The Role of Health Planning in Bioterrorism Preparedness

By Sonya R. Albury, AHPA President

Our lives were changed forever by the events of last year, and our future is shaped by the knowledge that we have gained. As a result of September 11th, the phrase “homeland defense” has become a permanent part of our vocabulary.

It is a unique time to bring together the forces of health planning and public health with a wide array of federal, state and local bodies. In fact, the local environment is most critical. Because the initial detection of a biological or chemical terrorist attack will most likely occur at the local level, the preparedness of the local medical community, both public and private, is essential.

Several plans are currently under development. The role of planning, together with the public and private health care delivery systems, is to assist in laying out this framework, performing needs assessments, engaging in community capacity building, and providing information for those in need of timely and accurate data.
There are five essential ways that we can assist. For those of us who have lived through previous disasters (both natural, e.g., hurricanes or floods, as well as intentional), we can build on our experience, taken together with our newfound knowledge post-September 11th and the subsequent anthrax episode that followed.

The five ways of assisting that have been identified to date are:

1. **Health and Resource Tracking**
   Community planning studies quantify and report the overall profile of the community, its needs, resources, such as local community hospitals and mental health providers, and monitor the health status of the community. We must also look at the armies of uninsured with a projected 44 million people nationwide who lack health care insurance, and the additional 2.2 million people estimated to have lost their insurance in 2001 due to the economic downturn. A recent article in USA Today, quoting Halstead and Lind of New America Foundation, noted that the growing number of people who are uninsured is “not only a personal disaster,” but it is increasingly more evident that it is a “threat to the security of all Americans.”

2. **First Responders**
   In many communities, health planners are currently working with the local emergency medical services and trauma personnel to maintain a smooth and efficient system based on standardized protocols. Local groups may be the first to see victims of bioterrorism and they will need appropriate and up-to-date training on a regular basis to keep abreast of new diseases and possible threats. According to the Emergency Nurses Association’s Washington Update, “Recognizing a bioterrorist attack quickly is a major part of containing it.”

3. **Communications and Education**
   Community health planners can assist with maintaining an up-to-date web site and on-going communication with providers. The practice of keeping current resource lists will support bioterrorism preparedness. We can also participate in educating the community, developing consumer-friendly information, and making it available to the public.

4. **Planning**
   Health planners and program developers are experienced at taking information and formulating appropriate plans for various needs including equipment, infrastructure, training and other related components. New resource allocations from federal and state governments, such as the nearly $3 billion in funding recently allocated to the states for bioterrorism preparedness, should be targeted to the most critical health and infrastructure needs.

5. **Leadership**
   The practice of health planning supports establishing a clear set of protocols for decision-making and designing methods of fast-tracking information for leaders to make informed choices.

In summary, a multitude of participants must be prepared to perform their roles in exactly the right manner, at the right time. This classic team effort will foster a collaborative understanding that must be realized concerning our community health, which affects us all. The successful marshalling of public health capabilities and health planning, from the shores of Florida to the plains of the Midwest, and the hilltops of Utah and beyond, requires that all the major partners will show that our most precious and productive resource is our citizens. This is our human capital — working together to preserve and protect our freedoms.
A Moment of Silence to Remember

Let’s take a moment of silence to remember those who lost their lives during the September 11th disaster, and those who strove so bravely to save others and also perished. In my hometown of Miami, we lit candles and took some time to remember those who are gone. We have much to be grateful for and must work together now, more than ever before.

Let us learn and plan for a safe and healthy tomorrow.

What Do You Think?

AHPA’s newly formed Planning Committee is discussing the role of the Association in Bioterrorism Preparedness. Committee members are in the process of reviewing the Department of Health and Human Services’ released guidance giving states direction on re-tooling their public health system and developing state disaster plans. If you have thoughts about the guidance and AHPA’s role, we would like to hear from you. Also, if you would like to join the Committee, you may contact me at <salbury@healthcouncil.org>. We look forward to hearing from you!

Our Barometer: The Uninsured

by Robert Vogel, Vice President, Managed Care Sisters of Mercy Health System–St. Louis

The number of uninsured rises and falls like a barometer measuring the changing condition of our fragile health care financing system. Jonathan Cohn, quoted in a New Republic article, says that the country faces virtually “perfect storm” conditions for another rise in the uninsured (Brownstein, LA Times, January 7, 2002). Like barometric pressure, the change in uninsured is not the problem, only an indication that unresolved structural problems are either masked or exposed as economic conditions change.

In the current economic environment, structural weaknesses are exposed, much as they were in the late 80s and early 90s. Politicians and pundits roll out every variety of band-aid to increase access, in conservative, moderate or liberal flavors. Applying solutions to the uninsured is like setting the marker on a barometer to “fair” weather and expecting the barometric pressure to rise.

Sometimes the debate broadens to “reform.” “Universal access” breeds discussion of a “single payer” system. All manner of special interest groups emerge, opposing essential reforms for philosophic or protectionist reasons, as happened to the Clinton plan.

What will happen during the current period of “low pressure”? Futurist Russell Coyle, Jr., describes the conditions that could lead to serious debate over reform and a possible “National Health” scenario: slow economic growth; unemployment passing 6%; high healthcare costs becoming a political concern; uninsured ranks increasing by 2 million a year; working poor, small businesses and pre-Medicare retirees severely affected; premiums exceeding $200 per member per month cause affordability crisis; employers adopt defined contribution options or drop insurance; and costs soar toward 16% of GDP. Some of these conditions are now apparent. However, marginal party control of Congress and the political and economic impacts of terrorists’ acts significantly cloud the focus on healthcare financing in crisis. We may experience the hyperinflation of the early 90s again before the crisis becomes unbearable and our political and social machinery responds.

Everything from access to quality to workforce to efficiency suffers in the interim. Recently, leadership from national healthcare associations, insurance industry associations, business coalitions, and political leaders banded together to organize a national forum on solutions to the uninsured problem. Why not a forum on the underlying structural problems rather than the symptom? I’m looking at my barometer knowing I can’t get results by setting the marker to “fair.”
Ms. Albury has been the Executive Director of the Health Council of South Florida, Inc. for eight years. She oversees all activities in the planning and development of health related projects for the agency. Her primary areas of emphasis include: a) increasing access to healthcare for the uninsured and underinsured; b) disease management; c) long term care; and d) health care ethics. Under her leadership, the Health Council has received awards for its Transportation Disadvantaged Project in Monroe County and the Attacking Asthma Initiative at Miami Children’s Hospital. Ms. Albury oversees the administration of a statewide insurance program for persons living with HIV/AIDS, which increased access to underserved populations by more than 75 percent for both Blacks and Hispanics and saved the State over $25 million in care and treatment dollars during FY2000-01.

Ms. Albury has undertaken research in the areas of children’s health insurance, healthcare financing models and disease management, utilizing the most recent technological advances in CD-ROM applications. Under her guidance and planning support, the Council helped launch the Florida Keys Healthy Start Coalition in Monroe County, and the Health Council established the Medical Futility Guidelines of South Florida, a set of ethical standards for end-of-life care developed under the auspices of the agency’s community based Health Care Ethics Committee. Most recently, she spearheaded the Hospice Medicaid Education Project with the nationally acclaimed Hospice Foundation of America.

Ms. Albury is the 2002 President of the American Health Planning Association. She Co-chairs the Data Committee for the Mayor’s Health Initiative in Miami-Dade and Co-chairs the Evaluation Committee of the recently funded HRSA Community Access Program (CAP) initiative, a $6.1 million program. Ms. Albury also serves on various local and state boards and committees, including the Board of Directors for the Dade/Monroe division of the March of Dimes; the Steering Committee Member of the Growing Healthy Task Force and was recently named Co-chair of the newly appointed Strategic Planning Review Committee, of the Greater Miami Chamber of Commerce. She has served on the Policy Oversight Committee of Florida’s Agency for Health Care Administration; and was a Special Advisor to the Statewide Panel for the Study of End-of-Life Care in Florida.

Prior to joining the Health Council, Ms. Albury was a healthcare consultant with Nancy Persily Associates and developed marketing plans for hospitals, nursing homes, adult congregate living facilities (ACLFs), rehabilitation facilities and related health care organizations. She helped establish the Southeast Florida Center on Aging at Florida International University and co-authored several chapters in the book *Eldercare: Positioning Your Hospital for the Future*.

Ms. Albury earned her Bachelor of Science from Taylor University in Indiana and her Masters of Social Work degree from Florida International University with a specialization in Community Development and Administration in 1981.
I’m starting off this new column by looking back at articles we’ve published recently and asking myself what has occurred since they were written. I’ve always tried to select topics of significance to AHPA members – health planning, health regulation (CON), and public health – and address them from a policy perspective. Here are three topics I think warrant updating.

Regionalization of Certain Hospital Services to Promote Better Outcomes

Three years ago, I wrote “Regionalization for Quality: Certificate of Need and Licensure Standards,” (accessible at <www.ahpanet.org/articles.html#Regionalization>) in which I promoted the use of CON and licensure standards in regionalizing certain high-risk services as being in the public interest.

The Leapfrog Group, composed of employers and healthcare purchasers, have recently undertaken an initiative which would require hospitals to meet volume standards for five high-risk surgical procedures, including two which are often subject to state standards: coronary artery bypass graft (CABG) surgery, and coronary angioplasty. In order to meet the highest standard for CABG surgery, a hospital would have to do a minimum of 500 surgeries per year. For coronary angioplasty, it would have to do 400 procedures per year.

For further information, see Birkmeyer, J.D., Finlayson, E.V., and Birkmeyer, C.M. “Volume standards for high-risk surgical procedures: Potential benefits of the Leapfrog initiative.” Surgery 130 (September, 2001), pp. 415-422. Based on this study, the Centers for Medicare & Medicaid Services will be exploring the establishment of volume standards for the Medicare population.

The Quality of Nursing Care

One year ago, I wrote “Regulating in the Public Interest: The Quality of Nursing Care,” (accessible at <www.ahpanet.org/articles.html#Nursing>). In January 2002, California Governor Gray Davis announced the nurse staffing ratios by hospital unit which would be mandated under a 1999 law. For medical-surgical units, it would be one-to-six, increasing to one-to-five, 12-18 months after the law becomes effective which is expected to be in July 2003. In emergency departments, it would be one-to-four, and in intensive care, one-to-two. For psychiatric units, it would be one-to-six (the CHA had wanted one-to-twelve).

This landmark state initiative has already had salutary effects. Within the state, Kaiser announced last summer that it would adopt a one-to-four standard for medical-surgical units in all 27 of its hospitals, and it reiterated that pledge upon learning of the state’s adoption of a lower standard. Already, Florida, Massachusetts, Ohio, and Rhode Island are considering nurse staffing laws.

Studies have shown that magnet hospitals achieve better outcomes and that they do so largely through better nursing ratios. One study that examined the performance of seven magnet hospitals found they had a nurse-to-patient ratio that was 74% greater than the national average for all hospitals. (Aiken, Linda, Havens, Donna, and Sloane, Douglas, “The Magnet Nursing Recognition Program,” American Journal of Nursing, March, 2000.)

Quality Indicators for Public Health

The last issue of the newsletter included “Community Health Planning and National Public Health Performance Standards” (accessible at <www.ahpanet.org/articles.html#chp>). The agency for Healthcare Research and Quality (AHRQ) has issued a set of Prevention Quality Indicators that identifies diseases that can be effectively treated with good community-based primary care. These indicators represent a refinement and further development of the Healthcare Cost and Utilization Project (HCUP) Quality Indicators. To download the indicators and statistical software, go to <www.ahrq.gov/data/hcup/prevqi.htm>.

If you have a comment or a question concerning this article, please email it to either <jjusteen@att.net> or <AHPAnet@aol.com>. We look forward to hearing from you!
CON Not Necessary To Supply Medical Equipment to Hospitals
Companies that seek to sell or lease medical equipment to healthcare facilities do not need to obtain a Certificate of Need (CON), the Alabama Court of Civil Appeals has ruled (Prime Lithotripter Operations v. LithoMedTech of Alabama, Ala. Civ. App., 2991270, 12/28/01). “Nothing . . . requires an entity that merely seeks to sell or lease equipment to a healthcare facility (for that facility to then use in providing a service) to obtain a CON,” the court ruled in an opinion written by Judge Sharon G. Yates. The ruling was a victory for Uroventure and LithoMedTech of Alabama. Both companies sought to provide mobile lithotripsy units on a rotating basis to Alabama hospitals. The State Health Planning and Development Agency (SHPDA) denied LithoMedTech’s certificate of need applications and required Uroventure to apply for certificates before leasing their lithotripters.

A competing mobile lithotripsy supplier, Prime Lithotripter Operations (PLO), petitioned the state to deny LithoMedTech’s applications and petitioned the trial court to require Uroventure to submit to CON review. Lithotripsy is a non-invasive surgical procedure that uses shock waves to dissolve kidney stones.

The appeals court decision ruled in favor of LithoMedTech and Uroventure, and affirmed trial court verdicts that found the two companies did not require CONs to provide mobile lithotripsy equipment. The decision consolidated appeals actions: PLO’s suit against LithoMedTech, SHPDA’s suit against LithoMedTech, and PLO’s suit against Uroventure.

Rule Struck Down
The appeals court reached its conclusion through a close reading of a Alabama Code 1975, section 22-21-261, which states that CON review seeks to “assure that only those health care services and facilities found to be in the public interest shall be offered or developed in the state.” UroVenture and LithoMedTech are not providing a service, but only a piece of equipment, the court explained.

“The sellers or vendors of equipment that healthcare facilities and HMOs use in order to provide such services need not obtain a CON,” the court ruled. “Facilities or organizations that provide those health services are the focus of the certification requirements.” LithoMedTech applied to SHPDA for a CON to circulate mobile lithotripters through rural areas of Alabama. PLO contested the application, maintaining that Alabama residents were adequately provided for by its own services. The state ultimately denied the applications, leading LithoMedTech to sue in Montgomery Circuit Court.

Uroventure, instead of applying for a CON, asked the state to waive its right to CON review. The state refused. Uroventure sued, seeking a court declaration that it did not need a CON to provide lithotripsy equipment. PLO intervened on the state agency’s behalf. As LithoMedTech’s applications were pending, SHPDA’s CON review board amended its rules to require mobile medical equipment vendors to obtain CONs.

The agency overstepped its bounds with the last minute rule-making, according to the court. SHPDA does not “have the authority to require CON review for entities or matters that are not expressly subject to CON review under the law as set out by the legislature,” the court said.

Dissenting Opinion
Dissenting from the opinion, Judge William C. Thompson said the majority was wrong in its interpretation of Alabama CON requirements. Thompson quoted the state’s CON Rule, section 410-2-3-.07(1), stating, “Each applicant for a Certificate of Need to provide a mobile
lithotripter for use” who demonstrates the equipment is safe and competitively priced “may be granted a certificate of need by SHPDA.” “The clear language of the preceding [rule] demonstrates that since the time the [state] initially authorized the use of mobile lithotripsy equipment,” Thompson said, “both the site at which the service is to be performed and the vendor providing the mobile lithotripsy equipment have been required to apply for and obtain a CON before offering services to the public.”

The requirement that CONs be obtained for both the site providing the service and the supplier of the equipment is nothing new in Alabama, Thompson said. CONs are required for magnetic resonance imaging equipment and mobile cardiac catheterization units, as well as the facilities using them. “Appellate courts generally accord deference to a state agency’s interpretation of its own regulations,” noted Thompson, who was joined in his dissent by Judge John B. Crawley.

