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Health Planning

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the newsletter of the
American Health Planning Association

President's Message Spring 2004

Health Planning TODAY . . . and Tomorrow

by Dean Montgomery, AHPA President and
Executive Director, HSA of Northern Virginia

This is the 101st issue of *Health Planning TODAY*. We hope you find the articles, opinion pieces, and other information presented interesting and useful.

You may note that, like the 100 issues that precede it, this is another eclectic collection. There is no overall theme or organizing principle. Unlike most other newsletters, it is not written by resident staff, formally edited, or otherwise shaped to form a coherent whole. The contents reflect member contributions, usually published unedited shortly after submission.

Beginning with this issue, we introduce a process that we hope will give future editions both a sharper focus and greater depth. We will continue to rely on the support and contributions of members for content and to ensure that the newsletter reflects the diverse interests and views of association members and other readers. Within this framework, future editions will be thematic, with a focus on topics of direct relevance to population-based

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Health Planning TODAY

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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:

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Donna Schuessler, Editor



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planning and regulation. The theme of each forthcoming quarterly issue will be announced, and previewed in the edition that precedes it.

This issue, for example, contains a couple of preview articles, "Demography & Destiny" and "Demography and Planning: Impact of Technology and Business Trends," on the importance of demographic data and information in health planning. Demography in health planning and CON regulation will be the focus of the next edition (June 2004) of *Health Planning TODAY*. We welcome timely submission of articles and commentary on that topic. Themes being considered for future editions (September 2004 and beyond) include:

- Population-based planning and regulation;
- Commonly used planning methods and tools;
- Evidence-based planning and regulation;
- Planning and regulation of long-term services;

- Technological change and planning;
- Preservation of community health assets;
- Use of small area analysis in planning;
- Rural health services planning; and
- State health data systems.

We invite your comments on these topics, and others you may suggest, as well as on the desirability and appropriateness of trying to sharpen the focus of the newsletter and to frame the topics and issues discussed. Articles on these and other topics may be submitted at any time and will continue to be published on a timely basis. We ask that submissions be original work. If a submission has been, or will be, published elsewhere, it is essential that this fact (or arrangement) be acknowledged and explained fully.

We appreciate your support and contributions. The quality and value of *Health Planning TODAY* will continue to be a function of your interest and participation.

Should you have questions about articles, commentary and other information you may wish to submit, please contact us at your earliest convenience. Inquiries are handled promptly. They should be sent to [<dschuess@mail.state.mo.us>](mailto:dschuess@mail.state.mo.us) or [<AHPAnet@aol.com>](mailto:AHPAnet@aol.com).



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Demography is Destiny

by Dean Montgomery, AHPA President and
Executive Director, HSA of Northern Virginia

Few planners would be likely to disagree strongly with the oft-repeated maxim that “demography is destiny”¹. The importance of reliable population, social and economic data in health services planning is widely acknowledged. Unfortunately, the acquisition, analysis and application of this information is not an easy or straightforward exercise, and is honored more in the breach than in the observance.

The next edition of *Health Planning TODAY* examines the role and significance of demography in health planning and certificate of need regulation. The focus is timely. The confluence of demographic trends, economic pressures, and the emerging pattern of health system infrastructure needs makes population-based, community oriented health services planning unusually important today.

A recent *Wall Street Journal* article illustrates the risk and opportunity current circumstances present². The *Journal* reports that hospitals are bracing for a sharp increase in capital spending. On average, about 75% of the hospitals surveyed expect capital spending to increase about 14% a year over the next five years. This compares with annual increases of only about 1% annually over a recent five year period, 1997-2001.

Increased capital spending is likely to be focused on state-of-the-art radiology systems, information technology, additional inpatient beds, and the expansion of emergency departments, surgical suites, and specialty inpatient services. Taken collectively, these plans suggest that hospital management now expects major increases in inpatient demand, notwithstanding recent heavy investment in outpatient services and facilities.

More intriguing than the survey results are the explanations offered by those surveyed for their change in spending plans. Some reasons, such as the observation that some capital spending was deferred during the recent economic downturn and the need to keep current with technological change, are straightforward and expected. Others reveal the underlying connection between perceived demographic patterns, health system changes, and capital spending. The risk of unexamined demographic assumptions, of adherence to a problematic demographic climate of opinion, is on full display.

Nearly half of the CFOs surveyed reported that the shift to more outpatient services encouraged by managed care reimbursement has subsided. The CFO of Stanford University Hospital and Clinics, for example, is quoted as saying that the shift to outpatient care has leveled off “just as we were seeing the effect of the graying of America”. The reporters note that pressure to add capacity and spend substantial sums appears to be greatest among hospitals “in states with swelling elderly populations”.

