

Health System Facilities and Services Evaluation and Planning

Summary of Findings from an Environmental Scan

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Introduction

This report summarizes an environmental scan of resources on the topic of health system facility and infrastructure capacity evaluation and planning. Wilder Research prepared this report for the Minnesota Department of Health's Health Economics Program to inform a potential evaluation of current and future health care needs and capacity in the state. Wilder Research reviewed a series of peer-reviewed articles and gray literature addressing this topic, and also reviewed historical and current capacity analyses and information from other states. This report summarizes key considerations around capacity evaluation and planning that were identified from this resource scan.

Resources

This environmental scan assessed peer-reviewed articles and gray literature reports addressing topics around health system capacity evaluation and planning. Wilder Research also conducted an online scan for health system capacity evaluation and planning efforts in the United States, looking at historical efforts as well as efforts that are underway and can inform similar work in Minnesota. The following report summarizes information from those resources that were relevant to the task of evaluating health system capacity in Minnesota and/or projecting future health care needs in the state.

The documentation included in this scan covered health systems within and outside the United States and included local hospital-based systems, broader multifaceted regional and national systems, and comprehensive statewide systems. A comprehensive list of these documents is included in the bibliography and additional sources section of this report.

Findings

Measures and data sources for health planning

The environmental scan of both the literature and state documentation pointed to a range of measures and data sources to consider when assessing and planning for health care needs and capacity. The most common measures used are shown in Figure 1. Measures are sorted into those that are demand-related and those that are capacity-related.

1. Measures for health system evaluation and planning

Demand Measures

Population counts, demographic characteristics, geographic distribution, and growth rate

Population health measures and disease prevalence

Care/service utilization (including telehealth)

Health insurance coverage

Unmet need for care (e.g., ambulatory care sensitive ED visits)

Unmet health-related social needs

Barriers to care

Capacity Measures

Workforce levels (e.g., primary care providers per 100,000 residents) and training/credentials

Equipment and facility availability (e.g., hospital bed occupancy vs. supply, patient volumes)

Patient wait times (for immediate as well as routine and ongoing care), patients waitlisted

Telemedicine availability and accessibility

Technology integration (e.g., electronic health records, patient portals, remote monitoring)

Cost of care

Payment models (e.g., value-based purchasing)

Sources: Bae et al., 2019; Broemeling et al., 2009; DeParle et al., 2024; Enam et al., 2022; Monsef et al., 2023

The environmental scan of literature and state reports also identified data sources that can be used to calculate the measures listed above. State-level data sources and/or estimates from these sources can be leveraged for evaluation and planning around health care needs and capacity in Minnesota. These sources are:

2. National data sources for health system planning

Federal Survey Data on Population Health and Insurance Coverage

American Community Survey (ACS)

Behavioral Risk Factor Surveillance System (BRFSS)

Current Population Survey (CPS)

National Health Interview Survey (NHIS)

Workforce Data

American Dental Association (ADA) state workforce data

Association of American Medical Colleges (AAMC) state workforce data

National Center for Health Workforce Analysis (NCHWA) workforce projections

U.S. Department of Health and Human Services (HHS), Bureau of Health Workforce (BHW)

Cost and Utilization Data

Healthcare Cost and Utilization Project (HCUP)

Transformed Medicaid Statistical Information System (T-MSIS)

CMS Hospital 2552-10 Cost Report Data

Quality Data

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Health Center Program Uniform Data System (UDS)

Healthcare Effectiveness Data and Information Set (HEDIS)

Hospital Characteristics Data

American Hospital Association (AHA) Hospital Statistics

American Hospital Directory

Centers for Medicare and Medicaid Services (CMS) Hospital Compare

2023 Compendium of U.S. Health Systems, Agency for Healthcare Research and Quality (AHRQ)

The environmental scan also revealed data sources specific to Minnesota that could be used to calculate the measures identified in Figure 1 in addition to other measures to support health system evaluation and planning.