**Court Rejects CON Challenge**

A CON for an invasive cardiac care center in the Meridian area of Mississippi was properly granted to Rush Foundation Hospital, the Mississippi Supreme Court ruled Oct. 31, rejecting a challenge filed by another cardiac center operating in the same area (Jeff Anderson Regional Medical Center v. Mississippi Department of Health, Miss., No. 2000- SA-02123-SCT, 10/31/01).

The state high court concluded that the methodology used by the Mississippi Department of Health to calculate the population base relevant to the CON application was not arbitrary and capricious, and held that the department properly considered the cost containment purposes of the CON laws in approving Rush’s application. After Rush’s CON was approved by the department, it was challenged by Jeff Anderson Regional Medical Center (RMC), which is an established therapeutic cardiac catheterization and open-heart surgery center servicing the Meridian area,” the court wrote. Jeff Anderson RMC argued that there was no need for duplicate cardiac services in the same part of the state. Following a hearing, the hearing officer recommended approval of the CON, and the CON was later approved by the state health officer.

**Court Reviews Methodology**

In evaluating Jeff Anderson RMC’s challenge, the court noted that Mississippi is divided into seven planning areas, and the state health plan indicates that a need determination using the designated planning area and a minimum population base of 100,000 per planning area is required. However, population outside the planning area also can be considered in determining need, the court noted, and the department uses a “market sharing” method of determining a population base when service areas overlap. “Rush included in its population base calculation the population of seven Mississippi counties, five of which are within its planning area, and two Alabama counties,” the court wrote. Jeff Anderson RMC argued that Rush did not submit adequate documentation to the department to justify consideration of the out of area population, “and therefore, the market sharing methodology was not properly applied,” the court wrote. According to Jeff Anderson RMC, the department engaged in speculation, which was arbitrary and capricious, when it allowed Rush to rely upon the populations of the two Alabama counties.

**Cost Containment Considerations**

Rejecting those arguments, the court concluded that there was substantial evidence to support the final order in the case, and that the methodology used was not arbitrary and capricious. The court decided that Rush presented adequate documentation as required by the state plan to allow the use of population outside the planning area to be considered in the CON analysis, and that Rush also provided statistical studies on Alabama patients. In addition, “the market share methodology has been approved by the Mississippi high court in many other cases,” the court wrote. The court also concluded that the record contradicted Jeff Anderson RMC’s contention that the department ignored the CON law’s cost containment purposes when it approved Rush’s application. For example, the hearing officer noted that the Rush facility would benefit the entire community by providing a cost-effective competitor,” the court wrote. Justices James W. Smith, Michael P. Mills, William L. Waller, Kay B. Cobb, Oliver E. Diaz, and Charles D. Easley concurred in the decision by Justice Chuck McRae. Justices Edwin Lloyd Pittman and Fred L. Banks did not participate.
Company Fun Equals Productivity and Profit
By Barton Goldsmith, Ph.D., CEO, Goldsmith Consulting

In companies where people have fun, the productivity and the profit are higher. The American Psychological Association has published surveys about this, and it’s a fact. Take the example of Southwest Airlines — do you know that "a sense of humor" is on their job application? I believe that this attitude and culture has helped their business become one of the major success stories of our time. After September 11th, when all the airlines were having major downturns, Southwest was still in the black. I believe this was because their "sense of humor" attitude made people feel comfortable to fly with them.

**Attitude**
Attitude and behavior are a choice, and I believe in banning bad attitudes. A great technique to integrate this culture into your business is to begin with a simple strategy called "Good Attitude Wednesday." Every Wednesday, everyone is in a good mood, no bad attitudes allowed. This energy is infectious, you can’t be in a bad mood when everyone around you is in a good mood. Once you begin, it’s easy to extend this into the rest of the week. The effect will appear in your bottom line, and lower turnover will be one of the many side benefits.

**Eliminate Negativity in the Workplace**
If you’ve ever had to let someone go because of a negative attitude, you probably got a response from the rest of the team that was something like, “What took you so long?” One negative person can bring down an entire workforce. When that person walks into the front door, the feeling they bring with them is almost palpable, you can feel it. It’s like a fog that causes dampened spirits in everyone. In one company, they had an individual who, though he was very important to the company and doing a highly detailed task, was a misanthrope. This individual did not like people, and people did not like him. Through some quality brainstorming, we came up with an idea that was a little off-beat, but seemed to serve everyone well. The CEO decided to clean out a storage closet, and put in a desk and computer so that this individual could have his own office. He would come in to the office in the morning carrying his lunch, go into his office, close the door behind him and leave at the end of the day. He was happy because he had an office of his own, and the staff was happy because they no longer had to contend with his negativity. Whether you have to let someone go, or find them a place where they won’t interfere with the rest of your team, I urge you to “sooner rather than later” remove negative individuals from your workplace.

**Implement Fun Experiences**
Keeping the energy high and incorporating fun takes a little thought, but there are many simple and inexpensive ways to do this. Every now and then, bring in something different and uplifting for your team, like an ice cream cart, a popcorn machine, or a cappuccino maker (you may actually want to keep this one). Bowling parties, outdoor meetings, retreats held in unusual destinations (like Bora Bora) are other ways to uplift people and get them thinking outside the box. It also builds that esprit-de-corps, the team spirit, that seems to fade away during difficult economic times, such as we are currently facing. It doesn’t take much thought and usually doesn’t cost much money to help people have a good time. Even something as simple as "Hawaiian Shirt Day" can turn a slow quarter into a positive attitude for the next quarter.

**Knowledge Lunch**
Here’s a different idea to help you educate your team for very little money. Once a week, have each team member select an article that they think is germane to the client or project you are currently focusing on. Bring in a couple of pizzas and during lunch, have everyone sit around a table and share their article with their co-workers. It’s a great way to educate them about new clients, new industries and any other current events that are pertinent to your business. For more information on the Knowledge Lunch idea, send an email to <Wendy@BartonGoldsmith.com> with “Knowledge Lunch” in the subject area.

Dr. Goldsmith may be contacted toll free at (866) 5-BARTON or the web site at <www.BartonGoldsmith.com>. ✨
Virginia Presentation
by Karen Cameron, Executive Director, Central Virginia Health Planning Agency (CVHPA)

The CVHPA staff regularly updates its Board of Directors and community organizations about healthcare trends and issues that are likely to impact our communities. The following is a presentation recently made to these groups relating to national health care trends and the forecast for the future. According to Karen Cameron, “the nation’s unwillingness to effectively deal with issues around access to and the cost of healthcare, the health needs of our aging population, and appropriate utilization of pharmaceuticals and technology paints an uncertain, if not gloomy, forecast. The issues that fostered the public outcry for health care reform in the 1990s are re-emerging in this decade, making it apparent that a booming economy, managed care and other private sector initiatives that theoretically should have resulted in increased access and long-term cost control have failed. Our national policy makers will have to step up to the plate and recognize the inherent problems in our current employer-based system.” For additional information about the CVHPA, see its web site at <www.cvhpa.org>.

U.S. Insurance Coverage for 2000

Annual Percentage Change per Capita in Health Care Spending and Gross Domestic Product (GDP) 1991-2001

2000 Personal Healthcare Expenditures

2000 National Healthcare Expenditures


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Health Spending Summary

Overall Health Care Spending
- Grew to $1.3 trillion in 2000, up nearly 7% from 1999, fastest acceleration in 12 years.
- Health care spending consumed 13.3% of GNP in 2000, the second consecutive year that health spending growth outpaced growth in GDP. Trend will continue.

Hospitals Driving Growth
- Hospital (inpatient and outpatient) spending increased 5.1% from 1999.
- Medicare hospital spending grew 4.5%, highest growth rate since 1997.
- Retreat from strict insurer management of medical care and providers’ reactions to managed care led to higher expenditures.
- Hospital labor costs are rising.

Private Spending Up
- Growth of 6.9%, up nearly a percentage point over 1999 growth.
- Due in part to accelerating private insurance premium growth ($444 billion in 2000).
- Growth of 6.9%, up nearly a percentage point over 1999 growth.

Prescription Drug Spending Still Rising
- Grew 17.3% in 2000, the 6th consecutive year of double digit growth.
- Consumer spending for outpatient prescription drugs represented the largest single component of out-of-pocket spending at 20%.

Other factors contributing to growth:
- Greater income growth.
- Insurers’ inability to negotiate increasing price discounts.
- Rising provider costs.
- Newer, better therapies requiring high cost branded product.
- Direct-to-consumer advertising.
- Health care usage in the United States begins to increase when individuals reach 40, then steadily increases.

Projected growth in health spending fueled partly by rapid increases in spending for prescription drugs:
- Considerable discretionary income.
- Internet access/other ways to obtain health information.
- Access to health insurance, but little/no choice.
- Uninsured.
- Medicaid population.
- No access to market-based health insurance.

Implications for Consumers

- In 1999, households spent 4.5% of income on health care expenditures out of pocket.
- In 2001, employees paid 15% of cost of single coverage and 27% of cost of family coverage.
- Workers are bearing greater financial risk for cost of prescription drugs.
- Health care affordability will likely deteriorate further in the near future.
- Greater out-of-pocket spending in the future:
  - Managed care companies: Demand for broad choice and rising payments to providers.
  - Consumers: Higher deductible, co-insurance, and co-pays.
  - Employees: Decrease in their contribution rate, consumers pay more of premium.
  - Number of uninsured will increase.

Consumer and Demographics

- Health disease will continue to cause more death and disability than all other illnesses. Cancer will rank second in mortality rates.
- Mental illness (especially unipolar major depression) will have a larger impact than cancer by 2010.
- People 65 and older will comprise more of the population and consume more health care. According to the AHA, health care usage in the United States begins to increase when individuals reach 40, then steadily increases.

Number of uninsured will increase.

Future Forecast

- More health costs and decisions will shift to government purchasers and consumers due to rising costs, changes in the workplace, and workers’ ages.
- 42% of employers are “very likely” to change to defined contribution approach from sponsored health plans. These companies recognized that only 40% of their employees are likely to be receptive to the change.
- The distinction between managed care organizations is becoming more relevant.
- In 2000, baby boomers started turning age 65, moving the United States toward a majority government-funded system.
- Medicare remains the second most popular program among the elderly; politicians need this demographic vote.
- State legislators may take initiative on health policy issues if there is federal partisan gridlock.
- Maine is the first state to threaten the pharmaceutical industry with price controls.
- The Health Insurance Association of America, the AHA and Families USA propose to expand Medicaid and the Children’s Health Insurance Program to cover all people with incomes up to 200% of the federal poverty guidelines.
Spring, CON & Moral Philosophy

Spring has arrived, baseball opening day is here, and state legislatures are in session. Don’t complain, two out of three isn’t bad.

Croci, and the always enlightening debate over Certificate of Need regulation and planning, are in full bloom. You can line up the usual suspects. The debate ebbs and flows, from Honolulu to Tallahassee. Its nature and focus tend to be state-specific, but perennial themes dominate: program termination; program “reform” and restructuring; changes in scope of service; deregulation of the more profitable services (e.g., outpatient surgery, diagnostic imaging, specialized cardiac services); budget reductions; and, occasionally, expansion of regulation.

Bees and lobbyists are buzzing, expenditure and pollen counts are up, but there is precious little fruit so far. CON fared reasonably well this year in Virginia, the only state where (as of this writing) the legislature has adjourned. There, efforts to deregulate cancer treatment centers, other profitable specialty ambulatory care services and major medical equipment, and to eliminate regional health planning agencies, fell short. A competent and well-organized educational effort by the state hospital association, and a political climate temporarily more benign than expected, were largely responsible for the favorable outcome. The debate continues elsewhere, and next year promises to be another season in Virginia.

Those wishing more information on the Virginia experience this year can find the CON and health planning bills introduced, as well as the disposition and recorded votes on each, at the state legislative website <http://leg1.state.va.us>.

A state-by-state summary of the legislative season, and the treatment accorded CON and health planning, will be presented in an upcoming edition of Health Planning TODAY.

Welcome to spring. Play ball!

Lafcadio Hearn, Jr.,
Special to Health Planning TODAY

Historical Highlights: Excerpts from AHPA’s Past

The American Health Planning Association (AHPA) was formed in 1971 as the American Association of Comprehensive Health Planning (AACHP), representing areawide and state health planning organizations and university graduate programs in comprehensive health planning. The AACHP was formed through the merger of the Association of Areawide Health Planning Agencies and the American Academy of Comprehensive Health Planning, both of which represented local and state health planning organizations created by Public Law 89-749, the Partnership for Health Act of 1966.

The Academy was formed in the late 1960s, while the Association of Areawide Comprehensive Health Planning Agencies grew out of the old Hill Burton health facilities program together with the new local comprehensive health planning (CHP[b]) agencies. For many years, the Association sponsored a major national meeting held annually in Chicago.

AHPA has come full circle from a collection of small scattered groups in 1971 to a large national organization representing hundreds of jurisdictions and a variety of constituencies by 1980, back to a small voluntary association in the 1990s. The Association has always been a hybrid of a professional trade association representing the interests of professional health planners and a voluntary organization representing the state and local volunteers who have been the hallmark of health planning in the United States.

Throughout its history, AHPA has remained steadfast in its dedication to ensuring that the American people have access to affordable health care as well as a voice in how that care is delivered. The American Health Planning Association and Its Board are committed to maintaining a viable organization dedicated to that mission.

You can look forward to more glimpses at our history next quarter when we review “Leadership Through the Years.”

Lafcadio Hearn, Jr.
Special to Health Planning TODAY
First Class

American Health Planning Association
... putting it all together
Planning for the Uninsured – States and Counties on the Move!
by Sonya Albury, AHPA President

Americans get ready! With 43 million uninsured and counting, and another 20 million or more underinsured, we are certainly at a crossroads in American culture. How is it that some states require everyone to have car insurance, but not health care coverage? America is truly in a unique position as one of the last remaining industrialized countries to not assure access to a basic standard of care for all of its citizens. The closest we come is to require that no one is turned away in an emergency situation. With our emergency departments overcrowded due to the growing nursing shortage, indigent care demands, liability considerations by health practitioners, and a limited availability of critical care beds, even this level of access is being compromised. What can be done? Who will do it? And, when will it be addressed?

Not ones to hold out for a national, governmental solution, planners and policy-makers across the nation are taking action. Through a wide variety of community

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Health Planning TODAY

a periodic publication of the American Health Planning Association

Sonya Albury .............. President
(tba) ........................ President-Elect
Robert Vogel .............. Past Pres./Secretary
Karen Cameron............ Treasurer

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Dean Montgomery, Business Manager
7245 Arlington Blvd., Ste. 300
Falls Church, VA 22042
Phone: (703) 573-3103 Fax: (703) 573-1276
Email: AHPAnet@aol.com

Information for the quarterly journal is due on March 1, June 1, September 1, and December 1. Articles should be short — no more than one page of text. The Editor reserves the right to edit any article or submission as needed.

Information may be submitted via e-mail to: “dschuess@mail.state.mo.us” or “tpiper@mail.state.mo.us” or faxed to (573) 751-7894.

Donna Schuessler, Editor

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Planning for the Uninsured

collaborations, states and local communities are developing their own models for increasing health care access. These models are not only theoretical, they are in practice today. Based on recent research by Phyllis Busansky, one of the original founders of the Hillsborough County Health Care Plan in Florida, these models are particularly exciting because they "showcase real work with real achievements in real communities that continue to be effective today."