So, a lot of money is being spent, and an extraordinary additional amount is about to be committed, to rebuild and expand hospitals nationwide. The technological, demographic, and economic reasons underlying these decisions should be subject to the most critical examination possible. The *Journal*, no opponent of capital investment, points out that “if hospitals fulfill their spending plans” there could be “a short-term surplus of medical services in some markets.” A private health care analyst observed that there could be “a period of over capacity until there is a more acute ramp-up in demand”.

Unfortunately, the “period of over capacity” is virtually certain, and the “more acute ramp-up in demand” may be a long time coming. The question now is how much unnecessary capacity will be developed, and whether the excess will extend over the full lifecycle of the facilities being developed. Reasons for caution include:

- Population growth is likely to be less than anticipated;
- Age-adjusted inpatient use rates are likely to decrease rather than increase;
- Much of the long anticipated demand from the “graying” of the baby boom population cohort is not likely to materialize;
- Technological developments are likely to favor outpatient care and demand; and
- Insurance payment schemes are likely to become more rather than less restrictive.

All of these considerations are worthy of careful examination by planners, particularly the likely effects of demographic patterns and trends. The reigning demographic climate of opinion, which is unduly colored by “baby boom” assumptions, will result in substantial over investment in inpatient capacity. It should not be accepted uncritically.

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The Wizard's Corner Age, Health Status, Spending

“Unfortunately, the assumption of a fixed age schedule of health status is improbable over a long forecast horizon.”*

“Official statistical agencies have systematically under-projected mortality declines and gains in life expectancy.”*

“As time passes, life expectancy increases in the population and mortality falls, reducing the proportion of the population near death at any given age, a change that is associated with an improvement in the average health at any given age.”*

“...the association of health spending with age derives from a more fundamental underlying relationship between age and the fraction of people who are near to death, at least for the older population.”*

The steadily declining mortality in the population not only means additional elderly for whom health care must be provided, but also means improving health status of the elderly at each age, and, therefore, lower spending, other things equal.”*

“Analysts have shown that at least over age 65, there is little variation in health spending with age for those who survive.”*

“USA Today has come out with a new survey - apparently, three out of every four people make up 75% of the population.”

- David Letterman

Moral:

- ✓ Do not die
- ✓ Do not read Health Services Research
- ✓ Read USA Today
- ✓ Watch David Letterman

*For more see: Ronald Lee and Timothy Miller, “An approach to forecasting health expenditures, with application to the U.S. Medicare system,” Health Services Research, October 2002. 🍏

Demography and Planning: Impact of Technology and Business Trends

by Robert Vogel, Vice President
Managed Care, Sisters of Mercy Health System

As the sponsor of inpatient hospital services in communities across four states, our health system is challenged constantly to determine the appropriate service mix, service capacity and resource allocation across several service lines. To do this, we must anticipate and understand health care technology and business trends. The determinants of need and demand are intermingled among: advances in cardiac care, cancer treatment, etc.; emerging technology in imaging and procedures (e.g., drug-eluting stents); business trends like Consumer Directed Health Plans; influences on quality improvement like disease management and bar coding of drugs; and organizational arrangements with physicians such as service line joint ventures.

Therefore, to refine our assessments of hospitalization use trends, we must identify these determinants and overlay our analysis of their impacts with an understanding of many other factors. These factors include population change, the shift to outpatient service sites, the economy, the healthcare industry (e.g., the shift toward consumerism) and social and cultural factors. In doing so, we come to understand, for example, that the anticipated increase in inpatient utilization based on population change is significantly moderated by the technology enabling outpatient care and non-invasive care, while payment, economic and social factors are essentially neutral.

By aggregating these analyses, we can “summarize” the impacts on a facility to create a comprehensive picture that allows us to integrally plan services, facility types (e.g., inpatient, outpatient, free standing), physician specialty needs, etc.

In doing so, resources are allocated to beds, procedure rooms, operating rooms, ancillary services, outpatient services – what ever the need – allowing us to meet demand created by multiple forces in an optimal fashion. This process takes us from strategic forecast to an operational forecast that, hopefully, comes very close to meeting forecasted need and demand for our services. For example, without modifying the population-based demand by the influence of technology, we may have expected an increase in need for inpatient beds more than 30% higher than with the analysis of technological impact. While the exact methodology is proprietary, the lesson is clear. Our analytical approaches must be multivariate and we must be driven by the need to allocate resources responsibly. 🍏

Policy Perspective

by John Steen

In my last column, I provided an addendum concerning a Certificate of Need (CON) application by four New Jersey hospitals to be licensed to do cardiac surgery. The addition of the four to the existing 17 licensed hospitals would not only reduce average volumes for all cardiac surgery units, it would also reduce revenues for the urban medical centers that are already licensed. Three of those four hospitals are suburban facilities. On February 11, 2004, the State DOH's Deputy Commissioner issued the decision to disapprove all four applications. The Health Commissioner has a conflict of interest by virtue of himself being a cardiologist from one of the existing facilities.