3. Minnesota-specific data sources for health system planning

Data on Population Characteristics, Health, and Insurance Coverage in Minnesota

- Minnesota Health Access Survey (MNHA)
- Minnesota State Demographic Center Population Projections
- Minnesota Behavioral Risk Factor Surveillance System (Minnesota BRFSS)
- Minnesota Vital Statistics System

Workforce Data

- Minnesota Health Care Provider Directory
- Minnesota Provider Certifications, Licenses, Registrations, and Rosters
- Minnesota Health Care Workforce Data and Analysis
- Minnesota Hospital Association Workforce Reports

Cost and Utilization Data

- Minnesota Health Care Cost Information System (HCCIS)
- Minnesota All Payer Claims Database (MN APCD)
- Minnesota Hospital Year-End Financial Reports

Quality Data

- Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

Hospital Characteristics Data

- Minnesota HCCIS Hospital and Provider Data

Outcomes and time horizons for health planning

Like any planning effort, health system planning requires making choices about priority outcomes that depend on the balance between demand and supply. These choices drive the selection of planning inputs, and planners must adjust these inputs as context evolves so that systems can achieve priority outcomes (Larsson & Fredriksson, 2019; Myrberg et al., 2024). Outcomes of interest when conducting health system capacity planning in particular could include: improved access to care, operational efficiency, cost effectiveness, quality and patient safety, preparedness for demand surges, and potential adverse impacts to currently available services, to be assessed using the measures identified in Figure 1.

While health system plans incorporate desired outcomes related to chosen inputs, the plans themselves also generate outcomes when the plans are used to make decisions—which is the goal of planning work. In this case, outcomes of interest generally have to do

with *how* jurisdictions have used their health system plans, such as to inform system priorities, to determine how to serve their residents, and/or how to distribute resources across the system. An example of such an outcome can be found in New York. In 2023 New York began requiring that proposed health facility changes—especially changes that would reduce, eliminate or relocate services¹—include an independent health equity analysis. The goal of this requirement was to identify potential negative impacts from these facility changes, especially in rural areas of the state and in “low-income urban neighborhoods of color” (Uttley, 2023). Two Health Equity Impact Assessments (HEIAs) of the Burdett Birth Center in Troy, New York, estimated that a potential closing of the birth center would reduce access for pregnant women from the 22% of Troy households without cars and for pregnant women in “distant rural areas” of the county in which Troy is located. One of the assessments also noted that Black pregnant women were concerned about potentially losing a trusted midwife-led birth center that has a low C-section rate. Ultimately, the state’s Department of Health denied the proposal to close the Burdett Birth Center based on these findings from the impact assessments (Uttley, 2024).

Time horizons

When planning and making projections around health needs and health system capacity, there is no prescribed time horizon for estimating outcomes, although longer horizons (greater than 2 years) are generally used for strategic planning purposes (Abbas & Goosheh, 2024; Soyiri & Reidpath, 2013). The resources reviewed for this scan included a range of time horizons. These horizons were shorter for studies focusing on infectious disease burdens (e.g., 14 days to 3 years) and longer (e.g., 5 to 60 years) for non-infectious diseases (e.g., cancer and cardiovascular diseases; Grøntved et al., 2024).

State planning mechanisms: Certificate of Need (CON) programs, strategic plans, community health assessments, and community health improvement plans

The following section highlights efforts around health system capacity planning currently underway around the country. A consideration of these efforts can inform ways that

¹ Several other states also have policies in place to that require review when health facilities propose the termination of services including Connecticut, Hawaii, Iowa, New Jersey, and West Virginia. The relevant policies in these states are part of each state’s Certificate of Need program (Rakotoniaina & Butler, 2024). Certificate of Need programs are described in the next section.

Minnesota could leverage existing resources in its effort to evaluate and project the capacity and needs around health care among its residents.