What are some of these models? In Pittsburgh, Pennsylvania there is the Coordinated Care Network. It offers a faith-based entrepreneurship model that focuses on disease prevention and prescription drug discounts. In Georgia, Emanuel County has launched a cross-sector disease management model that emphasizes public/private partnerships called Access Emanuel. A volunteerism model launched by physicians belonging to the Buncombe County Medical Society offers not only access to care, but their Project Access in Asheville, North Carolina is a model for management information system support of a community integrated delivery system. Marion County, Indiana devised the Wishard Advantage, a product that resembles a mainstream HMO with consumer choice of providers, a membership card and minimal co-pays that is funded through Federal Disproportionate Share dollars with matching county and city funds. Galveston, Texas Task Force on Indigent Healthcare created a health program that integrated social services and Milwaukee, Wisconsin incorporated Federally Qualified Health Centers as a strong component as well as dental care through its General Assistance Medical Program. One of the most intriguing financial structures can be found in Muskegon County, Michigan. Its Access Health initiative is an innovative model that expands coverage by lowering the threshold of cost for coverage for employers, employees and the county through a 30%, 30%, 40% cost-sharing plan. The Cambridge Health Alliance in Cambridge, Massachusetts is a great example of assuring cultural competency, investing $2.8 million for an interpreting program to reduce language barriers.

What are some of the lessons that have been learned by these varied, yet committed and community-oriented efforts? Here are what some of the communities said:

☛ Be open to new ideas and approaches;
☛ Be sure to document your starting point and track the progress made;
☛ Relationship building is crucial – it all runs on the relationships established through "reciprocal accountability";
☛ Keep communication lines open to promote a dialogue of ideas and encourage innovation;
☛ Educate the broader community of the need and possibilities – engage the media;
☛ Work with government and local agencies;
☛ Streamline procedures and applications;
☛ Engage the business community from the very start;
☛ Discern which approaches work best for the working uninsured separately;
☛ Determine what thresholds will work for buy-in programs and non-participating groups; and
☛ Develop a business plan, and measure your return on investment.

What else should be considered? Some of the most successful programs utilize the principles of health planning: emphasizing quality, accessibility and community acceptability of the program. They engage leadership across a wide array of organizations and sectors, have a shared vision and principles that they endorse, are inclusive, align their resources wisely in order to leverage the best return, and assure financial accountability. Lastly, the concept of an “organizing platform” is evident, offering a focus for on-going cooperation, development and administration of the initiative.

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Magnet hospitals provide a low patient-to-RN ratio and a higher ratio of RNs to unlicensed personnel who are never used to replace RNs. This has a strong bearing on avoidance of medical errors, a problem highlighted in a 1999 report by the Institute of Medicine that estimated that up to 98,000 deaths per year may occur through such in-hospital errors. Research has shown magnet hospitals to have lower mortality rates than comparable hospitals, 7.7% lower in one study, 4.6% lower in another, and they report significantly higher patient satisfaction. A study conducted by the Harvard University School of Public Health for the U.S. Department of Health and Human Services reported last April that a higher number of RNs was associated with a 3%-to-12% reduction in the rates of adverse outcomes in hospitals. Higher staffing levels for all types of nurses was associated with a decrease in adverse outcomes of from 2%-to-25%. To date, 47 hospitals nationally have been accorded Magnet Recognition, 11 of which are in New Jersey.

This January, California took the unprecedented step of mandating minimum standards for nursing in hospitals under a law passed in 1999. Already, Florida, Maine, Massachusetts, Ohio, and Rhode Island are considering their own nurse staffing laws. If there is opposition to mandating higher nursing standards, it is based on the difficulty in hiring additional nurses and the increased costs of doing so. However, the reduction in the rates of adverse outcomes, the significantly shorter lengths of stay, and the reduced need for intensive care all reduce hospital costs. Most significantly, higher standards for nursing practice better attract and retain professional nurses, and result in a better trained, more experienced nursing staff. The ultimate result is a hospital that performs better for its patients, as well as one that can compete better.

For all these reasons, an intelligent consumer would want to ask a hospital about its nurse staffing ratios, staff mix and experience, and turnover rates, but a concerned citizen will want the state to ensure that all hospitals are places in which nurses are encouraged to perform at their highest level for all their patients.

Almost a hundred years ago, our country confronted the question of quality medical education, then personal health care security, then adequate access, then health care costs. Now, we are trying to find a BALANCE among all of these factors. We are returning to the realization that COMMUNITY HEALTH PLANNING is a key to holding down costs, assuring access and promoting quality, while restoring the VALUE OF CARING to our delivery systems.

Amazingly, we continue to have 36 states (plus the District of Columbia) who have maintained public oversight programs known as Certificate of Need in Alabama and Missouri, or the Health Care Authority in West Virginia, or Permit of Approval in Arkansas . . . different names, same purpose. For the last 13 years, I have tracked the diverse trends of CON regulation and documented much of it in the National Directory of Health Planning, Policy and Regulatory Agencies. Not only does it show the services reviewed, but also the amount of money which must be spent for capital, major medical equipment and new services to require a CON (see <www.ahpanet.org/directory.html> to download the most recent copy). From this latest list of diverse review standards, I have selected a dozen states to give you a quick overview of how each is struggling to BALANCE regulation and competition.

First is MAINE . . . after reorganizing and redistributing their CON program in state government (a result, in part, of veteran director John Dickens retiring three years ago), they have strengthened their efforts a little through LD 1799, particularly as related to hearings. But, as with

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Massachusetts Medical Security Plan
by Mara H. Yerow, Director
Medical Security Program, MA Division of Employment and Training

I am pleased to write this article about the Massachusetts Medical Security Plan (MSP). I became the first full-time Director of the MSP in February. I want to take this opportunity to provide the AHPA membership with information about this unique and innovative program.

The MSP provides health benefits to unemployed individuals and their dependents. It was created in 1988 as part of the state’s landmark Universal Health Care Legislation which was a major platform of Governor Dukakis’ run for President. The Plan was implemented in 1990. Unfortunately, it was the only part of the legislation which survived and is the only program of its kind in the country. Other states and national policy organizations have asked Massachusetts for consultation as the issues of increasing unemployment and the uninsured are being addressed.

The MSP has been very effective in providing health coverage to individuals and their families who are eligible for unemployment insurance. The program is part of the Division of Employment and Training (MDET), the state’s unemployment agency. The MSP works closely with its “sister” programs within state government which provide health care to citizens of the Commonwealth – the Division of Medical Assistance (Medicaid) and the Department of Public Health which administers the Children’s Health Plan.

It is funded by an annual employer tax collected by MDET. The tax is levied on all employers with six or more employees. The employers pay the tax on the first $14,000 of each employee’s salary, or $16.80 per employee per year. The funds are collected quarterly and placed into a trust fund for MDET to pay claims and administrative costs.

To be eligible for MSP, a claimant must be receiving unemployment insurance benefits, or be eligible to receive unemployment insurance (UI) benefits; have been employed in Massachusetts; and be a resident of the state.

In addition, there are financial eligibility requirements. The annualized family income must be less than or equal to 400% of the current the federal non-farm poverty guidelines. MSP benefits terminate seven days after the end of UI benefits.

The MSP offers two benefit programs: Premium Assistance and Direct Coverage.

Through the Premium Assistance program, members who are able to continue enrollment in an existing health plan may receive monthly subsidies towards their COBRA premium payments which allows them to maintain the health insurance plan they had prior to unemployment. The current subsidy is for 80% of the actual premium paid, and is currently capped at $234 per month for an individual plan and $532 per month for a family plan. MSP applicants who have the option of extending their membership in an existing health plan are required to do so. However, these individuals may apply for a hardship waiver into the Direct Coverage Program.

MSP applicants who do not have the option of continuing an existing health plan, or who qualify for a hardship waiver, may enroll in the Direct Coverage Program. Direct Coverage is an indemnified comprehensive health benefit package with no premium cost to the enrollee; however, there are co-payments and deductibles that are required if medical services are used. The program only covers services provided within Massachusetts, with the exception of certain emergency conditions. MDET currently contracts with Blue Cross Blue Shield of Massachusetts to administer and operate the MSP.
Bring the Community In

A great deal of attention has been given to Bioterrorism Preparedness Planning over the past nine months. Is it too much to expect that even one government agency might recognize the need to bring stakeholders representing major community institutions to the planning table?

The wake-up call that destroyed our national complacency on September 11, 2001, demands an accommodation by our communities to threats of a frightening magnitude. That accommodation is being designed in new planning processes that are beginning all over the country, but not enough thought is being given to ensuring the successful implementation of those plans should that become necessary. What is going to be needed is greater appreciation of how the drastic measures that might have to be taken will be seen by the greater community whose cooperation will be crucial to their feasibility.

When the new plans are activated to deal with a major bioterror event, it will be too late to prevent what is likely to be the greatest danger: panic. People act on what they perceive, and when such an event occurs, the authorities will hope they have made their greatest investment in how it is perceived and understood by all those affected. That investment must be made in providing the community with the information it needs, and in developing the confidence of the community in the roles of all of the plans’ players, if those plans are to work.

Unprecedented threats call for unprecedented strategies, many of which have never been employed in our communities. The public needs to know beforehand why they may be denied entry to their own hospitals, why victims may be triaged in strange places, and transported to even stranger places. The formal planning process must seek community buy-in, consensus, and cooperation. Through stakeholder support, representing all of the community’s major institutions, the hard work of building alliances among all the sectors to be included for the first time in such planning can be assured. The diversity of our communities offers us strength we must use in overcoming the natural fear of the unknown. The inclusion of diverse constituencies in the consensus reached is the best guarantee we can have for the success of the plans.

Among the added benefits of this approach is that direct communication between our government leaders and community leaders avoids the filtering of vital information through the media that too often results in a sensationalistic spin. The media are players too, and must have a place at the table and a role as an accountable educator in the community. Their coverage of the planning process and its features will serve to set the stage for the participation of community members. For public health, this approach provides the opportunity to avoid the paternalism that pervades so many well-intentioned government mandates. And most of all, these planning initiatives offer a way in which we may once again come to see our government as what we have created to foster our best interests.

Nurse Staffing Ratios: Update


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The Not-For-Profit/For-Profit Hospital Debate

This has been simmering in the research for over a decade, but evidence in favor of not-for-profits has become convincing of late. See P.J. Devereaux, et al., "A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-For-Profit Hospitals." Canadian Medical Association Journal. 166:11, May 28, 2002. This research looked at U.S. hospitals. When even U.S. News and World Report’s list of the 20 best hospitals shows all of them to be not-for-profit, and 19 out of the 20 best HMOs to be not-for-profit, the media battle seems to have been won too.

ALASKA just completed their legislative session where CON was debated for the first time in many years. They have long had almost universal hospital and nursing home support. Instead of the “kill bill” promoted by ambulatory surgery interests, the legislature decided to fund a new badly-needed health facilities plan to update one almost 18-years-old.

A number of publications have recently focused on how TENNESSEE has wrestled with many accusations of a highly-politicized CON system where their director. Later in the year, the Commission itself was dismantled by the governor and legislature due to conflicts of interest and many other problems. But, they have taken serious reform steps through Public Chapter 780, strongly supported by their hospital association, to completely replace the old law.

In ALABAMA, there have been a number of attempts to change CON. A few of particular note include an effort to exempt lithotriptors (it failed), the establishment of a 40% Medicaid requirement for applicants before a proposal can be submitted, and an exemption for the replacement of an old facility with a digital hospital.

Another very tough debate was held in MICHIGAN this year. They ended their session without CON change. Ford Motor Company did specific studies at their plants to compare costs in states with and without CON. Some of their comparisons of MRI and Coronary Artery Bypass Surgery (CABG) services for their workers show that relative costs were 20-40% lower in Michigan than in neighboring non-CON states. When comparing Kentucky, Missouri and Michigan employee costs to Indiana and Ohio for hospital inpatient and outpatient services, rates for CON states were also from 15-25% lower. Daimler-Chrysler and General Motors have also studied their patient populations.

Finally, the Emergence of Evidence-Based Medicine
by Robert Vogel, Vice Pres., Managed Care Sisters of Mercy Health System

The British Medical Journal (in 2001) defined Evidence-Based Medicine (EBM) as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” One would think this is the rule rather than the exception. But in fact, much of current medical practice has not been rigorously tested through the scientific method. According to an article in the journal Patient Care (also in late 2001) “some experts estimate that only 20 percent of medical practices are based on rigorous research evidence.” (See editorial by Jack Hitt, the New York Times, December 9, 2001).

The implications for improving quality, outcomes and efficiency are enormous. Donald Berwick, M.D., President and CEO of the Institute for Healthcare Improvement, points to the following findings from various Medicaid, Medicare and Rand studies:

- 30% of children receive excessive antibiotics for ear infections;
- 20% to 50% of many surgical operations are unnecessary;
- 50% of X-rays in back pain patients are unnecessary.

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Governor Frank Keating signed House Bill 2604 on May 9, 2002, giving the State Health Department ongoing authority to monitor the financial solvency of nursing facilities. Patterned after a recent California law, Oklahoma’s HB 2604 requires facilities to report bankruptcies, tax liens, bounced payroll checks, and inadequate financial reserves. The Health Department can order corrective action before financial insufficiency results in immediate jeopardy or actual harm to residents. Policy-makers see the law as a much-needed extension of Certificate of Need requirements, which previously allowed only a “snapshot” review of a facility’s finances at the beginning of a project. For a copy of the bill, contact Hank Hartsell by e-mail at <hank@health.state.ok.us>, or call 405-271-6868.

The Chicago Department of Public Health (CDPH), through a private-public partnership, has initiated an effort to assess, monitor and understand health system capacity in Chicago by establishing a longitudinal, city-wide Healthcare System Capacity Tracking System. Health system capacity assessment will allow CDPH to facilitate three key activities like never before. First, with neighborhood-level health system capacity data, CDPH can enhance mechanisms of community engagement to assist in community health decision-making. Second, CDPH can influence policy as service gaps and underserved populations will be obvious. Third, an examination of regional provider arrays will allow for more effective response to emerging crises and the building of prevention networks. Most importantly, this resource assessment allows CDPH to assess both its role in the provision of personal health services; and, the larger health care system providers’ role in the provision of more traditional public health services. Ultimately, this analytical effort serves to enhance the role of CDPH in Chicago’s Healthcare System and significantly strengthen Chicago’s Public Health infrastructure. This initiative is funded by the Otho S.A. Sprague Memorial Institute, Chicago, IL.

Contact Patrick Lenihan, PhD, Deputy Commissioner Chicago Department of Public Health at 312 747 9786 or by e-mail at <Lenihan_Patrick@cdph.org>

OKLAHOMA

ILLINOIS
under the same health benefit programs and have found that their outlays per covered person were less in states with CON while costs were higher in states without CON.

In ARKANSAS, the CON director, Deborah Frazier, has been busy writing new rules and preparing for possible legislative reform next year. Meanwhile, the Governor has asked for CON and its effects to be studied with an eye toward possible change.

Two years ago, the VIRGINIA legislature scheduled CON to sunset, and began to put together an incremental transition plan. But today, after scrubbing the sunset plan, they have initiated several major studies to rebuild their health data systems. Again, like many of the other states, much progress was overshadowed by serious budget shortfalls.