This case illustrates how the profit motive in health care continually seeks opportunities to compete for the best reimbursed services and the best insured patients, and how a well-regulated state like New Jersey has the resources to provide due process to all parties and address the common interest in making its findings.

Unfortunately, in growing numbers of less regulated states, the common interest is much more vulnerable to the profit motive and to the capital it attracts. The challenge that "Boutique Hospitals" represent is being experienced in these states, but increasingly, for-profit hospitals of all kinds are being promoted in communities that lack the resources to defend themselves. The vulnerability of such communities lies in their desperate need for new jobs and capital investment, and in the lack of an effective CON program in their state. But most of all, it is the desire of local physicians to avoid uninsured patients, and of those physicians and local landowners to realize profitable investments, that drives the phenomenon.

It has grown into a major sideline for Tenet, HCA, and other for-profit chains, and Triad, an HCA subsidiary, specializes in finding weak non-profit hospitals to turn into for-profits. The most difficult to meet needs of the communities involved, the ones being met by the local non-profit, mission driven community hospital, are placed at risk when that hospital is undercut by those that siphon off the most lucrative services. Among the first services to lose out are mental health services, emergency services, and even pediatrics.

What is so often missing in these circumstances is an appreciation of a community's investment in its own hospitals and in the traditions of service to all in need that have guided their mission. This is just what these for-profits will not touch. Equally ignored is the obligation of communities to continue to provide oversight in how services are delivered; the loss of this function signifies that there is no longer a community in health care. In the more regulatory states, state health officials often act in the best interest of their communities, but this may not be appreciated in those communities where it may be seen as paternalism or politics.

The best answer lies in community health planning that educates all members of the public about these issues by inviting them to participate in the kind of civic life that continually renews communities and maintains our democracy. 🍏

Policy Perspective

Disaster Medical System

by Carl Adrianopoli, Regional Emergency Coordinator
Department of Homeland Security, Region V
National Disaster Medical System Section/FEMA

For decades, the nation has been fortunate in avoiding large numbers of deaths and injuries from natural disasters or terrorist events . . . until the attack of the World Trade Center in September 2001. With the potential dangers/fallout related to the use of “weapons of mass destruction”, the continuing threat from naturally occurring biological events such as SARS, influenza pandemics, and emerging infectious diseases, as well as, other catastrophic events such as earthquakes, floods, hurricanes, or hazardous materials disasters, a review of the National Disaster Medical System seems more relevant than ever.

In 1981, National Security Decision Directive 47 (NSDD-47) mandated the development of the National Disaster Medical System (NDMS). The NDMS was developed to address national security emergencies by providing back-up medical support to the Department of Defense (DOD) and the Department of Veterans Affairs (VA) medical care systems during an overseas conventional conflict.

The NDMS also supplements state and local medical resources during disasters or major domestic emergencies such as floods, hurricanes or even the uses of “weapons of mass destruction”. The Department of Defense and the Veterans Administration are partners with the National Disaster Medical System Section of the Federal Emergency Management Agency in the Department of Homeland Defense.

It is the policy of the United States to develop systems and plans to ensure that sufficient medical personnel, supplies, equipment, and facilities will be available and deployed to meet essential civilian and military health care needs in an emergency. The NDMS has lead responsibility for the assessment of health/medical needs, the provision of on-scene health and mental health services and victim identification/mortuary services.

The NDMS has three major components:

- ✓ Medical Response;
- ✓ Patient Evacuation; and
- ✓ Definitive Medical Care.

Medical Response:

At its most recent update (see the attached materials below), the NDMS has 39 operational Disaster Medical Assistance Teams (DMAT), 16 developmental DMATs, 10 Disaster Mortuary Assistance Teams (DMORT) and approximately 25 specialty teams. Although the NDMS system is being reviewed and improved, an operational DMAT can include up to 10-15 MDs, with up to 3 rotations of 35 volunteers each. The other team members include nurses, paramedics, logistics, communications and administrative personnel. Though the teams are “federalized” while on deployments, they are locally-sponsored and community-based entities that are also local/state assets. At disaster sites the teams conduct triage, austere medical care and casualty clearing/staging. Frequently the teams set up primary care centers or back-fill at hospitals or other locations.