Certificate of need programs

A key way that health system capacity planning currently occurs at the state level is through Certificate of Need (CON) programs. CON programs, which first launched in 1974,² regulate the number and capacity of health care resources in a given area by requiring hospitals and health systems to demonstrate community need before they can establish or expand health care facilities and/or services and, in some cases, before they can eliminate or substantially change services (NASHP, 2024). As of 2024, 35 states and the District of Columbia have CON laws, which were first put into place in an effort to contain costs by reducing overuse of services (NCSL, 2024).

CON methodologies

CON applications are generally reviewed using a standard set of review criteria situated within analyses of how the current supply of services meets the needs of the population and estimates of future demand. The following are state examples of these methodologies.

Washington

In Washington, the forecasted need for hospital beds is determined by dividing the forecasted number of patient days by an occupancy standard calculated for each of the state's Health Planning Areas (HPAs) based on the mixture of hospital sizes in the region. Washington's methodology takes into account that (a) people within an HPA may use hospitals outside the area and people from outside the HPA may use the HPA's hospitals, (b) people may change their patterns of use over time, and (c) age and sex groups may have significantly different use rates. The methodology uses state (or local, if available) population projections and HPA-specific utilization rates. When developing forecasts of future bed needs, the minimum occupancy standards for existing hospitals in HPAs range from 50% for hospitals with one through 49 beds to 80% for hospitals with 300 beds or more. For new hospitals, forecasted minimums range from 50% for hospitals

² CON programs were federally mandated under the National Health Planning and Resources Development Act of 1974, which was subsequently repealed in 1982 after which some states eliminated their CON programs (NCSL, 2024).

with an average daily census (ADC) of 25 or less, to 80% for hospitals with an ADC of 226 or more (Washington State Health Care Coordinating Council, 1987).

Michigan

Michigan determines county-level hospital bed need by calculating the monthly patient days used by county residents and using a regression model to predict patient days for the planning year. (If the model is not significant, the predicted monthly patient day demand is calculated by finding the monthly average of the previous three years and multiplying this average by 12.) Geographically underserved areas are identified by establishing a 30-minute drive time service area around each of the state's licensed acute care hospitals, such that any areas excluded from these service catchment areas are defined as geographically underserved areas. The population of underserved areas is multiplied by the average yearly patient day use rate for all state residents to estimate the expected number of patient days, and bed need is calculated using the method described above. To be approved, Michigan CON proposals must result in a hospital of at least 200 beds in a metropolitan county or 25 beds in a rural county, although an applicant proposing a new hospital in a limited access area does not need to be in compliance with needed hospital bed supply (Michigan Department of Health and Human Services, 2024).

Defining catchment areas for health system planning

Catchment areas (also known as service areas) are the geographic regions that are primarily served by particular health facilities or services. Defining catchment areas helps planners to examine resource allocation to ensure equitable access across populations. Planners may consider where patients come from based on their addresses, existing administrative boundaries (census tracts, zip codes, etc.), geographic features (rivers, roads, etc.), and/or travel time around a facility. Planners may also consider health resources in relation to the size of the area and its population, health indices for the population, and socioeconomic and demographic characteristics of the population (HRSA, 2018).

State Examples

Massachusetts defines a primary service area as “the contiguous geographic area from which a healthcare facility draws 75% of its commercial discharges, as measured by zip codes closest to the facility by drive time.” Additionally, the facility must represent a minimum proportion of all discharges in each zip code in its service area (Bloom & Rodman, 2025).

Oregon determines service areas for existing hospitals by taking into account both patient flow and hospital market share. Specifically, the service area is defined as including those zip codes that account for ten percent or more of the hospital's discharges, or in which the facility has at least 20 percent market share. Minor adjustments may be made to create a "contiguous service area" or to match demographic units used to report census data (e.g., counties) more closely (OAR 33-590-0040).

