

Health Planning In New York State – History and Present Activities

This paper examines “classic” health care planning as envisioned in the Metcalf-McCloskey Act, the federal Comprehensive Health Planning Act of 1966, and the National Health Planning and Resources Development Act of 1974. It will also consider current activities funded through the State’s HEAL program, those conducted by local health departments, hospitals, rural health networks, the mental hygiene agencies and their local partners, and others.

Comprehensive Health Care Planning

Health planning activities began in the 1920s in a number of places in New York State, including New York City, Rochester, and Syracuse. The federal Hill-Burton Act in 1946 provided an impetus for the development of a planning structure in New York, including convening of a state planning Commission and seven region planning councils. Until about 1960, these structures were primarily focused on the need for hospital services. The focus broadened under the 1964 Metcalf-McCloskey Act and the 1965 addition of Article 28 to the NYS Public Health Law to include need for other health services, but still focused on facilities and services and paid relatively little attention to population health status.

This service focus largely remained until passage of the National Health Planning and Resources Development Act of 1974 (the NHPDA), which required both the state Council and the local planning agencies (Health Systems Agencies or HSAs) to develop planning documents that covered a broader range of health care services and addressed population health issues. Until 1986, New York developed a State Health Plan (SHP) that set forth goals for inpatient acute and long-term care, and for primary care, disease prevention and health promotion, mental health services and the prevention and treatment of alcohol and substance abuse. The SHP also described factors to be addressed in the development and updating of public need methodologies issued under Part 709 and pointed to trends in health care costs and service utilization pertinent to the development and distribution of services during the plan period and over the longer term.

While the federal requirements for health planning agencies and activities were repealed in 1978 and federal planning funds were terminated in 1986, New York State continued to support both state and regional planning activities until 1995. Elimination of state funding led to the closure of six of the original eight HSAs; today the Finger Lakes HSA and the Central NY HSA continue to function with state, local, and private grant funding. With the repeal of the NHPDA and the gradual elimination of the funding for the HSAs, the State Health Plan was phased out.

Community Health Assessments and Community Service Plans

County Health Departments since at least the early 1990s have developed periodic (every 4 years) Community Health Assessments (CHAs). Community health assessment is a core function of public health agencies and a fundamental tool of public health practice. The CHAs describe the health of the community by presenting information on health status including epidemiologic and other studies of current local health problems, community health needs, health care, and community resources. The CHAs seek to identify target populations that may be at increased risk of poor health outcomes and to gain a better understanding of their needs, as well as assess the larger community environment and

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how it can help play a role in addressing the health needs of the community. The CHAs also include information on specific local health department programs that help address health challenges identified in the assessment.

The Community Health Assessment process was amplified and integrated into the Prevention Agenda in 2008, and will be renewed in 2012. In the Prevention Agenda process, the state identified ten public health priorities at the state level, and local health departments were asked to identify two to three local priority areas (e.g., Chronic Disease, Physical Activity and Nutrition, Health Mothers, Babies and Children, etc.) from among those ten to focus health improvement activities, working with local hospitals and other community.

Results of those activities have been summarized.¹ In brief, while there was evidence of widespread collaboration across the state by local health departments, hospitals and other partners to conduct health assessments and identify priorities, there was less progress on implementation of action plans to address the priorities. The Counties and their partners are beginning the 2013 cycle of activities now, in conjunction with the development of the state's Prevention Agenda 2013-2017.² The next phase of the Prevention Agenda is being led by an Ad Hoc Committee appointed by the Public Health and Health Planning Council. One of the proposed goals of the new state health plan is to strengthen sustainable public private and multi-sector partners that align policies and investments with health improvement goals.

The vehicle for hospital involvement in this process has been the Community Service Plan. Since 1990 hospitals have been required to develop (every three years) a Community Service Plan (CSP) describing the health and health care needs of the community and how the hospital is meeting those needs. Since 2008, hospitals have been charged with developing their CSPs in conjunction with the county health departments to advance Prevention Agenda priorities. In the next community service plan due in 2012, hospitals will be required to collaborate with local health departments.