This past year, FLORIDA used a special Task Force to conduct a statewide review of CON regulation. In spite of the three special sessions to deal with budget problems this year, these reforms efforts have been so strong that they will probably have a heavy influence on their next session.

In addition, a study conducted by the researchers at the University of Iowa drew some startling conclusions comparing CON and non-CON states. It was determined that outcomes for CABG patients was better in regulated states.

In order to compensate for dwindling state revenues, WISCONSIN is seriously considering the reinstatement of CON for hospitals and other acute care services to hold down health care costs. The legislative debate continues in a protracted special session trying to deal with a billion dollar state deficit.

OHIO is a state many of us have watched with great concern since it is practically the poster-child for post-CON rapid growth in services. For the past few years, I have relied on Gretchen McBeath, JD, for her “Status Report on Ohio After Deregulation from Certificate of Need” which is available on the Internet at www.bricker.com/newsevents/articles/71.asp (she is a partner specializing in health-care law at Bricker & Eckler).

Even without legislative changes of any type since 1999, MISSOURI has a few changes which we are enduring. Acute care and long term care moratorium sunsets are having a major impact since the 13 legislative attempts to restore hospital and other acute care review failed, as did attempts to reform long term care review. After the end of 2002, the long term care moratorium, enforced since 1983, will end and many new CON application will come forward.

In spite of these disappointments, we have had some much-needed successful reforms. Examples include:

- Average size of applications reduced 25%;
- Rulebook narrative reduced 35%;
- Financial forms reduced from 7 to 3;
- Applicant’s costs reduced at least 25%; and
- Review times reduced 40% for expedited reviews.

That’s it for the quick state overview. Now that we know how other states are dealing with the CON question, what about that Modern Healthcare accusation? Fact or Fiction? I believe it is FICTION . . . look at the MYTHS which many critics promote:

Myth: CON was a federally-driven program and it did not achieve its basic goals.
Myth: CON does not save money.
Myth: CON does not help quality.
Myth: CON is blocking access to MRI services.
Myth: CON is blocking access to PET services.
Myth: CON is hurting access.
Myth: CON process takes too long.
Myth: No one likes CON.

Now look at the FACTS:

Merit: CON repeal would adversely affect urban & rural populations & the uninsured!
Merit: CON promotes high volume of procedures, a recognized proxy for QUALITY!
Merit: CON takes the public’s long-term best interests into account!
Merit: Health care does not operate like a normal economic good!
Merit: CON helps constrain certain costs during a time when costs are skyrocketing!

You be the judge! The challenges for health planners are many and exciting.

For more information on national CON, visit the website of the American Health Planning Association at <www.ahpanet.org>. For more information about Missouri CON and its streamlining efforts, visit <www.dhss.state.mo.us/con>, and look at the CON Technical Advisory Committee (CONTAC). Or, contact me at <tpiper@mail.state.mo.us>. ﻿
Finally, the Emergence of Evidence-Based Medicine

As the American Health Planning Association engages in a renewed effort of developing a policy presence in Washington, D.C. it is imperative that we are knowledgeable about these and other success stories across the nation. If you have a story to tell, please email us a profile of your program and what you have learned. Highlights in our next issue.

While our current health system is robust and offers some of the most advanced technological achievements and high quality care available, there are still significant barriers to care, and the ranks of uninsured are mounting. A recent study of the Institute of Medicine confirms that racial and ethnic minorities tend to receive a lower level of health care, in the way of cancer treatments, cardiac medications, by-pass surgery, HIV treatments, kidney dialysis and kidney transplants. Immigrants and the working uninsured lack access to affordable coverage, and small businesses are the least likely to cover their employees.

As Thomas Edison once said, “There is a better way to do this. Find it!”

For more information on National Best Practice profiles, you may contact:

Phyllis Busansky, Senior Fellow
Hudson Institute
1000 North Asheley Drive, Suite 600
Tampa, FL 33602
Email: phyllisb@chln.org

or

Sonya Albury, Executive Director
Health Council of South Florida, Inc.
8095 NW 12 Street, Suite 300
Miami, FL 33126
Email: salbury@healthcouncil.org

50% of the elderly fail to receive pneumococcal vaccine;
50% of heart attack victims fail to receive beta-blockers; and
7% of hospital patients experience a serious medication error.

Clearly, quality can be improved and underlying waste and cost can be reduced.

Do I hear echoes of community-based health planning?

As planners, do we not start with data, accumulate evidence, provide information and courses of action through analysis, validate through an open and objective process, and demonstrate the value to the health and well being of our communities? What a great model for improving quality, access and efficiency. If we can ask the question about EBM for individual patients, why can’t we ask the question about our communities and what courses of action, based on evidence, will address our most urgent needs?

In this context, competition based on a consumer goods economic model, without restriction, would appear to be inappropriate. Resources are needed in other arenas such as public health, education, housing and job training. Unfettered cost increases will eventually force health care into a public good economic model as lack of access and unaffordable individual payment responsibility affect more and more of us.

In public health, a vision, mission and goals are ephemeral ideals made tangible by “planning.” Visions can endure, missions might be met, and goals are (sometimes) accomplished, but planning – as an art and science – has changed, evolving from an esoteric specialty taught in graduate schools to a strategic process now almost universally applied in both the public and private health arena.

A vision begins at the top, but is integrated and fed from below where detailed implementation and action are hammered out locally – in the trenches. No longer can effective planning be done in the vacuum of top management or by isolated specialists – “planners – writing thick tomes that traditionally have sat on dusty shelves. The days of traditional health planning in this detached void of reality – either by specialists or by top managers –

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Background:

In the mid-90s, management gurus such as Peter Drucker, David Osborne, and Ted Gaebler, ushered in a new era of competitiveness that demanded higher quality of goods and service. More integrated planning, continuous organizational improvement, more consistent quality and better ways to assess and meet client expectations were the hallmarks of this “movement.” Health care became a “manageable commodity” and the language shifted from treating “patients” to serving “clients.” The movement led to a transformation of American corporations at the end of the 20th Century. The private sector embraced and integrated “paradigm shifts” such as decentralized authority, flattening hierarchies, a focus on quality, and listening to the customer. But, unlike the flexible and quick-to-react, market-driven private sector, the public sector has not been effective at proactive and strategic thinking. All too often it has been reactive, mobilizing and responding to crises such as budgetary cuts or major policy shifts only when forced to do so. In spite of clear mission statements, for all their visioning and goal setting – and in spite of planning and planning for the future – the public sector has fallen behind in proactive strategic policy. For example, government agencies such as the IRS, the Departments of Education and Energy – and very recently, the FBI and CIA – have had to respond to external and internal pressures to reform, rather than strategically envisioning change and positioning their organizations to adjust through a deliberate strategic planning process. Most government agencies have also failed to recognize their key internal and external stakeholders and cut across functional program areas to make certain that both the inner and outer needs of the organization are represented and met.

In public health, planning was until recently a specialty of experts, the “planners.” Developing strategic plans was considered a sub-specialty, as were long-range, operational and the often oxymoronical “action plans.” This detachment and specialization was due to the development of the Health Systems Agencies in the 1960s and 1970s, when millions of dollars were pumped into a system that resulted in a plethora of esoteric health plans that sat on shelves for 40 years. Slowly, health planning faded into near-oblivion, resuscitated occasionally by an RFP for planning services or by the transformation of health planning councils into health care consultancies. It was not so much the severe budget constraints of the 80s that almost killed health planning, as its inability to define itself in a new environment.

Today, at the beginning of the 21st century, health planning has resurfaced, transformed into neither an art nor a science – not into an end unto itself – but rather into a method of creating visions, setting goals, and measuring outcomes utilizing the lessons learned from the private sector. For example, staff that had been responsible for implementing the plans of the public health program managers gradually became integrated as key internal stakeholders in the planning process, and their managers realized better performance when staff “bought into” the vision and goals of the organization, committing to their achievement. Focus groups of “clients” became a common way of listening to the needs and wants of the external stakeholders. Managers became more and more coordinators of information and measurers of outcomes responsible for providing the resources necessary for staff to accomplish the goals of the organization. This new public health model adopted from the public sector mandated all key stakeholders to understand, be involved in, and own the vision related to the services provided.

Strategic Planning in Public Health:

Strategic planning in public health can be defined as a process that a governmental organization uses to visualize its future and develop the steps to get there. It is a tool to help managers determine the “delta” – the gaps between a vision for the future and the strategies and operations to get there. Often, the result becomes a gaps analysis that forms the skeletal structure for a strategic plan, offering the goals and strategies to close the identified gaps.

Strategic planning is different from operational planning, which is the “how” to accomplish goals. It is also not long-range planning, which focuses on translating goals and objectives into current budgets and work tasks, ensuring that current operational trends will continue into the future. Strategic planning is about
identifying the barriers and issues – often through a gaps analysis – necessary to be trounced in order to meet the goals – the steps – that then, in turn, can realize a vision. Strategic planning anticipates new trends – and possible surprises – that can block the achievement of the goals. Strategic planning emphasizes an assessment of the eternal and internal environments that impact an organization, or an agency or CBO; therefore, strategic plans are used as tools to incorporate change in direction through the inclusion of a wide range of alternatives.

How to Conceive a Strategic Plan
It all starts with a "mission": the reason why an organization exists. Clarifying this purpose and linking everything the organization does to accomplish the mission can be difficult for the public sector. Too often in public health, the larger the bureaucracy, the more distance there can be between the organization’s mission and the work “in the trenches.” Writing a good mission statement is an exercise that should cut across operational areas and involve representation from all levels in the organization. A good mission statement should say why an organization does what, for whom and how in a simple, uncomplicated way. It should be concise, memorable and “pack a punch.”

By helping to define goals and accomplish objectives, a strategic plan can be used to advance an organization’s mission. A good strategic plan ties it all together – the mission, goals, objectives and strategies – assuring that the vision can not only be dreamed, but also achieved.

To conceive and develop a strategic plan in public health, three things need to happen:

1. The organization’s intentions need to be clear. What is the vision for its future? What is its mission? Do all workers – top to bottom – “buy into” the vision? Have they helped to articulate the mission statement? How is the organization going to accomplish its mission? Has management committed the necessary resources and support to align the goals and objectives with the strategies needed to implement them?

2. The organization needs to understand its external environment. What are the PEST (Political, Economic, Social, and Technological) trends influencing the organization? How can it use these PEST trends to anticipate, monitor and position itself most advantageously? Who are the stakeholders – friends and enemies and clients – of the organization? Has it identified key partners as well as competitors that help to shape the organization or benefit from it? How do the stakeholders view the organization from the outside; and

3. The organization needs to take a good, hard look at its internal environment – honestly and objectively. What are its SWOTs (Strengths, Weaknesses, Opportunities and Threats)? What is the organization’s “weakest link”, and how can it be compensated for? What internal threats should be recognized, and which ones should be handled?

Most of us who work in public health do so because we believe in a vision of good health care for all. Perhaps because we share this vision almost universally, it may be easier to perform strategic planning in the public health sector than in other governmental services. This vision, a shared dream of access to quality health care for everyone, sets the stage for effective strategic planning only if managers and line staff, if all external and internal stakeholders, are allowed to participate.

In our next issue, Ms. Souto will discuss “How to Develop a Strategic Plan for Public Health.”

Islara Souto, MPH, has 20 years of health planning experience. She has authored 22 community health plans, as well as Building Health Communities: Florida’s First Public Health Plan and the Strategic Plan for the State of Florida Department of Health. Currently, she consults in Strategic Planning for the National Cancer Institute, assisting government and community-based organizations in developing their infrastructure so that they can provide public health services in Florida, Puerto Rico and the US Virgin Islands.
The American Health Planning Association (AHPA) is seeking nominations for its Board of Directors. All AHPA members are eligible to serve on the Board. Directors are elected for three-year terms. There are usually four board meetings per year, as well as occasional conferences and other special meetings. New terms begin January 1, 2003.

The current AHPA Board believes the aim of health planning to be the development of community-oriented health systems designed to facilitate and promote access to necessary care of the highest quality and most reasonable cost. Furthermore, we believe that a public decision-making process that is sensitive to community values, to the concerns of consumers, providers, payers, and to the needs of the under-served populations, offers the best way of assuring accountability and equity in the design and direction of the future health care system.

If you share our vision, we need your voice!

If you are interested in being nominated or wish to nominate someone, please complete and return the nomination form found on the AHPA website. If you need additional information, please call 703-573-3103 or email AHPA at <ahpanet@aol.com>. We want and need your involvement and support.
Many leaders throughout the nation believe that the current approaches to health care planning, delivery and evaluation are fragmented, not sufficiently integrated, and may not be properly structured to offer appropriate access, oversight and accountability of both publicly and privately financed health care.

One of the symptomatic areas where the need for change is most evident is within hospital emergency departments (ED). EDs across the country are overcrowded, have long waits for treatment, and oftentimes lead to ambulance diversions that can prolong access to critical care in emergency situations.

During 1999, an estimated 102.8 million visits were made to EDs in the United States, about 37.8 visits per 100 persons. Trend data from the American Hospital Association show that the number of emergency visits nationally increased by 15% between 1990 and 1999. However, since 1992 the case mix of ED visits has...
changed, with a greater percentage of patients presenting with illness rather than injury conditions\textsuperscript{3}. Together, semi-urgent and non-urgent visits accounted for slightly over a quarter (26\%) of all ED visits in 1999 (refer to the chart below)\textsuperscript{4,5}. Leading patient complaints included abdominal pain, chest pain, fever, and headache, accounting for one-fifth of all visits\textsuperscript{6}.

Although there are many barriers to accessing health care, the most obvious is the lack of health insurance. When faced with barriers to accessing health care, people frequently turn to “medical care safety nets,” which primarily consist of community health centers, clinics operated by local or state departments of public health, privately operated charitable clinics, and the nation’s 4,000 EDs\textsuperscript{7}.

With the uninsured population estimated at over 44 million nationwide, it has been widely-observed that many individuals are utilizing the emergency department as their primary source for medical care and treatment. This situation has resulted in overcrowded EDs, extremely long waits for service, and increasingly inefficient medical treatment delivered in the least cost-effective setting available. The current nursing shortage has further aggravated the situation, necessitating many hospitals to put their emergency departments on “bypass” status. This situation has forced some emergency transport vehicles to re-route patients from the closest emergency department, thereby placing patients with true emergent conditions at potential risk.

Problems with the health care system, including nursing shortages, seem to be exacerbated in certain states, such as Florida\textsuperscript{8}. Florida’s nurse vacancy rate at 15.6\% (i.e., one of every six registered nurse jobs) is the third highest rate in the nation, compared to 11.0\% nationwide\textsuperscript{9,10}. Nursing shortages further complicate hospitals’ capacity problems by limiting their ability to staff existing beds, particularly those in critical care units and EDs\textsuperscript{11}. Furthermore, almost two-thirds of hospitals statewide report increased difficulties in hiring ED nurses and turnover rates for ED RNs (19.9\%) are the third highest among all RN specialty areas. Across the state, at least 90\% of hospitals report shortages in the ED area. Systemic issues must be addressed so that hospitals can effectively recruit and retain nurses.