North Carolina

North Carolina's CON program is guided by the 25-member governor-appointed North Carolina State Health Coordinating Council, which develops the North Carolina State Medical Facilities Plan (SMFP) each year. The purpose of the SMFP is to make an overall needs assessment for the state, providing policies and projections of need in order to guide local health system planning. Plan development is driven by the principles of promoting health care value, ensuring equitable access to care, and encouraging safety and quality in health care services. The plan provides projections of need for 12 types of health care facilities and services,³ includes information on the supply and utilization of each, and explains the projection methods used. The SMFP's projections of need are used in conjunction with other statutes and rules when reviewing CON applications. A CON application must fit within the parameters of this plan even if it meets all other statutory criteria, or the plan will be denied or only conditionally approved (North Carolina Division of Health Service Regulation, 2025; North Carolina General Assembly, 2011).

Virginia

Virginia also has a State Medical Facilities Plan that informs its CON program, referred to in Virginia as the "Medical Care Facilities Certified of Public Need," or "COPN" program. Among the COPN access requirements of Virginia's SMFP is a patient travel time maximum for each type of proposed service or facility. For example, new inpatient beds "should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district." The state's health planning districts are contiguous areas designated as planning districts by the Virginia Department of Housing and Community Development (State Medical Facilities Plan, 2007). (The boundaries of

³ These facilities and services include the following: acute care hospitals, operating rooms, burn intensive care services, open heart surgery services, transplantation services, inpatient rehabilitation services, end-stage renal disease dialysis facilities, nursing home facilities, adult care homes, home health services, hospice services, and intermediate care facilities for individuals with intellectual disabilities (North Carolina Division of Health Service Regulation, 2025).

these districts—which are periodically reviewed—are determined by a consideration of common economic and market interests across the district, proximity of local government offices to district offices, metropolitan, and micropolitan statistical area boundaries, the adequacy of the population base to ensure financial viability, and geographic factors and natural boundaries (Virginia Department of Housing and Community Development, 2014).) Virginia’s SMFP calculates projected new bed needs in a given health planning district over a five year planning horizon by finding the difference between current bed capacity and five-year projected bed capacity, both of which are based on total inpatient days for the district and current and projected adult population in the district (State Medical Facilities Plan, 2007).

Minnesota: A “Quasi-CON” state

Minnesota had a CON law in place from 1971 to 1984, but the state no longer operates a CON program (except for the case of ground ambulance). Instead, the state operates capital expenditure and public interest review (PIR) programs that function similarly to a CON program. Minnesota law places approval authority for these programs at the state Legislature, except in cases where there are multiple proposals for a new hospital.

PIR Program

Bed Capacity. To secure a license to expand the number of beds in an existing hospital in Minnesota, an applicant must initiate the standard PIR process for an exception to the state’s hospital construction moratorium, which prohibits increasing the number of hospital beds and operating new facilities/buildings.⁴ The applicant must submit a plan describing their project to the Minnesota Department of Health, which conducts an independent assessment to determine whether the additional beds are in the interest of the public. Based on this assessment, the Department of Health recommends action by the Legislature (Klarqvist, 2023; Minn. Stat. § 144.552; Minnesota Department of Health, 2023).

New Hospital License. To obtain an exception to the moratorium to obtain a new hospital license, the applicant must submit a letter of intent to the Commissioner of Health. The letter is posted to the State Register for review by other providers who may

⁴ There are a number of general exceptions to Minnesota’s hospital construction moratorium. For example, there are no restrictions on increasing the number of mental health beds or establishing a new psychiatric hospital. Additionally, within certain parameters, a replacement hospital may be built within five miles of the current site (Klarqvist, 2023).

have competing interests to the application. Based on community feedback, the commissioner may make a decision if multiple proposals are submitted, or they may move the application to the PIR process (Minnesota Department of Health 2023).

