ANNUAL REPORT FISCAL YEAR 2006

HEALTH STRATEGIES COUNCIL OF GEORGIA

appointed by the Governor
to advise and support the health planning mission of the

November 2006

FROM THE CHAIRMAN

Governor Sonny Perdue
Lt. Governor Mark Taylor
Speaker of the House Glenn Richardson
Members, Georgia General Assembly
Members, Board of Community Health
Commissioner Rhonda Medows, MD

Ladies and Gentlemen:

On behalf of the Health Strategies Council, I am pleased to submit our Annual Report for Fiscal Year 2006.

The Council continues to work toward its goal of promoting the development of high quality health care services which are both cost efficient and easily accessible. This year we welcomed several new members who have already demonstrated their talents and abilities.

Fiscal Year 2006 was a particularly productive and exciting time for the Health Strategies Council. The Technical Advisory Committees (TACs) for Psychiatric and Substance Abuse and Inpatient Rehabilitation met several times during the first half of the year in a an effort to develop or revise rules for the services in their respective categories. The end products of those TACs were revised rules for Psychiatric and Substance Abuse services, Comprehensive Inpatient Physical Rehabilitation services, Traumatic Brain Injury facilities, and new rules for Long Term Care Hospitals. As a result of their dedication and hard work, the Council approved rules submitted by each TAC. Those who served on each TAC are to be commended for undertaking this difficult endeavor and for their commitment to the overarching goal of improving health care in the State of Georgia.

Many challenges and opportunities lie ahead for the Council. We embrace and support the vision of Commissioner Rhonda Medows, and look forward to our continued involvement in the Department's health planning and policy development efforts. The Council stands ready to continue to provide guidance that would be in the best interest of the citizens of the State of Georgia.

Sincerely,

Daniel W. Rahn, MD, Chairman

COUNCIL MEMBERS

Members of the Health Strategies Council are appointed by the Governor to represent various health care interests. Members of the Health Strategies Council and their respective affiliations and categories of representation as of October 1, 2006, are as follows:

Member and Affiliation	Category of Representation
Daniel W. Rahn, MD, ***Council Chair*** President, Medical College of Georgia	Member at Large
Elizabeth P. Brock, ***Council Vice-Chair*** President, Pallets Incorporated	Health Care Needs of Small Business
Charles T. "Chuck" Adams Chief Executive Officer, Ty Cobb Healthcare System	Rural Hospital Representative
Tary Brown Chief Executive Officer, Albany Area Primary Health Care, Inc.	Health Care Providers – Primary Care Centers
Chris R. Bryson Chief Operating Officer, UHS – Pruitt Corporation	Health Care Providers – Nursing Homes
W. Clay Campbell Executive Vice President, Archbold Health Services	Health Care Providers – Home Health Agencies
Susan Chambers, RN Vice President and Chief Nursing Executive, Gwinnett Hospital System	Health Care Providers – Registered Nurses
Janet P. Deal Regional Director, ResCare, Inc.	Health Care Needs of Persons with Disabilities
T. Robert Dyar, Jr., MD Physician, WellStar North Cobb Women's Health, LLC	Health Care Needs of Women
Katie Foster Regional Director, Service Employees International Union	Health Care Needs of Organized Labor
John F. Freihaut, DDS Dentist	Health Care Providers - Dentists
Venus Gines Chief Executive Officer, Dia de la Mujer Latina, Inc.	Health Care Needs of a Population with Special Care Access Problems