Patient Evacuation:

The DOD has the lead responsibility for NDMS patient evacuation from the disaster area. All types of transportation will be utilized, although aero medical evacuation will be the primary resource to the extent that it is available. Patient reporting, regulation, movement requests, staging, lift (embarkation/debarkation, and coordination with various system elements) will be major functions of the NDMS Section of the Federal Emergency Management Agency.

At the disaster site, patients will be stabilized by DMATs or Specialty Teams for transport. In most cases, patients will be evacuated by the DOD aero medical evacuation system. Patients will be regulated to Federal Coordinating Center (FCC) areas. At the airport of the NDMS reception area, patients will be met by a local medical team that will sort, assess, and match those patients to participating hospitals, according to procedures developed by local authorities and the local area's NDMS FCC. Patients will be transported to

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participating hospitals using locally organized ground and air transport.

Definitive Medical Care:

The NDMS network of hospitals includes approximately 2,000 hospitals, with about 18,000 beds available for patient reception within 24 hours. There are 65 FCC (VA and DOD sites) which coordinate in excess of 82 patient reception areas. FCCs recruit hospitals and maintain local non-federal hospital participation in the NDMS; assist in the recruitment, training, and support of DMATs; coordinate exercise development and emergency plans with participating hospitals and other local authorities in order to develop patient reception, transportation, and communication plans; and, during system activation, coordinate the reception and distribution of patients being evacuated to the area.

NDMS responsibilities include:

- Coordination of definitive medical care in the assigned local areas;
- Solicitation and organization of community support services;
- Enrollment of non-federal local hospitals in NDMS;
- On-going coordination of NDMS bed availability; and
- Preparation of local NDMS patient reception plans, exercises and operations during activations.

Role and Benefits of Participating Hospitals:

NDMS hospitals voluntarily commit to support the NDMS and provide bed availability to local FCCs. They also participate in NDMS exercises. Accredited hospitals, usually over 100 beds in size and located in large U.S. metropolitan areas, are encouraged to enter into a voluntary agreement with NDMS. Hospitals agree to commit a number of their acute care beds, subject to availability, for NDMS patients. Because this is a completely voluntary program, hospitals may, upon activation of the system, provide more or fewer beds than the number committed in the agreement. The federal government will reimburse hospitals that admit NDMS patients. Although the NDMS is designed to respond to major disasters, there are immediate regional benefits to states and local communities that participate in the system. DMATs, specialty teams and other elements of the NDMS are available to

respond to local mass casualty incidents or on an intra-dtate basis. Thus, the NDMS not only enhances nationwide medical response capability, it also improves the ability of participating states and localities to respond to disasters within their own jurisdictions and under their own authorities.

The NDMS maximizes the utilization of existing federal, local and state medical resources. It provides identified levels of care, helps contain health care costs and has been designed to reduce mortality and morbidity resulting from national disasters by improving the nation's ability to mobilize and deploy teams, supplies, and equipment, evacuate patients and provide definitive care.

To obtain details on the current status of the NDMS teams and assets, as March 4, 2004, or for additional information about the National Disaster Medical System, visit our website: <www.ndms.fema.gov>.

(The views represented here do not necessarily represent those held by the NDMS). 🍏

Cont'd. from page 3: "Demography is Destiny"

If demography is destiny in health care, planners must be sure that they have a good understanding of demographic patterns and trends and how they now relate, and are likely to relate in the future, to health care needs and demand.

Your thoughts, experience and interest in these and related questions are welcome. The next edition of *Health Planning TODAY* will focus on demography in health planning and regulation. You are invited to submit articles, commentary and other information.

¹This maxim, attributed variously to Augustus Comte, Lord Acton, and others, increasingly is invoked rather indiscriminately to explain everything from the pending demise of Social Security to foreign policy failures. Demographic patterns and trends are unusually powerful and, consequently, warrant careful study. Uncritical acceptance of demographic truisms is, of course, risky and to be avoided if possible.

²V. Fuhrmans and K. Kranhold, "Hospitals to Boost Spending, A Move That May Hurt Profits," *The Wall Street Journal*, March 3, 2004. <<http://online.wsj.com/article/0>> Unless otherwise indicated, quotations shown here are from this article. The survey cited, of nearly 500 hospital chief financial officers (CFOs), was conducted by the Health Financial Management Association and GE Healthcare Financial Services. 🍏

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