Capital Expenditure Program

Minnesota's capital expenditure reporting law requires medical facilities to report each year all health care-related capital expenditures exceeding \$1,000,000. The state's Department of Health retrospectively examines all expenditures to determine their impacts on cost, access to care and care quality, their clinical and cost-effectiveness, and available alternatives. A capital commitment that fails review will not be prevented from moving forward, but failure means that the provider will be on prospective review for at least five years, such that the provider cannot make a capital expenditure worth more than \$1 million without obtaining prior approval from the Department of Health (Expenditure Reporting, 2024; Moran, 2015).

CON programs and health equity

At least half of states now include health equity criteria in the review of health facility applications. Iowa is one such state, taking into consideration how proposed activities would meet the needs of “medically underserved, rural residents, low-income individuals, racial and ethnic minorities, people with disabilities, and the elderly.” In other cases, states (e.g., Delaware, North Carolina, and Virginia) have required as a term of CON approval that health facilities implement financial assistance policies for patients who are unable to pay for services. Connecticut recently required a facility to maintain a charity care policy for Medicaid and indigent patients along with a community health needs assessment including implementation strategies (Pitsor & Parham, 2022).

Public participation in the CON process

Public involvement in the CON application and review process varies from state to state, with some states offering multiple opportunities for the public to provide feedback and others not incorporating public input into their processes. States seeking to involve the public in the CON process may do so in a number of ways. For example, some states require that applicants provide public notice of their intent to apply for a CON so that affected constituents have the opportunity to respond. States may also offer public hearings during the review period to allow for open comment. Additionally, states may have a CON review committee that includes individuals representing the public/consumer perspective (NASHP, 2024).

Vermont

Vermont is one state that builds public participation into its CON application and review process at multiple points. After receiving a CON application, the Vermont's Green Mountain Care Board issues public notice of the application in the newspapers circulating the region of the state affected by the application. The notice must identify the applicant, the purpose and cost of the proposed activity, how to obtain information about the proposed activity, the date by which any competing applications or petitions to intervene are due, and any other information that the Board determines to be relevant. The Board must hold a public hearing during the course of the CON review in order to allow for public comment and input. Members of the public may also submit written comment to the Board regarding a CON application until ten days after a public hearing (Green Mountain Care Board, 2013).

Strategic plans, community health assessments, and community health improvement plans

There are three types of existing health system plans that can guide comprehensive state-level planning efforts: organizational strategic plans, community health assessments (CHAs), and community health improvement plans (CHIPs; ASTHO, 2024). These plans can apply to the state, regional, or county/local level.

- Strategic plans “outline organizational goals, plans to achieve them, and how to measure success,” driving “resource allocation, decision-making, and other priorities” across an organization (ASTHO, 2024). Strategic plans that are especially relevant for health system capacity planning are those pertaining to health and human services departments.
 - **Strategic plan example:** “Hawaii Department of Health Strategic Plan: 2015-2018.” This report describes the plan for implementing the Hawaii Department of Health’s primary strategic goals for 2015 to 2018, including the impacts of interventions for priority and targeted populations; efforts to enhance health system connections to non-traditional systems and settings; and longer-term capacity building addressing prevention.
- CHAs leverage data and information around community demographics, health status, morbidity and mortality, socioeconomic characteristics, behavioral factors, and other health determinants to assess risks, resources, and factors that affect outcomes. CHAs inform areas such as health policy, program development, resource allocation, and

health improvement planning (ASTHO, 2024; CDC, 2024; Region IV Public Health Training Center, 2020).

- **CHA example:** “Minnesota Statewide Health Assessment, 2024.” Minnesota’s report uses a variety of state data to look at how social and structural factors impact the health of Minnesotans, highlighting insights offered by data on systems and emphasizing assets, strengths, and resources of communities related to health.
- CHIPs are strategic roadmaps that stem from CHAs, guiding the identification of priorities and resource allocation while steering program and policy implementation. CHIPs can go beyond traditional health and health services categories and may address environmental, economic, housing, land use, and other community issues that indirectly impact health (ASTHO, 2024; CDC, 2024; Pezzino & Hartsig, 2015).
 - **CHIP example:** “Ramsey County Community Health Improvement Plan (CHIP): 2019-2023.” This CHIP from Ramsey County, Minnesota, identifies eight community priorities for action--including health equity, health behaviors, and access to health services--and includes specific measures for each.

