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Health Planning

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the newsletter of the
American Health Planning Association

President's Message – Fall 2004

Hope, Faith and Charity

by Dean Montgomery

Troubled by health care costs, skyrocketing insurance premiums, and shrinking health insurance coverage? Be not discomfited. Your government is at work. The Federal Trade Commission (FTC), with help from the antitrust division of the Department of Justice, has assessed the situation and prescribed a cure for what ails our health care system.¹

And the magic elixir the good doctors of jurisprudence and economics prescribe? Why, good old American competition, of course. In a tome to make Herbert Spenser and latter day social Darwinists swoon, reliance on the “American free-market system” is touted as the yellow brick road to a “consumer-driven” health care system.

To paraphrase the immortal Pogo, they have found the enemy and it is we. Yes, my weak, benighted friends, you and I are the problem. Those of you engaged in, or supportive of, certificate of need (CON) regulation are, *de facto*, encouraging oligopoly and undermining consumer well being. So, States should eliminate CON

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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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faxed to (573) 751-7894.
Donna Schuessler, Editor



Hope, Faith and Charity *Cont'd. from page 1:*

and related planning programs, and you misguided regulators should go and sin no more, lest you invite the judgment of history.

What else? Well, we are far too dependent on Medicare and other third party health insurance schemes. Medicare, the preeminent example of “government-administered pricing,” distorts markets and competition. Consequently, it also spawns health system mutations such as ambulatory surgery centers and single specialty hospitals. The Commission and Newt Gingrich agree that the “third party payment model is inherently conflict ridden,” and such schemes necessarily “distort incentives and have unintended consequences.”

For the truly misbegotten, hoping for some form of government regulation or other intervention to reduce prescription drug costs, or keeping the faith for single payer national health insurance, the FTC offers a cold shower: “Government purchasing that reflects monopsony power would likely reduce output and innovation.” Enough said?

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Mann Gulch and Reconstituting Health Care

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

Why do we continue with fad solutions (ah!, money, pride) and not seek (yes, you have to work at it) thoughtful and sustainable solutions. The Commonwealth Fund recently released a report about consumer-directed health plans (CDHP) and lowering health care costs. I'm with the author, Karen Davis. For anyone interested in root causes (as in Dr. Davis' report), access, efficiency and quality, CDHPs don't offer very much.

What disastrous fire (as if tens of thousands of preventable deaths aren't enough) will lead to reconsideration of how to reconstitute our dysfunctional and disintegrated care model? I refer to the 1949 Mann Gulch, Montana, fire, in which 13 firefighters died, and the dramatic changes the Forest Service instituted as a result. Dr. Don Berwick of the Institute for Healthcare Improvement, describes the parallels in organizational thinking between Mann Gulch and health care in *Escape Fire*.

The lessons he draws are summarized in access (the promises we must keep), science (the knowledge we must apply), and relationships (the nature of help itself), challenging what it is that we produce.

Dr. Berwick challenges us to think differently about each element. The lessons of Mann Gulch – how the goals, premises, lines of thinking, and tools won't work when the situation is different than we perceive. In those situations, we need an “escape fire” – set aside what we think we know, what has worked in the past, what we have been taught – in order to escape and survive.

While a few are building escape fires, most are running up an impossible slope, in hopes of escape, carrying their useless tools, and likely not to reach the top.

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Donald M. Berwick, all rights reserved.
Published by The Commonwealth Fund. 🍏

Policy Perspective

by John Steen, Consultant, Health Planning and Health Policy

State regulators, and Certificate of Need (CON) staff in particular, should take note of new validation for the regionalization of open heart surgery programs in order to achieve superior patient outcomes through adequate procedure volumes. The report appears in *Circulation: Journal of the American Heart Association*, Aug 2004; 110: 784 - 789: "Is the Impact of Hospital and Surgeon Volumes on the In-Hospital Mortality Rate for Coronary Artery Bypass Graft Surgery Limited to Patients at High Risk?" and online (accessible at <http://circ.ahajournals.org/cgi/content/full/110/7/784>) This is just the latest in a series of research reports confirming the now well-established relationship between procedure volume and outcomes for this relatively high-risk operation. However, it is more specific than previous studies with regard to the relation of outcomes to volumes for both hospitals and surgeons, differentiating those outcomes by patient risk.

The researchers divided hospitals into volume groups based on a threshold for annual number of bypass operations at 200, 300, 400, 500 and 600. Surgeons were grouped according to thresholds set at 50, 75, 100, 125, and 150. The lowest risk of death was seen when coronary artery bypass graft (CABG) was performed by high-volume surgeons and a high-volume hospital. For example, even low-risk patients operated on by a surgeon with an annual caseload of at least 125 at a center with an annual volume of >600 were 48% less likely to die than their peers operated on by less-experienced surgeons at lower volume centers.