Other systemic issues have generated concern by health care providers. First, many hospitals point to the impact of the escalating malpractice insurance crisis on the issues of access and costs. This includes increases in malpractice insurance premiums as well as increases in the practice of “defensive medicine” by ED physicians. The sovereign immunity afforded to public hospitals exacerbates the liability of community EDs when patients experience poor outcomes. Ethical
Strategies to Strengthen Family Support
Karen Cameron, Executive Director/Chief Executive Officer
Central Virginia Health Planning Agency

As planners, we are often involved with assessing needs, whether for a population segment, community, service area, or state. Increasingly, people utilizing these assessments are understanding the need for effective targeting of intervention initiatives around best practice models, probably due to limited resources and/or the inability to quantify the actual benefits that come from these planning processes. Our agency recently completed a community needs assessment for a small, urban city which, like many others, identified children and their families (particularly families with young mothers and/or African-American families), as the population segment with the greatest unmet needs. As a result, the intervention strategies developed during the planning processes primarily relied upon research into programs that had been proven to provide family support. The following are some of the results of this research.

The Robert Wood Johnson Foundation funded a grant in 1995-1996 to develop guidance for communities and states to develop strategies to strengthen and expand family support programs, build statewide family support networks, and link family support more closely with broader child and family service system reform. The following conclusions were drawn for linking family support with systems change:

- The neighborhood-based aspect of support and service strategies is essential for success. Programs should be located in “natural hubs” where families feel comfortable, such as schools, community centers, housing projects, or churches. Recipients of services should be involved in the planning, allowing natural leaders to emerge, and hiring neighborhood residents as staff.
- Networks of family support must be community-specific, and public systems must individually link with each network. Connections between public and private resources within a neighborhood is the most important family support network.
- The most useful materials for communities as they develop goals and strategies are a set of principles and extensive examples of what has worked for other communities.

These principles and strategies need to be adapted to fit a particular community’s needs – not detailed replication of models.

- Peer technical assistance is effective for people at all levels. Peer interaction provides learning opportunities not available by other means.

Most successful practices that target prevention of negative behaviors by parents and/or their children are based on the social development model, which theorizes that enhancing protective factors, such as effective parenting practices, will decrease the likelihood that children or their parents will engage in problem behaviors. Perhaps the most highly studied and successful program in the improvement of parenting skills is the Healthy Families or Healthy Start program. In 1985, Hawaii started its Healthy Start Program and by 1994 it was the only mature, state-run home visiting effort in which the goal was to identify and prevent adverse health, social, and developmental outcomes in the families of all at-risk newborns.

Under the supervision of health or social services professionals, paraprofessional home visitors work with families to prevent child abuse and neglect, improve family functioning, improve child development, promote access to primary health services, maximize child health status, and promote readiness for school. While performance varied by program site (often linked to faithfulness to the program model), an article in the January 2000 edition of Pediatrics noted the following:

- Early identification determined risk status for 84% of target families;
- Families with higher risk scores, young mothers with limited schooling, and families with infants at biologic risk were more likely to enroll in home visiting;
- Half of those who enrolled averaged 22 visits during the first year;
- Most enrolled families were linked with a medical home (primary care provider); and
- Half of enrolled families received core home visiting services.

Hampton, Virginia, built upon the Hawaii program, included two components: Healthy Start, a targeted intervention for at-risk families modeled after the Hawaii program, and Healthy Community.
Is the Rising Storm “Perfect” Enough?
by Robert Vogel, Vice President
Managed Care, Sisters of Mercy Health System

Mid-term elections loom. Yet, surveys show that health care concerns are no longer among the top concerns of the voters, replaced by terrorism and the economy. Will the order of concern change by 2004? Let us count the “whys” and “why nots”.

In the “whys” column:

• Crisis of cost:
  You’re deaf, blind and dumb if you’re not up on this one. But, on the other hand, with a little bit of planning, the pressures of demographics, technology, chronic disease progression, etc. can be appropriately quantified and factored into a picture of national health policy. (We have a defense policy, why not a health policy?)

• Poor economy equals more unemployed:
  Although I’ve written of the uninsured as a barometer of the fragility of our health care system, the consequences for those who make up the statistics are real according to the Institute of Medicine in a May 2002 study:
  - Too little care too late;
  - Sicker and sooner to die; and
  - Receive poorer care when hospitalized, even for trauma care.

• The cost of the biomedical revolution:
  We have the drugs, the artificial parts, and the techniques. We also have the inequities of availability and access. The biomedical revolution paradox: great promise and inequity. (Center for Studying Health System Change, 2002.)

And, “why not”?

• Well, we’re not at the levels of inflation and unemployment of the early 90s;
• CHIPS has insured large numbers (but not nearly all) of our children in their teens and younger; and
• Incremental change versus political deadlock: interesting that the description “incrementalism” can be substituted for “my way or no way” in Congress.

What’s the fad of this decade? Consumer Driven Health Plans – CDHPs. By reverting to greater cost sharing with the employee, employers hope to engage them in efficiently managing decisions about what services and which providers they will seek. They also hope to reduce their health plan premiums. Economists have demonstrated how consumers have been insulated from buying decisions, so this reversion is somewhat rational in a quasi-market setting. However, the effect will be only temporary.

Some, but not all, employees can absorb some cost shifting, just as employers have absorbed cost shifting from under-funded government programs up to now. But, with inflation expected to be above 12% for the next couple of years, and even modest healthcare inflation running two to three times the cost of living, consumers will be unable to absorb a proportionate share of these increases in the best of times. Then what?

Looking back a couple of decades, a “green around the edges” health planner asks his mentors at what percent of the GDP our society finally says “that’s enough, we cannot sacrifice the future of education, housing, public works and the environment for a totally undisciplined and irrational non-system of health care”? The answer: something less than 100%.

My assessment: health planning’s time will come. We cannot support another medical arms race. There is no place left to cost shift. We can no longer believe that improving health status is a market commodity. The current question is whether the boom generation, as corporate and public leaders, will finally have enough skin in the game to call the question in 2004 or 2006 or 2008.
Policy Perspective

by John Steen

In my last column, I wrote on the absence of a communitarian perspective in the many state and regional Bioterrorism Preparedness Planning efforts now underway. As evidence of the national, and even international, blindness underlying the problem, and as a definitive description of its scope, there is a book that should be read by anyone who cares about public health, health policy, and public policy. It is Betrayal of Trust: The Collapse of Global Public Health, by Laurie Garrett (Hyperion, 2000). In 754 pages, including 154 pages of endnotes, the author details the recent epidemiological threats that have challenged world public health, including pneumonic plague in India, Ebola in Zaire, the collapse of public health in the former Soviet Union, and last but certainly not least, the erosion of public health in the U.S. at the very time when we are threatened by bioterrorism.

Amid a wealth of epidemiologic detail, Ms. Garrett manages to provide a cogent description and commentary on the American political milieu in which public health resources have risen and fallen. The nearest thing to a Golden Age of Public Health here was, in retrospect, the major advances in disease control made at the turn of the twentieth century. But all that seems to have been forgotten after World War II, except for a brief period in LBJ’s Great Society in the mid-1960s. Most recently, the Democratic Party’s elimination of universal health care from its platform six years ago has opened up a chasm among its own supporters into which Ralph Nader and the Green Party have moved.

The effects of our neglect of and even hostility toward, public health over the past 20+ years are detailed at the city (NYC), county (L.A. County), and state (Minnesota) level. Minnesota can be seen as having briefly developed a population health system with a communitarian focus that was arguably the best ever achieved by any state.

That public health’s problems are a reflection of an ancient dichotomy is best explained in the opposition of Hygeia and Panakeia in Greek mythology, where Hygeia represents public health promotion within a socialist political system, and Panakeia represents curative personal health within a free enterprise system. Our current perception of this is revealed in how we spend 1% of our healthcare dollar on hygiene, and 99% on panaceas.

Public health is contained within a political compact between people and their government, and when people no longer trust nor support their government, the commitment represented by public health can no longer be fulfilled. Ms. Garrett’s view here is as broad as that of the World Health Organization’s (WHO) World Health Report 2000 that was published at the same time as her book. Each details the failures of world health systems seen as a function of each nation’s quality of governance and stage of economic development. (For a summary of the WHO report, see “With Liberty and Justice for All?” in the 3rd Quarter 2000 issue of Health Planning Today accessible at <www.ahpanet.org/policy.html#Liberty>.) I would argue that the answer to public health’s problem is to be sought in a renewal of civic discourse and engagement, i.e., more democracy. That Ms. Garrett would probably agree is shown by her dedication of her book to the late Dr. Jonathan Mann, a powerful advocate of a very broad vision of public health as providing leadership in the promotion of human rights.

Laurie Garrett has been a science and medical reporter at Newsday since 1988, and the author of The Coming Plague, a best-seller in 1994. She is the recipient of the Pulitzer Prize and of Peabody and Polk Awards in journalism.
a set of comprehensive parent education and support services for all Hampton families. The Healthy Community component was considered important in developing widespread community support for the program, which is identified as a key factor in the growth of the initiative.

In the Healthy Start program, home-based services are provided by a family support worker (for up to five years) who:
- Helps families develop problem-solving skills, effective parenting techniques, and home management skills;
- Ensures that each child in the program receives well-baby care and age-appropriate immunizations;
- Provides parent education, child development screenings, and nutrition counseling; and
- Links families to available community services that meet their individual needs.

The Healthy Community program is a comprehensive parent education program for all Hampton families with children under 19 years of age, including:

- Parent Education Classes: A series of classes that help families learn what to expect as their children grow and develop and teach parents skills to nurture their children’s health and well-being;
- Welcome Baby Program: Voluntary home visits to provide new parents with support and information on parenting and community resources;
- Young Family Centers: A special section in all branches of the Public Library system and bookmobiles that offers books, cassette tapes, and videotapes with information to help parents become more effective and nurturing (they also offer programs that teach parents how to encourage early learning); and
- Healthy Stages Development Newsletter: A series of newsletters which provide useful information on child development and age-appropriate activities, immunization schedules, parenting tips, and family-oriented community resources.

All classes include meals and child care for participants. In fact, many of the “best practices” stressed the importance of offering meals and child care to encourage attendance by families, since many find it difficult to attend if they have to make meals and find child care after working all day. Others, especially in areas without public transportation, offer transportation to the programs. Hampton’s community partners include local restaurants, businesses, local hospitals, libraries, schools, churches, youth clubs, city agencies, and volunteers.

Other “best practices” have similar elements of the Healthy Start or Healthy Community components in working with various populations. These include:

- **Homebuilders Program:** This program is designed for the most seriously-troubled families (newborns to teenagers), who are referred by child service agencies. It includes four-to-six weeks of intensive, in-home services to children and families. A practitioner has a caseload of two families (18-to-20 per-year) providing counseling and other services and developing community support systems, spending an average of eight-to-ten hours per week in direct contact with the family and is on call 24 hours-per-day, seven days-per-week for crisis intervention. A full-time supervisor oversees four-to-six staff, who all have at least a BA degree in human services.

- **Nurturing Parenting Program (utilized by Hampton Healthy Community):** Based on a re-parenting philosophy, parents and children attend separate groups that meet concurrently with cognitive and affective activities designed to build self-awareness, positive self-concept/self-esteem and empathy. These include teaching alternatives to yelling and hitting, enhancing family communication and awareness of needs, among others. Group-based sessions run from two-to-three hours once a week for 12-to-45 weeks. The program is designed for all families at risk for abuse and neglect, with children 0-to-19 years old. For the parent groups, two facilitators are required. The children’s groups require two facilitators and two volunteers depending upon the age and capabilities of the children. Each parent receives a Parent Handbook that details their assignments, exercises and resource material. Videotapes are required for the delivery of the nurturing programs.

- **Parents Who Care:** An educational skill-building program created for families with children between 12-to-16 years to reduce risk factors and strengthen protective factors within family settings that are known to predict later alcohol and drug use, delinquency, violent behavior, and other...
behavioral problems in adolescence. The program is led by a facilitator and taught once a week in five-to-six sessions lasting one-to-two hours. Parents are provided with their own module for use at home.

**Strengthening Families Program:**
A 14-session family skills training program designed to increase resilience and reduce risk factors for substance abuse, depression, violence and aggression, delinquency, and school failure in high-risk, six-to-twelve year old children and their parents. Originally developed for children of substance abusers, the program is effective and widely used with non-substance abusing parents in many settings. Fifteen independent research replications, including culturally tailored programs, found the program to be effective in increasing family assets including improving family relationships, parenting skills, and the youth’s social and like skills. The curriculum includes three courses on parent, children’s, and family life skills training taught in 14 two-hour periods.

*For additional information, Ms. Cameron can be contacted at <kcameron@cvhpa.org> or 804-233-6206.*

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**Health Planning Opportunities**

*by Dean Montgomery, Executive Director*

HSA of Northern Virginia

The recent announcement by the Federal Trade Commission (FTC) that it is establishing a Merger Litigation Task Force is welcome news to those concerned with the continuing loss of not-for-profit community hospitals and health care plans. According to the announcement, the Task Force is to be responsible for “reinvigorating the Commission’s hospital merger program, which includes a review of, and potential challenges to, consummated transactions that may have resulted in anticompetitive price increases.”

Reportedly, inquiries and other information gathering efforts are already underway.

Long overdue, the FTC action may (or may not) be related to three consanguineous Washington, D.C. area announcements earlier this summer:

- **CareFirst**, the parent corporation of the three not-for-profit Blue Cross-Blue Shield Plans serving Delaware, the District of Columbia, Maryland and parts of Virginia, announced its intention to convert to a for-profit corporation and be acquired by WellPoint, the California health plan, which itself came into being through the conversion of the California Blue Cross Plan to for-profit status. CareFirst executives will reap nearly $50 million for their stewardship if the conversion is completed. A coalition is at work trying to help them avoid this embarrassment.

- **Hospital Corporation of America (HCA)** announced the re-purchase of Northern Virginia Community Hospital (NVCH), a money-losing facility that HCA acquired and disposed of more than a decade ago, for a reported $27+ million. Unfortunately, the buyer discovered that NVCH is obsolete, and thus must be replaced and relocated from the relatively poor neighborhood in which it is located to a distant poorly served affluent community.

- **Universal Health Services, Inc.** announced the opening of the new (replacement) George Washington University Hospital in downtown Washington, D.C. Universal purchased the non-profit university hospital and converted it to a for-profit venture during the last wave of conversions in the late 1990s. This conversion, coupled with the recent closure of the District of

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Columbia’s public hospital (D.C. General) has greatly reduced the availability of charity and reduced-price hospital care in the city. Universal’s subsequent attempt to acquire a not-for-profit community hospital in nearby Virginia was thwarted.

These ostensibly unrelated events make clear that, after a short pause in the late 1990s to shake off the effects of whistleblower revelations, U.S. Justice Department probes and Medicare fraud investigations, the mergers and acquisitions, conversion, and relocation merchants are back in force. They, and other entrepreneurs, are again seeking gain through the acquisition and conversion of public and not-for-profit private health care organizations to proprietary status and through the relocation of health care facilities from unappreciative poor neighborhoods to needy affluent communities.

Hence, the opportunity for health planners.

To date, planners have shown more interest in the charitable foundation monies generated by some acquisitions and conversions than in questioning the merits of the system changes that produce the money. The underlying rationale and justification of the conversions and sales merit a closer look. Few are better qualified than community-based planners to undertake the examination. For those willing to address the issue, opportunity abounds.