Additional state planning examples

The following section provides additional examples of select state initiatives around health system capacity evaluation and planning, highlighting reports from Connecticut, the District of Columbia, Hawaii, Massachusetts, New York, and Washington. Where applicable, state efforts to implement these initiatives are described.

Connecticut

The Connecticut Office of Health Strategy released its “Statewide Health Care Facilities and Services Plan” in 2024. This document, along with a biennial inventory of all health care facilities and services in the state, is meant to serve as an advisory document and resource for policymakers to understand the state’s health care landscape and as an input when OHS considers Certificate of Need (CON) applications. The plan also serves as an overarching policy document that highlights statewide trends and policies that impact the state’s facilities and services.

Factors considered during Connecticut’s planning process include: health insurance coverage, Medicaid expansion, rising coverage costs, health care consolidation, the entry

of private equity into the health care marketplace, racial and ethnic disparities in utilization and outcomes, growing emphasis on health-related social needs, deficits in certain workforce sectors like primary care, and an aging population. Analysts also considered the use of health care technologies and the shift from inpatient to outpatient care. The plan provides standards and guidelines around acute care bed need, outpatient surgery, cardiac services, imaging services and equipment, behavioral health and substance use disorder treatment, and labor and delivery services.

District of Columbia

The District of Columbia's State Health Planning and Development Agency (SHPDA) released its "Health Systems Plan" (HSP) in 2017 (District of Columbia Department of Health). The HSP is a health system roadmap that focuses on accessibility, equity, care quality, and cost effectiveness for the DC health system. It is meant to inform strategic action and to "facilitate cooperation" between the Department of Health and other entities in the public and private sectors. Additionally, like the Connecticut plan above, the HSP is meant to inform and guide the district's CON program, helping to ensure that applications support plan priorities. In particular, the district's plan will help in identifying benchmarks in the areas of "unmet need, service gaps, and/or service capacity," to guide CON applicants.

The district's HSP examines community characteristics, health status, and social determinants of health in order to identify health-related risk factors, causes of morbidity/mortality, barriers to care, and social determinants of health affecting DC residents. The plan examines health service utilization, capacity and claims data to identify service gaps/shortages, areas of unmet needs, and geographic distribution of services across the district. In addition, the plan analyzes utilization and claims data to look at utilization trends.

Implementation

According to a 2021 implementation report from SHPDA, the 2017 HSP informed the development of a broad series of recommendations contained in the SHPDA Health System Strengthening Framework, which serves as a roadmap for initiatives to reinforce the district's health system. SHPDA also drew on concepts outlined in the 2017 HSP to identify high-priority areas for inquiry (care transitions, primary and urgent care, and COVID-19 and emergency response) and developed HSP Action Plans for how the District should address them (District of Columbia State Health Planning and Development Agency, 2021).

Hawaii

Hawaii's "Health Services and Facilities Plan" (HSFP) was released in 2009 by Hawaii's State Health Planning and Development Agency (SHPDA). This plan, like Connecticut's and the District of Columbia's, is meant to serve as a guiding document for Hawaii's CON process and for statewide health care planning. Hawaii Revised Statutes (HRS) §323D-15 requires SHPDA to develop the HSFP and states that the plan must address inpatient care, health care facilities, and special needs. The plan must provide for an economical and efficient system that provides quality care and includes benchmarks for facility and equipment utilization. The plan must also provide for "the reduction or elimination" of underutilized, redundant, or inappropriate health care facilities and health care services."