The death rate for moderate- and high-risk patients was 38% lower at higher-volume hospitals compared to hospitals with annual CABG volumes less than 200. The disparity in mortality risk between low and high volumes narrowed as the defining volume threshold increased. "For both risk groups, patients in hospitals with a volume above any threshold consistently had lower observed mortality rates than those in hospitals with a volume below a threshold," said lead author Chuntao Wu, M.D., Ph.D., a research scientist and an assistant professor of epidemiology in the School of Public Health at the State University of New York in Albany. Co-authors of the report are Edward L. Hannan, Ph.D.; Thomas J. Ryan, M.D.; Edward Bennett, M.D.; Alfred T. Culliford, M.D.; Jeffrey P. Gold, M.D.; O. Wayne Isom, M.D.; Robert H. Jones, M.D.; Barbara McNeil, M.D., Ph.D.; Eric A. Rose, M.D.; and Valavanur A. Subramanian, M.D.

At most volume thresholds examined, high provider volume was associated with a significantly lower in-hospital death rate for patients at all levels of risk. "For all patients, not just those at high risk of mortality, high-volume providers – both hospitals and surgeons – are associated with a lower risk of death," said Wu. Previous studies have found that the benefit of high-volume hospitals is limited to high-risk patients. This has led to the suggestion that only high-risk patients be referred to high-volume hospitals. "Our findings support applying a volume-based referral to all bypass patients, not just those at high risk, when there are no better quality indicators available," Wu said. "But performing most bypass surgeries in high-volume hospitals could overburden them and cause hardships for many patients." He and his colleagues said it would be better to improve the quality of care at all hospitals than to send most bypass patients to high-volume medical centers. They note that a volume-based referral could

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Policy Perspective

Hope, Faith and Charity
Cont'd. from page 2:

Charity, too, is suspect. In the form of the internal cross-subsidies endemic in the current system, charity is even more corrosive than insurance schemes. Competition and subsidies simply are not compatible: "Competitive markets compete away the higher prices and supra-competitive profits necessary to sustain such subsidies." Robust competition should be favored over cross subsidization as "it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent."

A careful reading of *Improving Health Care* suggests that, all of the system issues discussed notwithstanding, the underlying problem is that too many of us do not have the courage or wit to treat health care as a commodity. The report laments that the public, both national and international, and many providers of health services see health care as an essential social good that should be available "without regard to ability to pay." Similarly, many if not most of us "perceive risk-based premiums for health insurance to be inconsistent with obligational [sic] norms and fundamental fairness." So, if you persist in placing societal interests and a misguided sense of fairness and equity over economic doctrine, how can you ever expect to "improve" health care?

Unfortunately, combating the pernicious effects of *Improving Health Care* will be far more difficult than mocking its faults. The attitude and assumptions underlying both the report and the process used to generate it all too accurately reflect both the day-to-day political reality, and the surreal environment, that is Washington, DC, today. One observation illustrates current Washington sensibilities. As they solemnly chastise us for our over dependence on insurance and subsidies, for our general lack of self reliance, and for our overly sentimental view of health care, the more than 1,000 officials and staff of the FTC are among the best insured people in the U. S. It is highly unlikely anyone reading this is now, or ever will be, as well insulated from the rigors and negative effects of a market driven system as the authors of this report.

Paul the Apostle held that faith, hope and charity are the three great virtues one should live by, and that the greatest of these is charity.

Apparently, our FTC-DOJ friends have yet to tread the road to Damascus. They see clearly: insist on blind faith in economic theory of questionable relevance, relegate charity to prescribed orthodox channels, and dismiss hope as benighted sentimentalism.

Improving Health Care is by any measure a doctrinaire treatise. It is and will remain for some time a force to be reckoned with. The ideas underlying the report are being pursued daily and enthusiastically by a host of Washington power centers (e.g., lobbies, conservative think tanks). These forces, and the FTC, have shown disdain for planning and have actively opposed CON regulation for decades. That will not change. Their views must be confronted in all appropriate settings. A detailed AHPA response to *Improving Health Care* will be posted on the AHPA website soon. We invite your involvement and help.

1Improving Health Care: A Dose of Competition.
A Report by the Federal Trade Commission and the Department of Justice, July 2004. All language in quotation marks is taken directly from the report. The full report is available at <http://www.ftc.gov>. 🍏

Policy Perspective

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increase the travel difficulties and expenses for many patients, and further reduce the number of patients treated at low-volume hospitals. "Thus, it is preferable to improve outcomes by identifying processes of care associated with superior outcomes, and implementing these processes in both high-volume and low-volume hospitals rather than to refer all patients to high-volume centers," Wu said.