Both the Affordable Care Act, with its new requirements for community benefit that require hospitals to conduct community health needs assessment,³ and the Public Health Accreditation Board⁴ that has established a process for voluntary accreditation of state and local health departments, are calling for community health assessments and planning. New York's decision to require collaboration by local health departments and hospitals in the development of the community health assessments and community service plans puts our health departments and hospitals well on their way to meeting these

¹ NYS DOH. **Prevention Agenda Toward the Healthiest State 2010 Update: Local Health Departments**
http://www.health.ny.gov/prevention/prevention_agenda/docs/prevention_agenda_report_2011.pdf

² Development of New York State's Health Improvement Plan 2013-2017.

http://www.health.ny.gov/prevention/prevention_agenda/health_improvement_plan/docs/population_and_general_health.pdf

³ Hilltop Institute. Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement.
<http://www.rwjf.org/publichealth/product.jsp?id=74014>

⁴ Public Health Accreditation Board. <http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf>

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new requirements. However, sufficient attention will need to be paid to the actual implementation of plans to address the needs identified in the assessments.

Rural Health Networks (RHNs)

The Department of Health, through the Charles D. Cook Office of Rural Health, funds 35 Rural Health Networks. Some of the networks are multi-county in scope, while others may cover only a portion of one county. Some are comprehensive in providing health improvement services, while others are specific to specific services, such as EMS. The networks bring health and human services providers, including local health departments, together to consider health services needs, to coordinate services provision among the providers, and to seek to develop new services as needed. In 2009, in some parts of the state, rural health networks conducted the community health assessments with, and on behalf of, local health departments.

Emergency Medical Services

The Emergency Medical Services (EMS) community presently has an extensive network of regional operational and clinical councils coordinating with state-level clinical and service policy councils. As part of the SAGE process of consolidating certain governmental functions, a bill has been introduced which would alter the structure of EMS regional and state councils, consolidating from the current 18 regional councils to proposed 6 regional boards. Regional boards would continue to review certificates of need for EMS services.

HEAL 9

In late 2008, the Department of Health released funds under the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) Phase 9 entitled “Local Health Planning Initiatives Grant Program” to reinvigorate local health and health care planning. Under this initiative, DOH provided 18 grants to not-for-profit organizations, public academic institutions, and local health departments around the state. In 2011, two additional planning grants were awarded.

These grants generally supported focused efforts in smaller geographic areas than the prior HSA areas to assess community health needs and priorities; barriers to appropriate care; health care trends that impact the availability, affordability and quality of care; and strengths and weaknesses of the public health and health care delivery system. Based on these assessments, the grantees were asked to develop recommendations concerning appropriate alignment of health care resources with community health needs, and stimulate the development of needed health care resources.

The HEAL 9 grants ran through 2011 (some have been extended because of delays in contracting with the grantees or in accessing data). The description of the projects as of September 2011 is attached at Exhibit 1 to this paper. Of equal importance to their defined outcomes, these grants brought community stakeholders together, including health plans, providers, consumers, and employers, to consider the health and health care needs of their communities. The HEAL provided seed money to create and reinvigorate health planning infrastructure. This infrastructure may now serve as a springboard for on-going health planning. HEAL 9 grantees from Buffalo, Rochester, Syracuse and

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Albany have joined together to create an Upstate Planning Collaborative. Other HEAL 9 grantees are working to create sustainable planning activities.

Rochester Area Community Technology Assessment Advisory Board

The Community Technology Assessment Advisory Board (CTAAB) is an independent board of business leaders, health care consumers, health plans, health care practitioners, and health care institutions in the Rochester area. Established in 1993, CTAAB assesses community need for health care services and new technologies proposed by licensed facilities (e.g, Article 28 hospitals and D&TCs) and private providers (e.g., physician practices). CTAAB reviews proposals that fall within its scope and that exceed \$750,000 in capital equipment costs or incremental community expenditure, as well as some project types that are always reviewed regardless of cost.

With capacity consulting support from the Finger Lakes HSA, CTAAB makes determinations on whether an application of a new technology or service, or novel application of an existing technology or service, represents an appropriate, evidence-based medical practice, and whether additional health service capacity is warranted, taking into account geographic location, access, cost-effectiveness, quality, and other community issues. CTAAB's recommendations are advisory only. However, payers use CTAAB's recommendations in formulating reimbursement policies. A memorandum prepared by CTAAB staff with additional information on its activities is attached.

Planning Activities of the Mental Hygiene Offices

Under the Mental Hygiene Law, the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People with Developmental Disabilities (OPWDD), are charged with guiding and facilitating local planning processes at the local governmental unit (County and New York City) level. Local governmental units are required to conduct a multi-stakeholder planning process to develop or update a local services plan on an annual basis, consistent with statewide goals and objectives. Local Community Services Boards gather community input and develop and approve local plans.

Those plans are used to develop five-year statewide comprehensive plans for services under the auspices of each agency. Prior to 2007, each state mental hygiene agency had its own requirements for conducting the local planning process. At the local level, even within single county agencies, planning for mental hygiene services was often fragmented and planning for each disability was frequently conducted independent of the other disabilities. Collaboration was largely absent from this process.