Member	Representation
Vernon E. "Trey" Googe, III Chief Operating Officer, Seven Oaks Company, LLC	Member at Large
Michael E. Greene, MD Physician	Health Care Providers – Primary Care Physcians
C. Thomas Hopkins, Jr. MD Physician	Health Care Providers – Specialty Physician
Donna W. Hyland Chief Operating Officer, Children's Healthcare of Atlanta	Health Care Needs of Children
Tamara L. King Director of Outpatient Services, Shepherd Center	Health Care Needs of a Population with Special Health Care Access Problems
Kirkland A. McGhee Attorney	Health Care Needs of Low Income Persons
Lynn B. Mullis Dentist	Health Care Providers – Primary Care Dentists
Grace G. Newsome, Ed.D., APRN, BC, FNP Professor of Nursing and Coordinator of Family Nurse Practitioner Program, North Georgia College & State University	Health Care Providers – Nurse Practitioners
Gary Oetgen President, of Gary G. Oetgen Agency	Private Insurance Industry Representative
Kelly Penton Chief Financial Officer, Doctor's Hospital	Urban Hospital Representative
Jessie L. Petrea Chief Executive Officer & Co-Owner, Southern Living Alternative	Health Care Needs of Elderly Persons
Louise Radloff Executive Director, Interlocking Communities, Inc.	County Government Representative
Sheila M. Ridley President and Chief Executive Officer, Sovereign Solutions, LLC	Member at Large
Mark Wilson Vice President and Director of Human Resources, Langdale Industries, Inc.	Large Business Personnel Representative
Julie Y. Wilkerson Director of Development, Macon Volunteer Clinic	

OVERVIEW

The Health Strategies Council is responsible for developing Georgia's State Health Plan and addressing policy issues concerning access to health care services. The members of the Council are appointed by the Governor and represent a wide range of health care and consumer interests. The Council focuses on providing policy direction and health planning guidance for the Division of Health Planning, the Office of General Counsel, and, where appropriate, the Department of Community Health as a whole.

The functions of the Council are set forth in O.C.G.A. 31-6-21 and provide for the Council to:

- Adopt the state health plan and submit it to the Board of Community Health for approval which shall include all of the components of the Council's functions and be regularly updated;
- Review, comment on, and make recommendations to the Department on the proposed rules for the administration of this chapter, except emergency rules, prior to their adoption by the Department;
- Conduct an ongoing evaluation of Georgia's existing health care resources for accessibility, including but not limited to financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness, and cost;
- Study long-term comprehensive approaches to providing health insurance to the entire population; and
- Perform such other functions as may be specified for the council by the Department or the board.

The role and impact of the Health Strategies Council has continued to expand and has strengthened over time and during Fiscal Year 2006. To fulfill its broad mission, the Council holds quarterly public meetings and regularly convenes committees consisting of providers, advocates and technical experts to advise the Department and the Division on the need for changes and improvements to the state health plan.

The Council has continued to play a key role in the updating of the Certificate of Need plans and rules to reflect the state's healthcare priorities while keeping the needs of Georgia's citizens at the forefront of the planning process. The Council is committed to ensuring planning policies that incorporate access, stewardship, quality of care, integration of healthcare services and the improvement of the health status of Georgia's citizens.

GEORGIA'S STATE HEALTH PLAN

A major duty of the Health Strategies Council is the development and ongoing refinement of Georgia's State Health Plan. The current State Health Plan consists of thirteen (13) comprehensive component plans addressing a wide range of health care services and facilities. In most cases, these component plans serve as the basis for administrative rules and regulations governing the certificate-of-need process and integration with other department programs. The Council also uses the health planning process to promote the achievement of community wellness and access to care, as well as the broader health missions of the Department of Community Health, the Governor and the State of Georgia.

The process of developing new or revised components for the State Health Plan often involves the appointment of advisory committees whose members bring a range of technical expertise to the development process. Members of these committees are carefully selected to include providers, consumers, payers, regulators, and other interested parties. Each proposed change to the State Health Plan and any resulting rule changes must undergo a public review and comment process. Also, the Department and the Board of Community Health must approve any changes to the components of the State Health Plan.