The researchers examined the records of 57,150 patients who had bypass surgery without other major heart procedures during 1997-99. They used data collected by the New York State Cardiac Surgery Reporting System, which has registered bypass patients and outcomes for operations in the state since 1989, and publicly reported those outcomes by hospital and surgeon. This encourages each of its hospitals to engage its CABG teams in continuous quality improvement.

Among all the patients, 1,260 (2.2%) died in the hospital – 312 (0.79%) low-risk patients, and 948 (5.37%) moderate-to-high-risk patients. 🍏

Convey the Message - Creatively!

by Sandra A. Walczak, Vice President
Partnership for Health and Accountability (PHA), Georgia Hospital Association

With assistance from the Partnership for Health and Accountability (PHA), Georgia's hospitals are "getting the message out" using creative and innovative bulletin boards.

With the many hats that every hospital employee has to wear, finding the time to create visual educational tools is difficult. Additionally, many small hospitals do not have the same resources, such as an in-house graphics department that larger hospitals may have. Despite their small size, those hospitals still need to keep staff and patients informed and up-to-date.

In response to these issues, the PHA developed a bulletin board initiative that began during Patient Safety Week in 2003. PHA developed a visual concept to help hospital visitors learn general information on health issues and better methods of preventive health measures and to help staff understand current regulations and hospital culture.

"We wanted to create catchy visual aids that both fit into the PHA mission as well as meet hospital needs," said Jan Potter, PHA Safety Communications Specialist. "We created them to match our community outreach topics of heart, asthma, diabetes, obesity, cancer and health literacy, and we created them in a way that hospitals with limited resources could simply download them and print them."

The community bulletin board topics include: asthma, eye injury prevention/fireworks safety, immunization, obesity, smoking cessation, influenza, heart, deep vein thrombosis, cancer control, GUARD (Georgia United Against Antibiotic Resistant Disease), SARS, health literacy, cholesterol education, diabetes, healthy eating, taking your medications and germs.

The bulletin boards have allowed PHA to work collaboratively with other organizations, such as the Department of Human Resources and the Guard Coalition. Together, PHA and DHR created the SARS bulletin board and the GUARD bulletin board was created through a partnership with the Guard Coalition.

"We decided to create community bulletin boards that are geared toward a team mentality," explained Potter. "We want patients to be responsible for their health – to be aware, be on the team, and do what they can do to be healthy. We also designed the bulletin boards to be low-literacy, meaning there are a lot of graphics and little text, so they are appropriate for all patients."

The staff bulletin board topics include: JCAHO 2004 Patient Safety Goals, change your culture, core measures and SARS for the staff. In conjunction with the staff bulletin boards, PHA has created posters and board games that can be used for staff training or to emphasize patient safety week.

The bulletin board initiative has been successful and has left Potter busy meeting the demand. "When the project began, we used the American Hospital Association calendar of monthly events to determine topics," she explained. "Now, when PHA staff visit hospitals or attend health care meetings, they are often approached by hospital personnel about new bulletin board ideas."

The ideas and requests have not been limited to Georgia hospitals – nine states, plus Canada and Japan are using PHA's bulletin boards.

The PHA website shows these completed bulletin boards with corresponding electronic files that hospital employees can download and print at their facility. To access the bulletin boards, see <http://www.gha.org/pha/resources/bulletinboards/index.asp>.

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The PHA is a statewide, voluntary patient safety program. Active since 2000, all 151 of the acute care hospitals in Georgia actively participate in the program. 🍏



Wizard's Corner

FTC Health Care Consumer Protection: A Newt's Eye View

Your Wizard is away, on temporary assignment as George Bush's syntax coach. Ever helpful, the Wizard has prevailed upon his maternal great aunts, spiritual advisors to Scottish kings and U. S. vice-presidents, to offer a glimpse of their health policy advice to their most recent clients, the U. S. Federal Trade Commission and Department of Justice.

First Witch

Round about the cauldron go;
In the **poison'd entrails** throw.
Toad, that under cold stone
Days and nights has thirty-one
Swelter'd venom sleeping got,
Boil thou first i' the charmed pot.

ALL

**Double, double toil and trouble;
Fire burn and cauldron bubble.**

Second Witch

Fillet of a fenny snake,
In the cauldron boil and bake;
Eye of newt and toe of frog,
Wool of bat and tongue of dog,
Adder's fork and **blind-worm's sting**,
Lizard's leg and owl's wing,
For a **charm of powerful trouble**,
Like a **hell-broth boil and bubble.**

ALL

**Double, double toil and trouble;
Fire burn and cauldron bubble.**

Third Witch

Scale of dragon, **tooth of wolf**,
Witches' mummy, maw and gulf
Of the ravin'd salt-sea shark,
Root of hemlock digg'd i' the dark,
Liver of blaspheming Jew,
Gall of goat, and slips of yew
Silver'd in the moon's eclipse,
Nose of Turk and Tartar's lips,
Finger of **birth-strangled babe**
Ditch-deliver'd by a drab,
Make the gruel thick and slab:
Add thereto a tiger's chaudron,
For the ingredients of our cauldron.