By 2008, through the development by OASAS of an Online County Planning System (CPS) and the development of the statewide Mental Hygiene Planning Committee, this changed. Mental hygiene planning at the local level became more integrated and uniform across the disability areas. At the state level, the three state agencies, in combination with their local partners, came together in founding the Mental Health Planning Committee (MHPC). The Committee includes planning staff from the three state agencies plus representatives from twelve local units. In 2008, the MHPC developed an integrated mental hygiene local services planning process that fully met all the local planning requirements of the three state agencies. The integrated process allows the local units to address cross-system issues that affect people with co-occurring disorders. A subcommittee of the MHPC provides a "learning

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collaborative” of local planners to promote best planning practices, techniques for assessing local needs and priorities, and identification and use of available data resources.

Health Planning at the State Level Today

Since the demise of the HSAs and the abandonment of the State Health Plan process, statewide health planning has been sporadic and issue-specific. In 2005, to address excess capacity and financial instability in hospitals and nursing homes, the Commission on Health Care Facilities in the 21st Century (commonly referred to as the Berger Commission) was created to right-size the State’s acute, inpatient and residential health care facilities. Its recommendations, issued in 2006, included the merger or restructuring of 48 hospitals, the closure of 9 hospitals and several nursing homes, the elimination of 4,200 acute care beds, and the elimination of approximately 3,000 nursing home beds. Notably, the Berger Commission’ report stated:

The Commission’s work should be considered a beginning, rather than an end, of a broader reform effort. We need to build on this effort to address an ongoing need for structured decision-making regarding health care resource allocations. The speed of change in health care, driven by changing technology, populations and finance, makes it essential that the work of reforming the system and the regulatory framework be continuous. New York State should implement an ongoing process to sustain the efforts initiated by this Commission.

Since the 2006 Berger Report, the State Department of Health has also engaged in proactive health care planning in response to various health care crises, an identified need for services, or a surge in CON applications for a specialized service. For example, the closure of two Queens hospitals prompted an evaluation of health care resources and need in Queens and the award of grants to address that need. More recently, an MRT Work Group evaluated the health care delivery system and health needs in Brooklyn.

In addition to these activities, a variety of public health programs within the Department's Office of Public Health have strategic plans that describe measurable goals, objectives, strategies and interventions to address specific public health issues. The overall plan is the Prevention Agenda toward the Healthiest State for 2008-2012. As described earlier, this plan is being updated for 2013-2017.

Other plans that are currently in use include the following:

- Division of Chronic Disease and Injury Prevention, Strategic Plan 2010 – 2013
- Viral Hepatitis Strategic Plan 2010 – 2015
- Oral Health Plan 2005 (Currently being updated)
- NYS Cancer Control Plan, a strategic plan for cancer control that addresses the breadth of the cancer experience, from prevention and early detection, through quality of life issues, treatment, research, data and surveillance, health workforce issues, palliative care and public policy. A new plan for 2012 – 2016 is near completion.
- AIDS Institute Strategic Plan 2008-2011, being updated for 2012-2015.

The Future of Health Planning

A consensus appears to be building around the importance of bringing together diverse stakeholders to address the issues affecting our health care delivery systems and community health. Population health, the financial stability and quality of health care providers and the cost of health care are all inter-related and critical not just to providers, health plans and consumers, but also to businesses, local governments,

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civic organizations, and the education system. Issues such as over-treatment, inattention to prevention and coordination, lack of patient engagement in care, unwarranted variation in medical care, and medical errors drive poor outcomes and unnecessary growth in health care costs. All of these stakeholders and others can play an important role in addressing them.

Recent developments in health care delivery and information technology can support, and be supported by, health planning efforts. The growth of health IT infrastructure and the RHIOs has made health data more accessible and created new collaborations among providers and health plans. New health system configurations and payment mechanisms have also spurred collaboration.

The concept of strengthening health planning, and local or regional planning in particular, raises a number of difficult questions:

- *What should be the role of health planning organizations?*
 - *Population health*
 - *Collect and analyze data*
 - *Make CON recommendations*
 - *Quality collaborative*
 - *Patient engagement*
 - *Build consensus on strategies to address need*
 - *Other*

- *What role should local/regional planning play in CON?*

- *In the context of new systems of care and payment mechanisms, such as health homes, patient-centered medical homes, behavioral health organizations, ACOs, and value- and risk-based reimbursement, can regional health planning organizations support cost-effective system development and practices?*

- *If we seek to strengthen regional health planning, what regions should be used and how should the infrastructure be funded?*