Forces conducive to a new wave of mergers, acquisitions and conversions have been building for some time. Planners need to be aware of these developments and their cumulative effects:

- Demand for inpatient hospital care is on the rise again in most parts of the country. Though likely to be short-lived, this increase, coupled with the continued growth in outpatient service demand, is substantial in many communities and is helping fuel a spending and building boom not seen for more than a generation. A boom psychology is already in place in many communities.

- Population growth was higher than expected during the 1990s and, though likely to moderate, is expected to remain strong for some time. Population growth and aging are likely to make inpatient demand more stable over the next decade than it was over the last two.

- The shift to outpatient care (in lieu of inpatient care) will continue, but at a slower rate. This, too, is likely to result in less variation in inpatient demand.

- Proprietary hospital operating returns and hospital development and management stock are relatively high, and may remain so for some. These related phenomena generate low-cost capital that can be used to fund mergers, acquisitions and other takeovers.

- Erosion of the ethical environment in health care continues apace. This has weakened both the social and political standing of community-oriented health care entities, and the related ability of governing boards and communities to resist corporate raiders.

- Nationally, health care facility development and life cycles are such that a large percentage of U.S. hospitals will require major renovation or replacement within the next decade, particularly those built during the rapid build-up of capacity in the 1970s. This process is already well underway in many regions. Capital requirements are (will be) substantial. This, coupled with economic uncertainties and uneven leadership in many not-for-profit community hospitals, presents extraordinary opportunities for hospital chain operators and other entrepreneurs seeking profitable acquisitions.

- Hospital chains are negotiating settlements of fraud charges and investigations, removing potential obstacles to additional acquisitions, mergers and conversions. Both HCA and Tenet, have shed their old tainted names (Columbia-HCA and National Medical Enterprises, respectively), paid substantial fines to settle charges of improper billing, and are reinventing themselves.

So, is there reason for concern?

Does it really matter whether hospitals and health plans are proprietary or not-for-profit? Do changes in ownership result in significant operational changes or differences? Although there are partisans on both sides of the debate, the weight of the evidence shows that, compared with not-for-profit facilities and services, for-profit entities:
Cont’d from page 8
(Health Planning Opportunities)

offer a smaller array of services and have lower average program volumes;

have higher average program charges and profits (operating returns);

provide less charity care and serve fewer Medicaid and other indigent patients; and

have less favorable treatment outcomes (e.g., higher in-hospital mortality).

There is a substantial body of literature, and decades of experience, that support these findings. If quality, access, cost (charges or prices), and character are planning issues, these phenomena merit the undivided attention of planners and others who might have the interest, standing and ability to assess these developments and to challenge them where necessary.

So, what’s a planner to do?

Each case and circumstance differs. Some acquisitions and mergers may prove both unobjectionable and potentially beneficial. Some conversions may be necessary, even if not desirable. Whatever the local circumstances, it seems advisable that, at minimum, planners can and should:

Become informed.
There is a substantial body of literature on the subject. A good starting point is the March/April, 1997 issue of Health Affairs <www.healthaffairs.org>, which was devoted to the merger-acquisition-conversion question. Another is the Volunteer Trustees Foundation for Research and Education, which has published a useful guide titled When Your Community Hospital Goes Up For Sale <www.volunteertrustees.org>. You also may want to get a copy of the primer Profit and the Public Interest: A State Policymaker’s Guide to Non-Profit Hospital and Health Plan Conversion, National Academy of State Health Policy, December 1996.

Assemble basic facts about your local health care system.
Identify facilities likely to be takeover targets. Get to know the principal managers and governing board members. Often, the key to affecting merger, conversion and relocation actions is timely information and targeted intervention. Too often, irrevocable decisions are made before knowledgeable, disinterested persons are aware of the issues involved.

Identify sources of information and support (local and elsewhere).
Copies of basic management and financial documents usually are obtainable from public sources. These include: annual reports, corporate bylaws, governing board membership, Medicare-Medicaid cost reports, corporate tax reports (Form 990 and attachments for not-for-profits), SEC 10-K reports (for-profit corporations), investment research reports for publicly traded corporations (available for small fees), consultant reports. Labor unions and medical and nursing staffs are especially helpful in many instances.

Appreciate the magnitude of the question and the problems likely to be encountered.
There are substantial monies and egos at stake in most mergers and conversions. Few planning questions involve as much money, passion, or ideology. Greed, profiteering and conflicts of interest are not uncommon. Try not to be intimidated. Be prepared for “nasty” arguments and charges of malicious interference. Conversely, there are few questions where planners can have as much effect, and be of as much genuine and lasting service to the community, as on these questions.

Develop a strategy and action plan.
It should be tailored to the specific local circumstances and opportunities. Seek help locally. Nearly all communities have the resources needed to ensure that any proposed sale and conversion is examined carefully and is ultimately transparent. Collectively, AHPA’s membership has direct experience in dealing with a number of merger, acquisition and conversion cases. Some are currently so engaged. Those seeking help or advice on specific questions and circumstances can reach us at <ahpanet@aol.com>.

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considerations need to be carefully weighed as they relate to the rights of patients to "public protection" juxtaposed with preservation of financial viability for local health care providers who deliver that care.

Given the myriad of complexities related to our health care system, including the growing number of uninsured, the need to re-assess the underlying causes for inappropriate use of the ED and to examine alternative models of care - for patients presenting with non-urgent care conditions and/or chronic conditions is appropriate. Clearly, this is a crisis that not only affects the uninsured and indigent populations, but also has a dramatic impact on the entire population and its access to care.

Initiatives and special studies are underway to help form the basis for understanding what strategies should be implemented for outreach initiatives, community engagement, and collaboration with providers, insurers and other decision-makers for effecting sound health policy change.

What does health planning bring to the table? First, we have a recognized process of health planning that can be applied. Health planning professionals emphasize quality, validity, appropriateness, relevance and usefulness. Because of our historical research endeavors and knowledge of the health care delivery system, the American Health Planning Association and its members are suitably positioned to help initiate and coordinate these reforms.

In South Florida, we are beginning our efforts by partnering with a local health foundation and conducting key interviews with local hospital providers, performing a literature review, and analyzing existing utilization patterns. This study will be launched next month. However, we are already seeing major changes in institutional practices, outpatient care delivery, triage systems and urgent care centers.

What are others doing throughout the country to address overcrowded emergency departments; the nursing shortage; and the malpractice liability insurance crisis? The development, formulation and implementation of sound public policy to improve our healthcare delivery, requires a team effort by all players in the health care system.

I'd like to hear about your community's initiatives. Email me at <salbury@healthcouncil.org> to share your experiences!

3. Ibid 1.
4. Ibid 1.
5. "No triage" means the hospital did not determine immediacy rating upon arrival at emergency department. Emergent is less than 15 minutes, urgent is 15-60 minutes, semi urgent is 1-2 hours, and non-urgent is 2-24 hours.
8. Florida's Nursing Shortage: It is Here and It is Getting Worse, Florida Hospital Association, November 2001.
9. Ibid.
Excellent AHPA-Sponsored Planning Sessions

2011.0*: Sunday, November 10, 2002: 8:00 AM-11:30 AM, Oral Session
Planning Data: Finding, Analyzing and Utilizing Health Data for Community Assessments and Planning Studies
AHPA-sponsored Continuing Education Institute

The American Health Planning Association, in cooperation with the Community Health Planning and Policy Development Section (CHPPD) of the American Public Health Association (APHA), is sponsoring a Continuing Education Institute (CEI) at the November meeting of the American Public Health Association in Philadelphia. Entitled, “Planning Data: Finding, Analyzing, and Utilizing Health Data for Community Assessments and Planning Studies”, the workshop will be held Sunday, Nov. 10, from 8 a.m. to 11:30 a.m. There will be a fee for this half-day workshop.

This CEI has been designed by AHPA members to meet the needs of public health professionals and other parties involved in health planning activities and who require access to data for the preparation of community assessments, documentation of need, program evaluation, and strategic planning. The half-day workshop will cover four components related to data for planning:

1) A description of the data sets—health and non-health and inside and outside public health agencies—that are necessary and appropriate for planning and assessment activities;
2) A description of sources of these data sets and how to find and access them;
3) Steps involved in processing, analyzing and interpreting data from disparate sources; and
4) Applying, tracking and evaluating the data within planning and assessment contexts.

Participants will benefit from the extensive data research carried out by the faculty and, to the extent time allows, participate in hands-on exercises in finding, analyzing and interpreting data for planning and assessment. Participants will take away handouts and other materials that will immediately assist them in their data management activities.

The workshop should be of interest to public health professionals involved in community assessment, program planning, program evaluation, and strategic planning activities, other health professionals involved in planning and assessment activities, researchers, and students in public health and other health-related programs.

8:00 AM Introduction
8:10 AM Categories of data for public health planning and assessment activities
Richard K. Thomas, PhD
8:50 AM Finding and assessing health and non-health data from public health and non-public health sources
John W. Steen
9:30 AM Break
9:45 AM Managing, analyzing and interpreting data from disparate sources for planning and assessment activities
Dean Montgomery, Richard K. Thomas, PhD, John W. Steen
10:25 AM Utilizing, tracking and evaluating data within a planning and assessment context
11:20 AM Wrap-up
11:29 AM Close

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4245.0*: Tuesday, November 12, 2002: 4:30 PM-6:00 PM, Oral Session
AHPA President’s Session: Empowering Communities Through Planning and Community Health Initiatives

The President’s Session is designed to offer concrete planning approaches to empowering local communities. The initiatives to be profiled include a discussion of community based initiatives sponsored by both the public and private sectors that empower local communities through the

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* catalog number for sessions at APHA Annual Conference
establishment of action plans that are data driven and supported by the community leadership who are invested in the project’s outcomes and success. Key sponsors include Miami-Dade County government, the Kellogg Foundation, the Chicago Public Health Department and other major funders. Issues that will be addressed are: reducing the number of uninsured residents in a major metropolitan area with an uninsured rate of 25%; lowering inappropriate use of the emergency room; improving preventative health care access, and increasing access to specialty care, pharmacy and oral health services.

The shared goal of these initiatives is 100% access to affordable, convenient, quality health care for all. Key areas of involvement include: education and outreach on available public/private health services and programs; policy planning and sustainability; program development for underserved populations; innovations in health care financing and delivery; and elimination of policy and insurance barriers that prohibit access to essential public and private health services. A special focus will be on involving the business community in each initiative’s efforts to promote greater access.

4:30 PM Advancing public/private partnerships: A call to health care action
   Sonya R. Albury, MSW

4:50 PM Community health planning and public policy development
   Leda Perez, PhD

5:10 PM Illinois: A state-local partnership for community planning
   Laura B. Landrum, MUPP

5090.0*: Wednesday, November 13, 2002: 12:30 PM-2:00 PM, Oral Session
Improving Community Health Status by Enhancing Community Health Planning Content Process and Execution

Many public health entities, community coalitions, community service organizations, and other public and private organizations are faced with both the demands for program development and enhancement and opportunities emerging from the focus on public and private health care services following 9/11. The presentation will describe how health planning tools such as population-based needs assessment and resource deployment and capacity management could contribute to substantive plans for funding key services.

The speakers will detail many concrete opportunities to enhance community-based, public and private planning efforts intended to create and implement appropriate and effective plans that address community health and related needs. These opportunities include an e-Planner web-based communications exchange and resource repository, practical planning tools and templates for a variety of scenarios, and access to technical assistance.

Learning Objectives: Participants will learn the details of concrete opportunities to enhance community-based, public and private planning efforts including how a web-based tool can be used to enhance the health planning skills of public and private public health professionals whose responsibilities encompass aspects of community-based health planning, how consultants expert in community health planning can provide technical assistance to the public health community in order to enhance the quality of the products of their community engagements and research and how community health planning templates are transferable to other program types and community scenarios.

12:30 PM Enhancing community health planning through access to best practices, proven tools and successful templates
   Robert Vogel

12:50 PM Enhancing health planning through access to web-based professional consultancy resource
   John W. Steen

1:10 PM Enhancing health planning through an e-Planner web-based communications exchange and resource repository
   Thomas R. Piper
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for the 2002, fourth quarter newsletter. Articles are due on December 1. They should be short — no more than a single page of text.

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President’s Message
Winter 2002

Emergency Preparedness and Response: Building Responsive Communities
by Sonya R. Albury, AHPA President and Executive Director, Health Council of South Florida, Inc.

During the holidays, there is a very different atmosphere than a year ago. Last year we were still reeling from the turmoil surrounding the aftermath of September 11 and many of us were leery of venturing out, let alone engaging in long distance travel. Now, most Americans are in the swing of things again, traveling and enjoying our freedom to come and go.

Nonetheless, we are different. We are much more concerned and alert; we will continue to do our best to be prepared for the unwanted, the unthinkable, because we know it can happen to us.

In mid-November, a large group of health care leaders had the opportunity to hear from an expert representing the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In his talk on Community-Based Planning, Joseph Coppello, Vice President of Accreditation Field Operations provided some helpful insights on how prepared the health care industry is across the United States. He identified the ten most commonly-shared issues that each community still faces.

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• Evaluation Criteria for SHP Programs
Health Planning TODAY

a periodic publication of the American Health Planning Association

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Send information requests to:
Dean Montgomery, Business Manager
7245 Arlington Blvd., Ste. 300
Falls Church, VA 22042
Phone: (703) 573-3103 Fax: (703) 573-1276
Email: AHPAnet@aol.com

Information for the quarterly journal is due on March 1, June 1, September 1, and December 1. Articles should be short — no more than one page of text. The Editor reserves the right to edit any article or submission as needed.

Information may be submitted via e-mail to: “dschuess@mail.state.mo.us” or “tpiper@mail.state.mo.us” or faxed to (573) 751-7894. Donna Schuessler, Editor

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Surge Capacity
First, he identified the concept of “surge capacity”. To what extent is a community ready to handle a sudden need for health care beds? Hospitals alone may not be able to maintain the capacity required if there is a sustained need over time. Medical equipment would need to be brought to other venues, e.g., hotels, public buildings and other locations as alternative settings. Home health and primary care centers would most certainly serve as important sites for the delivery of medical assistance.

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Preserving Organizations and Staff
Mr. Coppell observed, “All disasters are local. You have to be prepared to stand alone.” Government can’t be there for sure until 72 hours have passed after the event. Key decisions will need to be made at the local level such as: Who gets the vaccinations? Who decides? Which providers will be most important to receive preventable treatment, the emergency service professionals, or hospital personnel?

Other questions relate to training. How many staff should be trained prior to a disaster? How does a community sustain it? There is already a high degree of slippage back to a sense of complacency, near pre-September 11 levels. Some may simply say, “The new Department of Homeland Security will take care of it.”

Security is another major consideration. Each provider must seriously think about how to maintain the security of the facility and anticipate the contingency of implementing a lock-down procedure. Health care leaders must determine what the decision-making process will be prior to execution.

Disruption of Health Care Delivery System
In the unlikely, but possible, event of a disaster, there is a need for flexibility of existing regulations. It should be acknowledged by the governing bodies that no one can control the event, only manage it. For example, a recent flood in Houston resulted in several feet of water. Unfortunately, the major health care providers had located their communications equipment, emergency supplies, labs and generators all in one place – the basement. The only option they had was to manage the situation and look for alternative back-up systems.

The best direction given during the Houston disaster was to provide a general set of instructions and let supervisors and managers engage in decision-making, within their sphere of influence. General directions included:

1) preserving lives;
2) preserving the facility; and
3) being prepared to evacuate if you need to.