COMPONENTS OF THE STATE HEALTH PLAN

COMPONENT PLAN	DATE OF LATEST ADOPTION
Ambulatory Surgical Services	June 1998
Continuing Care Retirement Communities	January 1998
Home Health Services	February 2001
Inpatient Physical Rehabilitation Services	October 1994**
Nursing Facilities	August 2000
Perinatal Health Services	February 1999
Personal Care Homes	August 2001
Positron Emission Tomography (PET) Services	February 2002

Psychiatric and Substance Abuse Inpatient Services	July 1990**
Radiation Therapy Services	May 2001
Short-Stay General Hospital Beds	April 2003
Specialized Cardiovascular Services • Adult Cardiac Catheterization • Open-heart Surgical Services • Pediatric Cardiovascular Services	May 2001^^
Traumatic Brain Injury	May 1990**

Note:
**Revisions in process.
^^Amended to allow participation in a national research trial.

FISCAL YEAR 2006 ACCOMPLISHMENTS

During FY 2006, the three Standing Committees of the Health Strategies Council namely, the Acute Care Services, the Long Term Care Services, and the Special and Other Services Committees met in September and October 2006 to review the thirteen components of the and to make recommendations to the Health Strategies Council about the need for revisions and updates.

Committee members used a wide range of mechanisms to inform their decision-making process, including presentations from industry representatives, oral and written public comments, and information and data from the Department of Community Health. Each Council member was asked to serve on at least one Standing Committee. The Council Chair served as an ex-officio member of each committee. Committee members appear below:

Acute Care Committee

- + Donna Hyland
- Susan Chambers, RN
- Venus Gines
- Vernon " Trey" Googe III
- Kirkland McGhee, Esq.
- Lynn Mullis, DDS
- Kelly Penton
- Sheila Ridley
- Mark Wilson

Long Term Care Committee

- +Chris Bryson
- Elizabeth Brock
- Tary Brown
- William " Clay" Campbell
- Janet Deal
- Tamara King
- Grace Newsome, Ed.D., APRN, BC, FNP
- Jessie Petrea
- Louise Radloff

Special & Other Services Committee

- +Michael Greene, MD
- Charles Adams
- T. Robert Dyar, Jr., MD Katie Foster
- John Freihaut, DDS
- C. Thomas Hopkins, Jr., MD
- Gary Oetgen
- Julie Wilkerson

Note: + Committee Chairperson

The three Standing Committees addressed each of the following components of the State Health Plan:

Acute Care Services

- General Short Stay Hospital Services
- Open-heart Surgical Services
- Perinatal Health Services
- Psychiatric & Substance Abuse Inpatient Services
- Cardiac Catheterization Services

Long Term Care

- Nursing Facilities
- Personal Care Homes
- Home Health Services
- Inpatient Physical Rehabilitation Facilities
- Traumatic Brain Injury Programs
- Continuing Care Retirement Communities

Special and Other Services

- Positron Emission Tomography
- Radiation Therapy Services
- Ambulatory Surgical Services

Below is a summary of the recommendations of the Standing Committees and a synopsis of other ongoing health planning activities that were undertaken in several areas during 2006.

ACUTE CARE SERVICES STANDING COMMITTEE

The Acute Care Standing Committee, chaired by Donna Hyland, recommended that there be no changes to the State Health Plan and Rules that govern the development of Short Stay General Hospitals, Specialized Cardiovascular Services, Freestanding Birthing Centers, or Inpatient Psychiatric and Substance Abuse Services. The Committee recommended the establishment of a technical advisory committee (TAC) to review the State Health Plan and Rules for Perinatal Services in light of recent changes and emerging trends in those services. The Committee also decided to wait for the final report of the State Commission on the Efficacy of the CON Program before further reviewing the adverse impact exception in the CON rules that relate to Acute Care Services.

LONG TERM CARE SERVICES STANDING COMMITTEE

Chris Bryson, Chair of the Long Term Care Services Standing Committee, and the other committee members recommended that there be no changes to the State Health Plans and Rules for Continuing Care Retirement Communities, Home Health Services, and Nursing Facilities, or to the new Long Term Care Hospitals, Comprehensive Inpatient Physical Rehabilitation, and Traumatic Brain Injury Rules.