Hawaii's HSFP assesses need and accessibility by evaluating acute care and long-term care bed supplies, waitlisted patient numbers, and health insurance coverage. The report examines the financial health of health care facilities by analyzing insurance coverage, rising costs, inadequate reimbursement rates, uncompensated care, and fee-for-service payment structures. Workforce levels are assessed through physician numbers (per 100,000 residents), geographic distribution, age distribution, and specialty areas, as well as numbers (per 100,000) of nurses, physical therapists, EMTs/paramedics, and dentists. Hawaii's HSP also considers its unique geographic challenges with rural island areas and its growing and aging population that is concentrated in those areas.

Implementation

Hawaii's 2009 HSFP continues to inform the state's CON program, which requires applicants to articulate how proposed projects align with the needs identified in the 2009 HSFP. Specifically, applicants must describe, where relevant, how proposed projects relate to the Plan's capacity thresholds and how the projects relate to statewide and regional priorities for relevant service areas (Hawaii State Health Planning and Development Agency, 2009a).

Massachusetts

New legislation in Massachusetts was signed into law in January 2025 requiring statewide health planning with increased data collection and coordination between agencies. The legislation establishes a new Office of Health Resource Planning under the state's Health Policy Commission and charges this new office with developing a "state health resource plan," that will identify anticipated health care needs (for services, providers, programs, and facilities), existing health care resources, the projected

availability of resources to meet anticipated needs, and recommendations for the supply and geographic distribution of resources during a five-year planning period. The office is also instructed to examine and make recommendations to address the causes of disparities and maldistribution of capacity in relation to need. Plan recommendations should address the commonwealth goals around care quality and access, workforce adequacy and stability, cost growth benchmarks, care delivery innovation, alternative payment models, unnecessary duplication of resources, health equity and health disparities, integrated care, alignment of housing and care needs, utilization tracking, standards of care, and equitable access to health care resources across the commonwealth (An Act Enhancing the Market Review Process, 2024).

Massachusetts' new legislation also allows the new Office of Health Resource Planning to create an inventory of health care resources statewide, expands the range of providers (registered provider organizations; RPOs) from which data can be collected by state agencies, increases the scope of information collected from RPOs around ownership and governance, and increases penalties for RPOs that do not comply with reporting requirements (An Act Enhancing the Market Review Process, 2024).

New York State

New York State's most recent health improvement plan, called "Prevention Agenda 2019-2024," is intended as a roadmap for improving the health and well-being of New Yorkers through state and local action with an emphasis on promoting health equity (New York State Public Health and Health Planning Council & New York State Department of Health, 2023).

The Prevention Agenda draws on a 2018 statewide health assessment that examines contributing causes of health challenges in the state, catalogues state assets for addressing these challenges, and looks at progress to date at the local level (New York State Department of Health, 2018). Based on this assessment, the Prevention Agenda focuses on modifiable social determinants of health as it lays out a strategy for implementing strategies to improve population-wide health and wellbeing. The Prevention Agenda calls for cross-sector partnerships to address social determinants of health around economic stability, education, social and community context, health and health care, and neighborhood and the built environment (New York State Public Health and Health Planning Council & New York State Department of Health, 2023).

Priority areas for the Prevention Agenda are: improvement of health status and reduction of health disparities; prevention of chronic diseases; promotion of a healthy and safe environment; promotion of healthy women, infants, and children; promotion of well-

being and prevention of mental and substance use disorders; and prevention of communicable diseases (New York State Public Health and Health Planning Council & New York State Department of Health, 2023). Objectives for the Prevention Agenda are monitored through nearly one hundred state tracking indicators and 70 county tracking indicators on the New York State Prevention Agenda Dashboard (New York State Department of Health, 2025).

By implementing the Prevention Agenda's priority action plans, state and local collaborators aimed to improve major cross-cutting health outcomes and reduce health disparities. These outcomes were measured using the premature death rate, the difference in premature death rates by race/ethnicity, preventable hospitalizations, the difference in preventable hospitalizations by race/ethnicity, adult health insurance coverage rates, and percentage of adults with a regular health care provider (New York State Public Health and Health Planning Council & New York State Department of Health, 2023).