This decentralized decision-making was empowering to health care workers during a very difficult time. It permitted them to make more efficient and appropriate decisions as
they were closer to their individual group’s situation than a higher level administrator could be at that given time.

Mental Health Issues
In an emergency situation, health care and other emergency response professionals exhibit an extraordinarily high level of dedication. As a result, they may push themselves to the point of exhaustion. Those in charge must force rest after 6-12 hours to assure recovery and protect against over-dedication. Each group will need a relief team.

The “worried” will also need to be managed. These individuals are overly concerned and have no real health emergency; nonetheless, they can overwhelm the system if not appropriately managed and extricated from the areas where true emergencies are being treated.

Involvement of the Public
Keeping the public involved and informed is key to enlisting the public as partners. Local neighborhoods can help build up the home care infrastructure to support the medical community. They can also help with the multi-lingual needs of different communities.

Communication Issues
Communication is one of the top issues for any type of disaster, natural or man-made. There must be non-vulnerable systems of communication that can operate under a wide array of conditions. A common language needs to be established that all sectors of the health care industry understand with common acronyms and symbols. Codes red, blue and black need to mean the same thing to the police, fire, emergency medical services, and hospital personnel. For example, in some settings, “blue” may mean “ready to go”, whereas in another, it may mean “bypass”. The communication equipment must also be compatible across settings and battery life or expiration dates must be taken into account.

Information and the Media
Needless to say, there should be a media engagement plan. Emergency personnel and government leaders must be prepared to release timely, honest and complete information to assist the public, the provider community, first responders and families. There should be a patient tracking system within each hospital so that families and friends can locate their loved ones.

Accountability
This is where it gets tricky. What will be used as the bar of measurement that we have a higher level of readiness? How will we know if we are ready? What are the standards of measurement, and who will oversee the process?

Last, but not least, is the battle for control of funds. Many communities have seen “gladiatorial battles for control” among the leading medical centers. A new spirit of trust and cooperation needs to replace outdated competitive models. Each community must ask, “How do we overcome these barriers for the common good?”

Funding
Of course, there is the question of the allocation of resources. How do we layer additional requirements for health care institutions without additional resources? Clearly, the national leadership understands that, albeit it may not come at the rate and amount the health care industry might want. Funding may be held up at the state level, and there may be difficulty deciding where and who will build the necessary isolation rooms. Still, health care providers have the responsibility to be ready. Effectively and efficiently managing resources is the issue and will require a coordinated effort by all to work together.

Drills
Finally, each part of the response team should conduct drills to test their ability to react effectively to a crisis situation. These trials need to be as close to an actual event as possible, raise real issues and reflect realistic threats. The event should stress the system to determine any weak areas and identify areas for improvement and strengthening.

Of course, there are always the imponderables, such as the impact of HIPPA legislation, the lack of health insurance coverage to a large segment of the population, credentialing of expanded/volunteer emergency personnel, and having sufficient vaccines. As the Hart/Rudman Report stated in October 25, 2002, “America remains dangerously unprepared to prevent and respond to a catastrophic terrorist attack on U.S. soil.”

Clearly, there is no room for complacency; but through community-based planning, we can be better prepared than ever before. ✅
This has been the Year of the Nurse, to take media reports seriously. Research documenting the role played by nurses in avoiding treatment errors and in achieving better patient outcomes provided a firmer basis than ever before for those reports. In August, the Joint Commission on Accreditation of Healthcare Organizations reported that inadequate nurse staffing played a role in 24 percent of the 1,609 cases involving death or serious injury reported since 1997. The JCAHO cited "magnet hospitals" as a partial solution to this in that they had better patient outcomes, nurse involvement in decision-making, and a lower turnover rate in their nursing staff.

The October 23/30, 2002 issue of JAMA reported on a 20-month study of 232,342 cases in 168 Pennsylvania hospitals revealing that the chances of dying within 30 days from complications of routine general, orthopedic, and vascular surgery, such as knee replacement or gallbladder removal, increased seven percent for every additional case the nurse was responsible for. The study's main outcome measures were risk-adjusted patient mortality and failure-to-rescue within 30 days of admission, as well as nurse-reported job dissatisfaction and job-related burnout. About four million such surgeries are performed nationwide each year with an overall mortality rate of about two percent. Nurse-to-patient ratios following surgery at the study hospitals ranged from a little under 4-1 to a bit over 8-1. The upshot of this study is that the difference in those two ratios translates into 20,000 deaths per year nationwide.

The U.S. Pharmacopeia reported the findings from its Medmarx national voluntary reporting database for 2001 in December (available at www.usp.org). In 1999, the first year of its analysis, staffing issues were cited in 27 percent of medication error reports. In 2001, that figure rose to 36 percent. Staff workload was cited in 24 percent of these errors. The most commonly-mentioned factors contributing to errors were distractions, increased workload, and inexperienced or temporary staff.

While mandated minimum nurse staffing ratios and magnet hospitals are well intentioned, what will be needed to ensure better quality of care is a true collaborative commitment between labor and management involving the total healthcare work force. The earliest signs of such collaboration may be found in the partnership created by Kaiser Permanente and some of its labor unions in California, one that serves allied healthcare workers and non-clinical workers as well as nurses. Meanwhile, the federal government does nothing. In 1996, the Institute of Medicine in its report, Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?, recommended that Congress require by the year 2000, a 24-hour presence of registered nurse coverage in nursing facilities as an enhancement of the current 8-hour requirement specified under OBRA 87. (RECOMMENDATION 6-1). It further recommended that payment levels for Medicare and Medicaid be adjusted to enable such staffing to be achieved. All the Center for Medicare and Medicaid Services has done to date is to contract (with Abt Associates) for studies stating that it is inconclusive whether the benefits would be worth the costs, and whether better RN staffing would be the most cost-effective strategy to achieve the patient benefits.

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The Future of Public Health

A new Institute of Medicine Report, *The Future of the Public's Health in the 21st Century* (www.nap.edu/books/0309086221/html) is the first governmental report to emphasize the inclusion of diverse, nongovernmental players in strategies to protect population health. It recommends building partnerships across the public and private sectors to develop and promote workplace and community health education programs, and investing in the federal, state, and local government public health infrastructure. To date, only about 30 percent of all federal bioterrorism funding is going to state and local public health agencies. This has once again NOT been the Year of Public Health.

Health Policy Information on Certificate of Need Regulations

by Peg Heatley, Administrator, Health Services Planning and Review, New Hampshire Department of Health and Human Services.

Ms. Heatley is currently in the University of New Hampshire Masters of Public Health Program. As part of that program, she was to prepare a policy brief assignment. Simultaneously, there was a legislative study on the not-for-profit status of hospitals. Certificate of Need (CON) was being described by some committee members as a “state sponsored monopoly” that only increases the cost of health care. The following has been excerpted from the original policy brief submitted to the chair of the committee to help clarify the role of CON in New Hampshire.

Overview:

In the state of New Hampshire, access, quality and utilization control of health care services are functions of CON regulation and are often overlooked by CON “opponents” who value “free or open markets” within the health care delivery system. An important study published in the October 2002 Journal of American Medical Association (JAMA) titled “Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without CON Regulation” by Vaughan-Sarrazin, Hannan, Gormley, and Rosenthal (2002) finds that the volume of cardiac surgery and the quality of the service are inversely related.

The higher the volume of cardiac surgery, the lower the mortality. The lower the volume of cardiac surgery, the higher the mortality. Thus, it is important to recognize that CON regulation has merit relative to the quality of health care services and mortality rates. Repeal or elimination of certain programmatic elements can be expected to have a negative impact on health outcomes, which may not be in the public’s best interest.

Key findings of Study:

- Risk-adjusted mortality was 22% higher in states that had no CON regulation for cardiac surgery than those states that have CON regulation.
- A greater number of hospitals were classified as lower volume hospitals in states without regulation and a greater percentage of patients had Coronary Artery Bypass Graft surgery (CABG) procedures in those lower volume hospitals than those in states with CON regulation.
- Hospital volume was 84% higher in those states with CON regulation than those states without CON regulation.
- The higher proportion of patients undergoing CABG surgery in low-volume hospitals may underlie the higher risk-adjusted mortality in states without CON regulations.

Importance and Uniqueness of Study:

Two additional findings are reported by Vaughan-Sarrazin et al. (2002):

- At the heart of the CON regulation debate are concerns about whether elimination of the regulation will adversely affect the quality of care or result in excess use of services (p.1859); and
- There have been several studies investigating whether CON regulations have affected health care investment; however, few studies have evaluated the relationship of CON regulation with quality of care (p.1860).

This deficit in the literature has been a source of frustration to public health professionals and for advocates monitoring CON-related legislative activities. The absence of thorough scholarly reviews and analysis prevents legislators from receiving objective information on CON.

Discussion:

Should cost containment be the sole focus of legislative review for the CON process? Regulatory and public health advocates are skeptical that an unregulated “free” market has the ability to achieve acceptable positive outcomes especially in the areas of access and indigent care. In support of the...
regulatory and public health advocate position, optimal market conditions for a healthy competitive market may not be able to exist because certain key characteristics of the market are not present.

The results of the Vaughan-Sarrazin et al. (2002) study provides public health professionals and policy makers with an opportunity to focus their attention on the merits of CON regulations in areas other than cost. The topic of quality of care is most likely a subject that everyone considers vital and, therefore, may be neutral ground. It is important for policy makers to also recognize that other studies (Thiemann et al. 1999 & Birkmeyer 2002) have linked quality with the volume level of select medical procedures. This may put the subject of quality on solid ground when evaluating the CON regulations in New Hampshire.

Summary:
CON in New Hampshire is more than just a cost control measure. CON relates to access, quality and utilization control of health care services. There is literature that supports CON as an appropriate regulatory mechanism to prevent high-risk procedures from being performed in low volume settings (Vaughan-Sarrazin et al. 2002; Thiemann et al. 1999; Birkmeyer 2002).

New Hampshire is fortunate to already have the CON mechanism in place. Longest (2001) finds that policy makers should acknowledge that market relationships change with deregulation and deregulation affects indigent care (p.72-73). Further, policymakers should carefully consider the potential adverse effects of repeal of CON regulations. Policy executed over the next few years will be critical to the continued financial viability of indigent care providers and access to care for the growing numbers of uninsured and underinsured Americans (p.75).

References:


Detroit (MI) Medical Center reported a 62% decrease in medication errors after medication rooms were renovated to improve lighting, acoustics and work flow; Methodist Hospital (Indianapolis, IN) reported a decrease in the number of patient transports/transfers following the consolidation of their cardiovascular unit and step-down units and a subsequent renovation which created “universal rooms”. The decrease in patient transfers was accompanied by cost savings, and reductions in medication errors and in length of stay; and Lenox Hill Hospital (New York, NY) has reported an improvement in patient satisfaction following the renovation of patient rooms (3).

Personally, I am encouraged by these research efforts because they bring some science to what that nurse and I both knew: improvements in the “environment of care” will ultimately benefit patients.

NOTES:

Defining Demand: A Critical Task
by Richard K. Thomas, Ph.D.

Introduction
The demand for health services ultimately drives all health planning activities. In fact, the demand for services is the raison d’etre for any healthcare organization. Most decisions on whether or not to offer a service will be predicated upon presumed levels of demand. Once a service is offered, virtually all decisions related to the provision of that service should be a function of the level of demand demonstrated by the population of the market area. For these reasons, health services planners spend a great deal of their time and effort trying to determine current and future levels of demand for overall health services or for the specified services offered by the organization involved in the planning process.

In the case of community-wide planning, demand for the widest range of services possible must be taken into consideration. To be truly comprehensive in the planning approach, the demand for virtually any type of service must be determined. The planner at the community level is interested in the level of demand for the full complement of health services, ranging from consumer education programs to chronic disease management to trauma care.

At the organizational level, the focus is considerably narrower. The emphasis will be on the demand for the services currently offered or for specific services that are being considered for offering. If the organization is multi-purpose, like a hospital, the planner will need to consider a relatively wide range of services (although not as comprehensive as that considered by the community health planner). On the other hand, a local home health agency serving exclusively Medicare patients, for example, will involve a fairly narrow view of the demand for services.

Defining “Demand”
This discussion raises the question of how demand is defined. “Demand” is an imprecise concept as applied to health services and the term is often used interchangeably with other terms. In fact, there is technically no one definition in common usage (other than a few narrow economic ones). The concept is sufficiently vague and used in so many different ways that it is difficult to provide an operational definition. Perhaps the best way to approach the concept...
of demand is by examining its component parts. From a planning perspective, demand can be conceptualized as the ultimate result of the combined effect of: 1) healthcare needs; 2) healthcare wants; 3) recommended standards for healthcare; and 4) actual utilization patterns.

Health Care Needs
Health care needs can be defined in terms of the number of conditions found within a population that require medical treatment. These are the health conditions that an objective evaluation, e.g., a physical examination, would uncover within a population. These might be thought of as the absolute needs that exist in “nature” without the influence of any other factors. All things being equal, the absolute level of need should not vary much from population to population. These are the epidemiologically based needs that a team of health professionals would identify in a “sweep” through a community and could be considered to represent the “true” prevalence of illness within the population.

A population with certain characteristics can be expected to manifest a specified level of various health conditions. However, these absolute needs, at least in contemporary societies, do not translate directly into demand. In fact, the mismatch between these baseline needs and ultimate utilization of services is substantial. There are many conditions that go untreated (indeed, even undiagnosed) for various reasons. There are many other conditions for which treatment is obtained that would not be identified among the absolute needs of the population. For example, no team of epidemiologists assessing the health care needs of a community is likely to identify sagging facial skin as a health problem. Yet, tens of thousands of facelifts are performed in the United States every year by medical doctors. The lack of a clinically-confirmed need, then, is not a pre-requisite for the emergence of demand and, ultimately, utilization.

Health Care Wants
Health care wants can be conceptualized as wishes or desires for health services on the part of the population. Unlike needs, wants would not necessarily be uncovered by a sweep of clinicians through the community. Wants are shaped less by the absolute needs of the population than by the variety of factors that influence the consumption of other goods and services besides healthcare. In fact, many health services that are consumed are considered medically unnecessary or elective, reflecting the operation of wants rather than needs. Examples of these services include cosmetic surgery and laser eye surgery. The U.S. health care system has adapted itself to the existence of wants as well as needs, and important components of the system cater to those desiring elective services.

The extent to which health care wants are a consideration in the planning process depends on the type of planning being performed. Community health planning ideally should emphasize the baseline needs of the population, although, realistically, the wants of the population must be taken into consideration if the approach is to be truly comprehensive. At the organizational level, the type of organization and the services it offers will dictate whether needs or wants are the main consideration. Certainly an AIDS clinic is dealing with basic needs, and there are few elective procedures relevant in AIDS treatment. On the other hand, a plastic surgeon specializing in body sculpting is likely to focus on the want-driven demand generated by those motivated by vanity. At the same time, if this plastic surgeon also maintains a reconstructive surgery practice for trauma victims, both wants and needs may be a consideration in planning.

Recommended Standards for Healthcare
The third component involves recommended standards for the provision of health care. As health professionals have become more attuned to prevention and early detection, the number of established standards has grown. This component of demand involves primarily diagnostic procedures, the administration of which can typically be linked to fairly clear-cut indications. Therefore, a wide range of diagnostic procedures are now indicated for certain age groups and other population segments at risk of various health conditions.