The Committee endorsed the Department's recommendation regarding consideration of adding an exception in the Personal Care Home rules to allow Personal Care Homes to add beds for spouses and other family members without CON approval. After significant input and discussion, the Committee also recommended that an ad hoc committee be formed to address the relocation exception in the Department's rules.

In addition to recommendations to update selected state health plans, the committee discussed comments from Home Health Services providers who expressed concern about the three percent (3%) indigent and charity care commitment that is required for applicants seeking to offer these services. The Committee agreed to refer these concerns to the Indigent & Charity Care Ad Hoc Committee for consideration and policy development.

SPECIAL & OTHER SERVICES STANDING COMMITTEE

The Special and Other Services Committee, chaired by Dr. Michael Greene recommended no changes to the State Health Plan and Rules for Radiation Therapy Services or Ambulatory Surgery Services. The committee did receive updates regarding the Positron Emission Tomography (PET) Services and Stereotactic Radiosurgery TACs. It is anticipated that these TACs will begin their work during late 2006. The committee recommended

authorizing the Stereotactic Radiosurgery TAC to consider including this service in the Radiation Therapy rules, or remain a single service with distinct rules.

WORK PLAN INITIATIVE

During Fiscal Year 2005, Council members embarked on a process of identifying critical issues that are impacting the healthcare delivery system. Members agreed that the outcome of this process would serve as a blue print for the Council's work for the coming years. The Council remains committed to continuing to augment the list and to establishing some reasonable time frames in which to address these identified issues.

Access to care was a central theme that was evident during this issues identification exercise. Among the access areas that Council members identified were: manpower, cultural, financial, administrative and geographic considerations, including the following:

ACCESSIBILITY - MANPOWER ISSUES

- Physician Coverage in Hospital Emergency Rooms
- Trauma Care – (funding and physician coverage)
- Healthcare Workforce Issues (misdistribution and shortage of providers)

ACCESSIBILITY – CULTURAL ISSUES

- Racial/Cultural disparities

ACCESSIBILITY - FINANCIAL /COST ISSUES

- Financing of Georgia's health care system (long-term outlook for payer and providers)
- Relationship between the cost of dental care and demand for dental services
- Relationship between state revenues and budget cuts

ACCESSIBILITY - ADMINISTRATIVE ISSUES

- Medicaid Reimbursement rates
- Medicaid Managed Care

COMPREHENSIVENESS OF CARE

- Role of education and prevention in good health outcomes

OTHER

- Market based solutions- role of public-private collaboratives
- Legislative Mandates and Initiatives
- Recommendations based on the findings in the final report of the State Commission on the Efficacy of the CON program

ONGOING HEALTH PLANNING ACTIVITIES

INPATIENT PHYSICAL REHABILITATION SERVICES AND PSYCHIATRIC & SUBSTANCE ABUSE INPATIENT SERVICES

In 2006, the Health Strategies Council voted unanimously to adopt revised Comprehensive Inpatient Physical Rehabilitation and the Inpatient Psychiatric and Substance Abuse rules. In the new Comprehensive Inpatient Physical Rehabilitation rules, the adult and pediatric components were combined, rules specific to the spinal cord program were deleted, and rules for Traumatic Brain Injury programs were separated into their own set of rules. The new Inpatient Psychiatric & Substance Abuse Services rules include the "pediatric" classification to replace the "children and adolescent" classifications. In addition, the numeric need methodology for Inpatient Psychiatric and Substance Abuse was eliminated.

LONG TERM ACUTE CARE HOSPITALS

The Health Strategies Council voted to approve new rules for Long Term Care Hospitals. An accompanying component plan for these rules is expected to be published in early 2007.

