** in promoting necessary adjustments to fit changing circumstances.

 - **Local participation fosters credibility and legitimacy.** It may also promote public acceptance of change as opposed to predictable defensive reactions to a “legislative mandate” and serve to enhance ability of boards of trustees to act in the public interest as they carry out their fiduciary responsibilities.

 - **Local processes are more likely to achieve a better understanding of unique factors and be attuned to relationships among sectors of care.** They are also better positioned to evaluate the impact that decisions in one sector can have on the other and to negotiate and consider tradeoffs which may be necessary.

 - **Local processes can effectively deal with system change and restructuring** evidenced by hospital closures and mergers, development of shared services, Community Access Hospital conversions, new practice networks, reductions in length of stay, and diversion of surgery and other procedures to outpatient settings over the last twenty years.

- The mechanism for health planning **should have capabilities that incorporate or build on the basic characteristics of a health systems agency.** These include:
 - a regional focus and responsibility
 - a diverse board structure representative of major stakeholders (consumers, providers, government, payors, and business) and not tied to any single interest group or association.
 - access to data and an analytical capability with professional staff resources to carry out planning and review functions, needs assessments, and special studies.

Our Vision: To address and promote community health improvement, access to affordable health care, information-sharing, education and advocacy.