There are standards that call for diagnostic tests at a certain frequency, the performance of certain medical procedures at specified times, and the carrying out of various treatment plans on the part of patients. For example, an annual mammogram is recommended for all women over 50, an annual prostate exam for all men over 40, and regular cholesterol measurement for individuals at risk of certain conditions.

As Americans have become increasingly health conscious, a growing number of standards have been put into place. A few years ago, cholesterol tests were limited to patients actively under medical management. Today, cholesterol tests are recommended for everyone at specific intervals, along with pap smears, breast exams, prostate

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exams, and a growing number of other diagnostic and screening procedures. As a result, the demand for recommended tests and procedures must be factored into health planning activities.

Health Services Utilization
The fourth component of demand involves the actual utilization of services. This is frequently used as a proxy measure for demand, in that utilization rates can be calculated for virtually any type of health service or product. More data are available related to health services utilization than for the other components of demand, primarily because utilization data are routinely collected for administrative purposes whenever a health service is provided. More so than any other measures discussed here, utilization rates indicate the level of activity within the health care system.

Because of the perceived relationship between demand and utilization, planners may work backward from utilization levels and use them as a proxy for demand. However, utilization does not equal demand and, depending on the circumstances, the level of demand may exceed actual utilization or, conversely, utilization levels may exceed reasonable demand for services. For example, there may be less utilization than expected because of limited access to health services. On the other hand, some services may be over-utilized for various reasons (e.g., insurance coverage, physician practice patterns) unrelated to the actual level of demand.

Conclusion
A determination of the demand for health services is critical to the health planning process. Such a determination, however, is problematic given the factors that must be taken into consideration in estimating the demand for services. Data on the utilization of health services may be more readily attained than other measures of demand and these data may be used as a proxy. Yet, utilization rates represent a measure of the use of services and this may not equate to demand. Indeed, it is often argued that past or current utilization of health services cannot be assumed to reflect future utilization of services in a rapidly changing industry. The health planner must thus consider the existence of health care needs, the desires of the target population with regard to health care wants, and the necessity of providing for recommended services. All four components must be considered in developing a true picture of health services demand.

Richard K. Thomas is a Memphis-based healthcare consultant and vice president of Medical Services Research Group. He is currently working on a revision of his book Health Services Planning (Irwin, 1999).

AHPA Workshop Huge Success!
On November 10, the American Health Planning Association (AHPA) sponsored a Continuing Education Institute in conjunction with the annual meeting of the American Public Health Association (APHA). The workshop, which was attended by over 50 registrants, focused on health data for community assessment and planning studies. Components were included which addressed:

- Types of data required;
- Sources of relevant data;
- Methods for analyzing the data; and
- Application of data to concrete planning situations.

The workshop was developed and coordinated by Rick Thomas, who served on the “faculty” with Mara Yerow and John Steen. The half-day program was well received by the large group of participants who provided useful feedback on the various aspects of the workshop. Those in attendance were impressed with the qualifications of the faculty and, while giving high marks to all aspects of the program, were particularly impressed with the component on health data sources. Useful suggestions were offered for improving the workshop for future presentation.

The workshop provided valuable exposures for AHHA; many participants had not been previously exposed to the organization. It is hoped that the workshop can be offered at future APHA meetings and modified for presentation in other venues as well. Look for excerpts from the workshop in future issues of the newsletter and on the AHHA web site.

This caricature was done during the recent APHA conference in Philadelphia. Do you know who these folks are?
Initially, this observation (it’s academic, so it’s not a conclusion) shocked me. Especially from a Canadian source, a society more rational about health care, I believe, than we in the U.S.

As I delved into an analysis of the Canadian Medicare program, I fully anticipated finding “rational planning” as one desirable attribute of models proposed to address the program’s ills. The analysis is contained in Discussion Paper # 8, Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?

The paper addresses a critical distinction in how questions are asked about improving Medicare. Those questions are reflected in the juxtaposition of the title: complicated and complex systems.

The basics regarding complicated and complex problems are captured simply:

.shiro

Complicated problems are symbolized by sending a rocket to the moon. You have basic production recipes plus high levels of expertise for multiple components of the problem. Once the problem is solved, there is high likelihood of success in the future.

.shiro

Complex problems resemble raising a child. Formulae have limited applicability. Experience is gained but with no predictability of applying it successfully in the future. The uniqueness of each child lends itself to uncertainty of the outcomes.

Applying this analytical framework to understanding the problems of (Canadian) Medicare, the authors explore four clusters of characteristics to understand how they differ between complicated and complex problems. The clusters are Theory, Causality, Evidence, and Planning.

According to the authors, “(T)he planning cluster identifies the notion of decisions as emergent from processes rather than events. It stresses the need for understanding of actual practices and argues that big changes can occur from small interventions in complex systems.”

Now I understand. The authors define rational planning as decisions emergent from events. In a complex system, decisions emerge from processes.

I’m saved! It’s a matter of semantics. We agree on content (decisions emerging from processes), but not on terminology (rational = linear in complicated problems).

Next time we’ll explore the reality of this model, especially how planning is a cornerstone to successful change. Linear thinking, beware!

1Globerman, Sholom and Brenda Zimmerman, York University, July 2002.

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**Evaluation Criteria for SHP Programs**

by Sherry J. Fontaine, Ph.D., Assoc. Professor
Dept. of Geography and Planning
Buffalo State College, New York

**Introduction**

The criteria used to evaluate public sector health planning programs at the state level can be a determinant in their success or failure. The rising cost of health care, particularly for publicly funded health programs, is a long-standing and continuing concern for state legislators. As a result, state legislators and policy-makers often rely on cost containment as the primary performance and evaluation measure for state funded health care programs. An over-emphasis on cost containment as a performance measure could result in secondary consideration being given to equally important evaluative measures such as access to health care, quality of care, and improved health status. The evaluation criteria used to assess the continuation of Certificate of Need programs provides insight into the type of criteria used to assess program performance, and the relative importance of differing criteria in the evaluative process.

**Background**

Federal CON mandates began in 1974 with the passage of P.L. 93-641, The National Health Planning and Resources Development Act of 1974. However, more than 20 states already had a form of capital expenditures review before P.L. 93-641 was passed (Campbell and Fournier, 1993). Although initiated in a climate of rising health care costs, CON programs were intended to achieve multiple goals. These goals were: (1) to control health care costs, (2) ensure access to health care services, particularly in underserved urban and rural areas; and (3) to promote quality of care. Yet despite the CON programs multiple goals, the principal performance measure that used in the evaluations of CON programs was its ability or, as is evidenced in the literature reviews, inability to contain costs.
The emphasis on cost containment as an evaluative measure for CON provides a starting point for the examining the role evaluation criteria have in determining the future of state health planning programs.

Methods

Program evaluation reports for CON programs issued by state legislative research agencies or by other organizations responsible for the evaluation of state health planning and health services programs were reviewed to ascertain to what extent costs, whether identified as cost-efficiency, effectiveness, or cost-savings, are considered as principal evaluative measures for state health planning programs. Often legislators use the cost of programs and/or the attendant cost-savings of programs as a focal point for programmatic decisions. As a result, many legislative agencies responsible for evaluating program performance also rely primarily on the use of cost criteria in assessing program performance. While it is recognized that cost efficiency or cost savings attributable to a program are important evaluative measures, it is contended that these should not be the sole criteria in the evaluation of health planning or health services programs that have multiple objectives. Relying on a single evaluative criterion, such as achieving cost savings or controlling health care costs, to assess the performance of a health planning or health services program could jeopardize the future of the program. The evaluations of the CON programs demonstrate how the criterion of cost can be used to justify the elimination of or to scale-down an existing program. Program evaluation reports for CON programs issued by state legislative research agencies or by other organizations responsible for the evaluation of state health planning and health services programs were reviews for the following states: Delaware, Pennsylvania, Florida, Ohio, and Washington.

These evaluations were developed to assist legislators in the deliberations on whether or not to retain, modify, or eliminate CON programs in their respective states.

A review of the literature coupled with the findings of evaluation reports of state CON programs commonly cites the inability of CON programs to contain costs or achieve cost-savings for the health care system as a measure of program failure (Salkever and Bice, 1978; Eastaugh, 1982; Mendelsohn and Arnold, 1993; Conover and Sloan, 1998). Cost containment appeared to be the principle criterion in all of the evaluations reviewed in this study. Each study did include the criteria of quality and access to care as additional areas of evaluation. Cost containment, however, was considered to be a critical performance measure, particularly when considering whether or not to continue CON programs.

Evidence of the relative importance of cost containment as an evaluative measure was also evident in the organization of and the scope of analyses presented in the reports. For example, each study presented the evidence of cost containment as the first subject for review. Importantly, cost containment was the most extensively analyzed measure in each of the studies. The latter is in part due to the fact that there are comparatively more studies conducted on the impact of the CON program on health care costs than on any other aspect of the CON program.

While each report included in its objectives an evaluation of cost, quality, and access, the criterion of cost appeared to outweigh quality and access in determinations of CON program continuation and the scope of CON review. The Delaware Cost Containment Commission Evaluation of Certificate of Need concluded that the limited benefits of CON in terms of access did not outweigh the cost of the program. Cost-effectiveness, in this instance appeared to be a heavily weighted factor in evaluating CON performance and the continuance of CON legislation. This report, which included analyses on the consequences of repealing CON in states that eliminated the program, provided an in-depth economic analysis of the impact of CON on a range of health care costs. The report concluded that CON should be terminated for the State of Delaware and advocated that market forces would better serve the goal of health care cost containment (Delaware Cost Containment Commission, 1996).

The Certificate of Need Study for the Community Hospitals and Health Systems of Florida was prepared in anticipation of legislation in the coming 1999 session to eliminate CON review. The study framed the analysis of the CON program in Florida and nationally within a broader policy perspective. The report examined proposed CON deregulation in the context external factors, specifically managed competition, which resulted in changes in the health services system rather than on the failures of CON.

The questions raised in this report regarding managed competition reflect a core belief held by some legislators and policy analysts, which is in contrast to the regulatory approach presented by CON legislation. This belief, which is also reflected in varying degrees in the evaluation of the CON programs, is that managed competition supplants
the need for regulatory mechanisms such as CON programs. Thus, the establishment of managed competition in health care is considered a strong factor in the decline of legislative support for CON programs (Moore, 1997).

As noted earlier in this study, cost containment is not the sole objective of the CON program and evaluators did consider the impact of CON programs on quality of care and access to care. There was less unanimity in the reports in evaluating the impact of CON programs in promoting access to care and quality of care. The evaluation of CON programs conducted by Lewin-VHI in Pennsylvania and Georgia noted that the CON program was effective in promoting quality and access to health care services (Legislative Budget and Finance Committee, Pennsylvania General Assembly, 1996; Nathan, 1998). An earlier evaluation by Lewin-ICF and the Alpha Center for Ohio did not include in its findings that the CON program met state objectives for access to care and quality of care, but did recommend retaining the CON program with an emphasis on promoting access to care and quality of care rather than cost containment (Lewin-ICF and the Alpha Center, 1991). Other evaluations did not conclude that CON programs had a positive impact on either access to care or quality of care. The evaluation of CON for Washington State found limited literature and weak or conflicting evidence to this effect (State of Washington Joint Legislative Audit and Review Committee, 1999). More negative conclusions were expressed in the evaluation of CON for Delaware, which contested the majority of findings on the effectiveness of CON on promoting access to care and quality of care (Delaware Cost Containment Commission, 1996). The mixed findings on access to care and quality of care suggest that we cannot dismiss the potential benefits of CON on these measures. Since the reports relied mainly on literature reviews, it is also evident that the literature on the measures of access and quality is scant in comparison to evaluations on the effect of the CON program on health care costs.

For advocates of managed competition, there may be other means than CON regulations, which can promote quality of care and access to care. For example the authors of the evaluation of the CON program for the State of Delaware contend that the emergence of managed competition and the strength of market forces in health care negates the need for CON programs as either cost-control strategy or to promote access and quality of care (Delaware Cost Containment Commission, 1996). However, there is an overriding concern expressed in the issues the evaluators were asked to address and in legislative debates regarding terminations of the CON program that conflicts with the views of managed care proponents. It is the protection CON offers to urban and rural hospitals that serve indigent populations and the consequences that repealing CON would have on these hospitals that is troubling to state legislators. This same concern over deregulation is addressed in the evaluations of CON programs. Again, the findings are mixed, however, there is evidence in both the literature and in the evaluation reports that there is greater support for retaining CON for the purposes of: (1) promoting access to care, particularly for vulnerable populations and the hospitals that serve these populations; and (2) to ensure quality of care. The latter is based on CON’s establishment of volume and utilization standards for high-risk procedures. Despite the relative paucity of literature on the impact of CON programs on quality and access, the evaluation of the Ohio Certificate of Need program, for example, recommended that rather than continuing to focus on CON as means of controlling acute care costs, the CON program should be retained but with an emphasis on promoting access to care and quality of care (Lewin-ICF and the Alpha Center, 1991).

There are also some conflicting practices regarding CON review as a cost-containment tool. Every state that has retained CON review includes long-term care within the CON review process. Ohio maintained CON review only for long-term care services while Nebraska and Oregon removed CON review for almost all services but retained CON review for long-term care. Seven states that that terminated their CON programs enacted nursing home bed moratoriums (American Health Planning Association, 2001). It has been suggested that states have been reluctant to remove CON for long-term care because state Medicaid finances approximately one-half of the costs of nursing home care (Nathan, 1998). If states are reluctant to remove CON due to concerns over a surge in the growth of long term care beds and subsequently costs, why would this same concern not apply to the health care system as a whole? The example of long-term care indicates that despite the poor results of the CON program in controlling costs it is the consequences of an absence of regulation that appears to be a concern for states in debating whether or not to eliminate CON or other regulatory mechanisms; particularly when state monies are significantly affected.

Conclusions
The criteria evaluators choose to use, the value attached to particular measures, and the scope of evaluation efforts all play a significant role in
determining future state health policy. Health planning legislation has often been driven by the uncontrollable rise in health care costs. In response, evaluations of state planning programs, as demonstrated by the CON program, have measured the success or failure of a program according to its ability to contain costs. As health planning programs reestablish themselves and discover new planning tools that strengthen the planning process, evaluators will need to consider a broader range of evaluative criteria that reflect the changing role of health planning programs. One such criterion will be the use of outcomes measures in the health planning process. Patient outcomes and outcome measures related to system performance can provide valuable information regarding the ability of a program to improve the health status of a population. Evaluators should assume that improving the health status of a population is the overriding goal of any health program. Additionally, outcome measures, by determining the appropriate utilization and allocation of limited resources, can provide a means of measuring effectiveness and efficiency in the provision of health services.

Incorporating outcome measures in the planning and CON review process reflects a new role for health planning. As Robert Hackey states:

"Relieved of their unrealistic role as the principal means of controlling health care costs, CON programs have found new niches since the expiration of federal health planning legislation in 1986." (Hackey, 1993: 935).

The new niche for CON programs that Hackey refers to is based on the success of CON programs in defining the appropriate utilization of services and supporting this determination through the use of measures of patient outcomes.

A lesson to be learned from the evaluations of CON programs is that future evaluations of state health planning programs should consider the multiple objectives of these programs and assess their performance based on the effect health planning programs have on improving the delivery and allocation of health care resources, promoting access to care and quality of care. The aforementioned measures will ultimately impact the overriding goal of any health care program; which is improving the health status of the population.

References


Happy Holidays!

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