STEREOTACTIC RADIOSURGERY AND POSTITRON EMISSION TOMOGRAPHY (PET) SERVICES

During Fiscal Year 2006, the Council agreed to recommendations of forming Technical Advisory Committees for Stereotactic Radiosurgery and PET Services. The focus of the PET TAC will be on mobile service providers and their ability to continue to operate in locations with hospitals that also have a CON to provide PET services. The Stereotactic Radiosurgery TAC will focus on developing new rules for the oversight and administration of this emerging service.

ATLANTIC CPORT RESEARCH PROJECT

The national Cardiovascular-Patient Outcomes Research Trial II (C-PORT II) is now underway. Georgia has ten hospitals that are participating in this randomized trial that compares angioplasty outcomes at hospitals with or without on-site, open-heart surgery. There are currently 34 hospitals without on-site, open-heart surgery programs participating in eight states. The trial anticipates that up to 50 hospitals from a total of 10 to 12 states will be participating within the near future. The states currently participating include Pennsylvania, New Jersey, Ohio, Illinois, Alabama, North Carolina, Oregon and Georgia.

The trail is progressing very well both nationally and in Georgia. The outcomes at each facility are closely monitored each facility's IRB, an IRB at Johns Hopkins Medical Institutions, a national C-PORT monitoring committee and other entities. On October 17, 2006, after a review of the national, state and facility data, the national Data and Safety Monitoring Board (DSMVB) recommended continuation of enrollment into the study.

The Health Strategies Council first undertook discussion of Georgia's participation at the May, 2004 meeting when Thomas Aversano, M.D., the principal investigator made a presentation to the HSC. After receiving the recommendation of the HSC, the Department of Community Health adopted Rule 111-2-2-.21, effective May, 2005, which authorized Georgia to participate in C-PORT II. The first Georgia hospital received certification and saw its first patient in April, 2006. By July, nine facilities were participating with the tenth hospital receiving approval to see patients in October. Each facility has to reach certain annual volume standards and the participation will cease at the earlier of removal form the trial, upon completion of the trial or three years from the date the facility saw its first authorized trial patient. The chart below provides information about the participating facilities located in Georgia.

Georgia C-PORT Project Recruitment

Site Number	Site Start Date	Randomized[1]	Consented Not Randomized[2]	No Consent[3]	Approximate Total Elective Cath Patients at Site[4]	Primary[5]
1	April 2006	66	346	46	458	30
2	June 2006	43	245	68	356	13
3	June 2006	92	468	110	670	17
4	June 2006	123	210	390	723	13
5	June 2006	52	164	47	263	19
6	June 2006	67	167	2	236	14
7	June 2006	34	147	2	183	0
8	June 2006	79	192	24	295	12
9	July 2006	31	178	139	348	19
10	October 2006	22	74	6	102	3
		609	**2191**	**0.277955272**		

[1] Total number of patients entered into the trial (rule of thumb is 1/3 of patients receiving a diagnostic cath will also need a therapeutic cath-the actual percentage is 28%). Per the randomization protocol, 1/4 patients has PCI at the hospital with on-site cardiac surgery.

[2] Total number of patients who gave informed consent to participate in the trial, but generally found not to need a therapeutic cath. They were treated with medical therapy, required cardiac surgery, may have required PCI with a device not available per protocol at the hospital without on-site cardiac surgery, or were considered too high risk for PCI at the hospital without on-site cardiac surgery.

[3] Total number of patients who did not give their informed consent. They may have refused, but generally, these patients were never approached about participating in the trial.

[4] Total number of caths at the facility since inception of trial at each facility. (Excluding primary)

[5] Total number of patients receiving emergent primary therapeutic cath. This data is maintained in a national registry.

INDIGENT AND CHARITY CARE

The Health Strategies Council recommended the establishment of an Indigent and Charity Care Ad Hoc Committee to review the Department's current definitions of indigent and charity care and to provide the Department with clear definitions that would provide uniformity and equity for providers when collecting, calculating, and reporting indigent and charity care in the state.