Implementation

An implementation report has not been issued for the Prevention Agenda. However, a review of the Prevention Agenda Dashboard shows that 30.3% of state indicator objectives have been met as of February 2025. Indicator performance was best in the area of improving health status and reducing health disparities, with 37.5% of indicator objectives met. The lowest area of performance was in the area of preventing chronic diseases, with 16.0% of indicator objectives met (New York State Department of Health, 2025).

Washington State

The Forecasting Division of the Washington State Office of Financial Management released "Strategic Health Planning: A Progress Report" in April 2010, an in-depth assessment of the data needed to construct a formal health resources strategy for the state. The report notes that existing data do not support accurate forecasting of health resource needs in the state, but the authors identify steps that can be taken to support accurate forecasting including the development of new databases that contain missing elements required for this analysis. Without these critical data, the report focuses on describing the current status of Washington's health care system in terms of resource availability and use.

Washington's 2010 report identifies key data used in the report, including population estimates and forecasts, a facility license database, health professional license information, employer industrial insurance accounts data, health behaviors and population health, hospital abstract reporting data, death data, and hospital fiscal year-end reporting data.

Data gaps include accurate and detailed health workforce data (including active vs. inactive status), detailed information on health facilities, utilization data beyond inpatient services, population health information for children/teenagers, and racial/ethnic health data.

The report uses available data to examine inpatient hospital utilization, geographic variation in utilization, hospital admissions for ambulatory care sensitive conditions (ACSC), disease cluster analyses in relation to health behavior patterns, provision of unnecessary care, and regional workforce variations. In order to conduct accurate forecasting of health resource needs, the authors call for the following databases to be developed: a census of active health care professionals, a census of health services facilities, an all-payer claims database (APCD), a “comprehensive population-based, socio-economic and health database” similar to the California Health Interview Survey (CHIS) or an expanded BRFSS for Washington.

Washington’s 2010 report was followed by a narrower topical update on health care use and need in 2023: “Hospital care utilization: Washington, 2010-2022” (Stahre et al., 2023). The new report revisits the data gaps identified in 2010, compares Washington population and inpatient demographics, analyzes inpatient bed use and availability, and projects future inpatient utilization through 2030.

Conclusion

A scan of peer-reviewed and gray literature along with available public information on state activity around health system planning reveals a number of resources and strategies to consider when approaching a potential evaluation and planning effort in Minnesota. The information presented here points to tested measures of current and future health system capacity and demand as well as data sources for operationalizing these measures, along with potential outcomes that planners may consider. This scan also points to the utility of existing planning resources for informing future planning initiatives

Common planning measures that are used by states in this report—and that should be considered by health planners in Minnesota—include care utilization, unmet need for care, workforce capacity, facility/service availability, insurance coverage and costs, population demographics, social determinants of health, payment models, health equity and disparities, and racial/ethnic health data. Data sources for capturing these measures are available at both the national and state level, with Minnesota having a particularly rich inventory of its own data for producing these measures and for assessing corresponding outcomes.

Planners in Minnesota should also consider the health equity criteria used by other states when assessing its capital expenditure and public interest review programs to ensure that the health care needs of rural residents and other underserved populations are served by proposed health facility and service changes. Equity reviews could be conducted through independent equity impact analyses as in New York or using measures such as the maximum patient travel time standards used in Virginia and Michigan. Minnesota may also want to consider the establishment of health planning areas/districts like those used by Washington and Virginia to determine catchment areas and forecast need on a more tailored regional level, or the state could consider a county-based approach such as the one used by Michigan.

An examination of current activities around health system evaluation and planning in Minnesota and other states provides insight into the possibility of leveraging existing planning resources for future planning initiatives. While all resources examined here offer insight that can inform Minnesota's planning work, Minnesota is especially well situated to benefit from its own 2024 health assessment when working to incorporate public interest goals around social and structural factors impacting the health of Minnesotans and improving health equity in the state (Minnesota Department of Health, 2024).

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