EDUCATIONAL OPPORTUNITY & LEGISLATIVE UPDATE

GEORGIA'S MEDICAID MANAGED CARE

During 2006 Council members were provided with an opportunity to learn about the status of the Georgia Healthy Families Program, the partnership between the Department and Care Management Organizations. The goal of Georgia Healthy Families is to deliver health services to Medicaid and PeachCare members by allowing them the opportunity to select a plan that best fits their needs. Kathy Driggers, Chief of Quality and Managed Care provided an update on the implementation of the program and its challenges and accomplishments.

STATE COMMISSION ON THE EFFICACY OF THE CERTIFICATE OF NEED PROGRAM

During FY 2005, the Georgia General Assembly adopted HB390. This bill authorized the formation of a Commission, whose primary responsibility is to conduct a review of the CON program, including examining the effectiveness of the CON program, the impact on health care, and the cost of continuing or discontinuing this program. The Commission will determine if changes to the program are needed to achieve state policy objectives. The Commission is composed of eleven (11) members, and is divided into four subcommittees: Acute Care Services, Long Term Care Services, Special and Other Services, and Legal and Regulatory Issues. The Chairpersons of the DCH Board and the Health Strategies Council are ex-officio members. The Commission is expected to issue a final report to the Governor and the General Assembly in January 2007.

CERTIFICATE OF NEED

The development of the Certificate of Need plans and rules along with the collection and analysis of information about Georgia's health care system is the cornerstone of the Division of Health Planning's responsibilities. The Health Strategies Council provides policy guidance to the Division and the Department while the Office of General Counsel, among other things,

manages the CON review and implementation process, following adoption of the plans and rules by the Health Strategies Council and the Board of Community Health.

A Certificate of Need (CON) is a document issued by the Department of Community Health that indicates that a proposed health care project is necessary to meet community needs. Georgia's Health Planning Statute, Title 31, Chapter 6, requires the issuance of a CON before proceeding with certain kinds of health care projects. Georgia's Health Planning Statute covers almost all health care facilities, including:

- All public and private hospitals, including general, acute-care, and specialized hospitals;
- Nursing homes;
- Ambulatory surgical services or obstetrical facilities;
- Home health agencies;
- Personal care homes (with 25 or more beds);
- Inpatient rehabilitation facilities treating traumatic brain injury;
- Diagnostic, treatment and rehabilitation centers (whether for-profit or not-for-profit). These facilities must obtain a CON before:
    - Offering radiation therapy, biliary lithotripsy, cardiac catheterization, or surgical procedures outside a hospital setting; or
    - Acquiring any diagnostic or therapeutic equipment exceeding the equipment threshold.

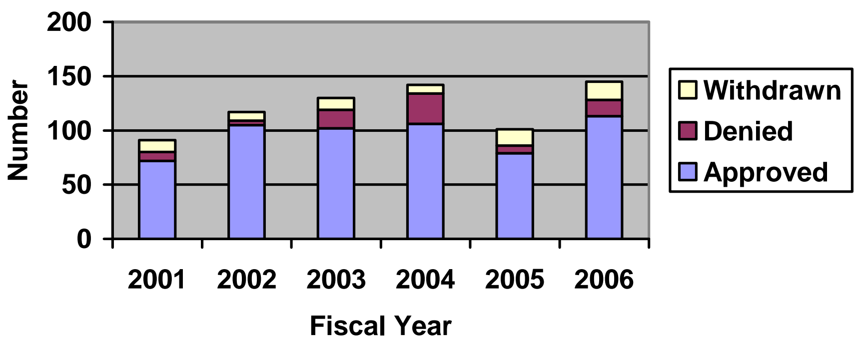
A CON is required before a health care facility can:

- Proceed with a construction or renovation project or any other capital expenditure that exceeds the construction threshold;
- Purchase or lease major medical equipment that exceeds the threshold amount for equipment acquisition;
- Offer a health care service which was not provided on a regular basis during the previous 12-month period; or
- Add new beds.

Following is a summary of the Certificate of Need applications that were submitted to the Department for review from FY2001-2006. The charts that follow provide a comprehensive review of all CON applications that were submitted to the Department during this period but also offer a snapshot of three major categories of CON applications: construction, procurement, and service change projects. Data regarding the number of appeals and decision reversals is

also shown. Data related to Letters of Non-Reviewability and Letters of Determinations are not included.

CON Projects Submitted FY2001 - FY2006

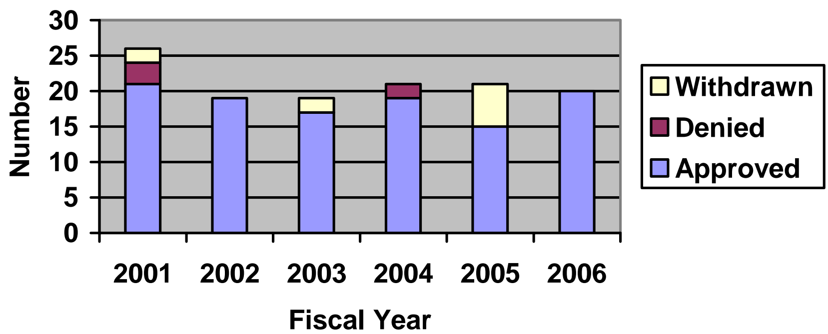


Source: Georgia Department of Community Health (as of 10/26/06)

Between FY2000 and FY2006, seven hundred and twenty-eight CON applications were submitted to the Department, an average of 121 applications each fiscal year. During this six year period, 79% (577) were approved, 11% (79) were denied, and approximately 10% (70) were withdrawn. Each year has seen an increase in the number of applications submitted, with the exception of FY2005 when the number submitted decreased to 101 from 142 the previous year.

Procurement projects relate to those applications seeking to acquire or replace medical equipment. Procurement projects represented approximately 17% of all projects submitted to the Department during FY2001 – FY2006. The chart below depicts the history of Procurement projects from FY2001 – FY2006. Eighty- eight percent (111) projects were approved, four percent (5) were denied, and eight percent (10) were withdrawn during this fiscal period. On average, twenty-five Procurement projects were submitted each fiscal year. During FY2002 and FY2006, all Procurement projects that were submitted were approved.

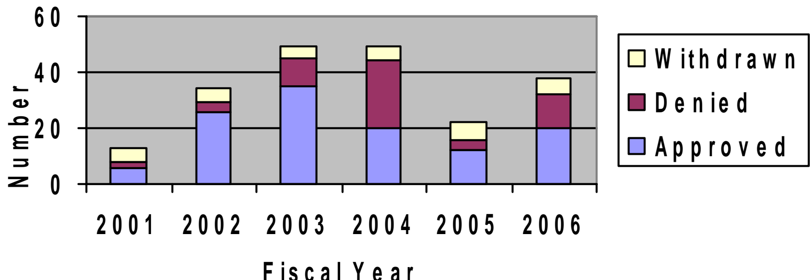
CON Procurement Projects FY2001 - FY2006



Source: Georgia Department of Community Health (as of 10/26/06)

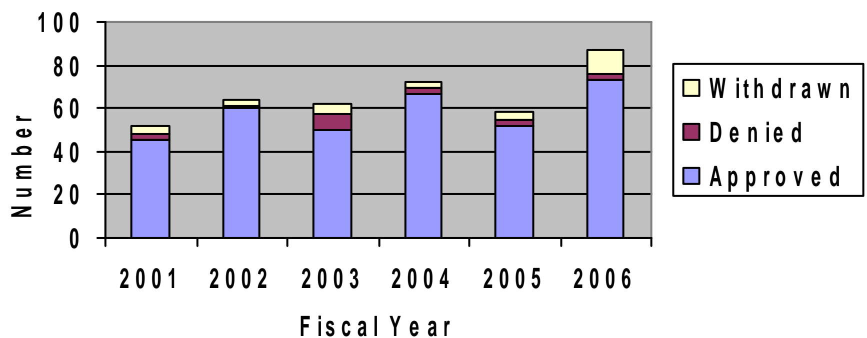
Between FY2001 and FY2006, two hundred five (205) CON applications were submitted requesting service changes. Applications representing services changes accounted for approximately twenty-eight percent of all CON applications submitted during this time period. Of the total number of applications submitted seeking service changes, 119 (58%) were approved, 55 (27%) were denied, and 31 (15%) were withdrawn. FY2003 and 2004 saw the highest number of Service Change applications submitted with forty-nine each. Of the 49 submitted in FY2003, 20 were appealed and two decisions were reversed. In FY2004, 20 of the 49 submitted applications were appealed, and none of the Department decisions were reversed.

CON Projects Requesting Service Changes FY2001 - FY2006



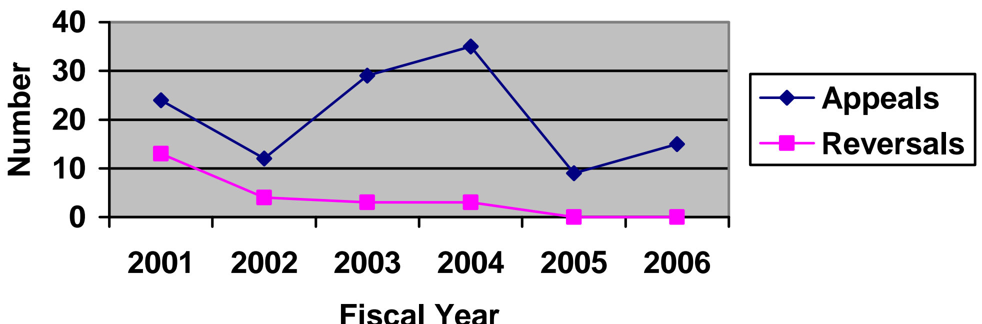
Source: Georgia Department of Community Health (as of 10/26/06)

Construction projects represented most (55%) of all CON applications submitted during these six fiscal years, three hundred ninety-seven altogether. On average, the department received 66 applications for Construction projects during this period. As referenced by the chart below, eighty-seven percent (347) of these projects were approved, five percent (19) were denied, and seven percent (29) were withdrawn.



Source: Georgia Department of Community Health (as of 10/26/06)

During FY2001- FY2006, of the 726 CON applications that were reviewed by the Department, 17% (124) of those decisions were appealed, and only 3% (23) of those decisions were reversed. Most of those reversals occurred in FY2001. There were no decisions reversed in FY2005 or FY 2006.



Source: Georgia Department of Community Health (as of 10/26/06)

NOTES PERTAINING TO ALL CHARTS

Withdrawn - Withdrawn prior to a DHP decision
Appealed - Information is incomplete for appeals submitted between 6/2000 and 10/2001; information for appeals submitted prior to 7/84 may not be reliable
Percent Appealed - The percentage of DHP decisions that is appealed; not valid if you have selected all years
Decisions Reversed - Refers to DHP decisions that are reversed upon Administrative Appeal or Judicial Review; does not take into account instances in which projects were remanded to DHP and the agency changed its decision; not available prior to 1989.

This data continues to support and substantiate the quality of the Department's State Health Plans and Rules that are regularly updated by the Health Strategies Council's Technical Advisory Committees and is further testimony to the efficiency and consistency of the Department's staff in interpreting the intent of the Plans and Rules.

Published for the Health Strategies Council by the
Department of Community Health/Division of Health Planning

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