ALL

**Double, double toil and trouble;
Fire burn and cauldron bubble.**

from Macbeth, Act 4, Scene 1

Match the TUNE to the TALE

Subsidies [*poison'd entrails*]: "Competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care. Governments should consider whether current subsidies best serve their citizens' health care needs." * (Ex Sum, 23)

Doctrine [*eye of newt*]: "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty - even when complex products and services such as health care are involved." * (Ex Sum, 28-29)

Self-Referral [*adders fork*]: "These single-specialty hospitals (SSHs) differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility. The Agencies [FTC & DOJ] encourage further research into the competitive significance of SSHs, including whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs."* (Chapter 3, 18)

CON Regulation [*blind worm's sting*]: "... CON programs risk entrenching oligopolists and eroding consumer welfare." * (Chapter 8, 6)

Medicare [*charm of powerful trouble*]: "Government-administered pricing by CMS inadvertently can distort market competition." ... "Medicare's administered pricing system has substantially driven the emergence of SSHs [single specialty hospitals] and ASCs [ambulatory surgery centers]"* (Ex Sum, 20 & 28)

Service Volatility [*hell broth boil and bubble*]: "... robustly competitive markets in which entry and exit is determined by market forces maximizes consumer welfare."* (Chapter 3, 28)

Health Insurance [*tooth of wolf*]: "Third-party payment of health-related expenses can distort incentives and have unintended consequences. The result is that insured consumers have limited incentive to balance costs and benefits and search for lower cost health care with the level of quality that they prefer." * (Ex Sum, 9)

Benighted Benevolence [*root of hemlock*]: "Many members of the public and many health care providers view health care as a 'special' good, not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay." * (Ex Sum, 7)

Self Reliance [*birth-strangled babe*]: "A large majority of consumers purchase health care through multiple agents. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests." * (Ex Sum, 11)

*For more see: **Improving Health Care: A Dose of Competition**. A Report by the Federal Trade Commission and the Department of Justice, July 2004. The full report is available at <http://www.ftc.gov>. 🍏



American Public Health Association
**Community Health Planning and Policy Development (CHPPD) Section
Annual Conference Sessions conducted by AHPA members**

Wednesday, November 10, 2004

8:30 AM-10:00 AM

5019.0

Health Planning Today: A Way Forward (Oral)

Health planners in all sectors must respond to an increasingly diverse and complex health care system. The utility and effectiveness of traditional planning methods and processes are being challenged. This session would explore the current state of community-based health services planning and propose strategies for making planning more effective by responding to changing social and market conditions. Principal topics and questions to be explored include:

- Evidence based health services planning and regulation;
- Integration of public and private planning efforts;
- Common methods and processes used to
 - Insure a community focus and orientation in program planning and service development,
 - Expand access and assure quality,
 - Promote patient and service provider equity,
 - Preserve community health care assets,
 - Obtain and intelligently apply health care data and information; and
- AHPA's web-based ePlanner initiative in support of community and population-based planning and regulation.

The session would entail brief presentations (15-20 minutes) from three practicing planners, each from a different setting and offering a distinct perspective on the health care system and on the current state of planning. Substantial audience interaction would be expected and accommodated.

Learning Objectives: Attendee should gain a better understanding of 1. The value of systematic planning in meeting health care needs efficiently; 2. The evolution of planning in response to changing economic, political and technological environments; and 3. The value and potential of systematic planning as a tool to integrate public and private health initiatives.

See individual abstracts for presenting author's disclosure statement and author's information.

Organizer(s): [Dean Montgomery](#)

8:30 AM: [Maryland Community-based Planning Initiatives](#)
Paul Parker, MPH

8:50 AM: [Evidence Based Health Services Planning](#)
Dean Montgomery, MSPH, MA

9:10 AM: [Health Planning Data: Sources, Methods and Uses](#)
Richard K. Thomas, PhD

Organized by: [Community Health Planning and Policy Development](#)

CE Credits: Health Education (CHES)

12:30 PM-2:00 PM Wed

5094.0

Certificate of Need Challenges:

Efficient Management in a Competitive Marketplace (Oral)

Certificate of Need (CON) regulation has been controversial since its inception in 1964. The debate over

competition vs. regulation continues unabated, particularly around the following questions:

- Can government oversight use supply-side management, service cooperation and public understanding to improve access, assure quality and restrain costs?
- Can health care providers, by serving highly profitable niche markets, produce better treatment outcomes and lower costs and charges than those operating in planned franchise environments?
- Can a reasonable balance be drawn between public planning and regulation, and private investment and innovation to achieve reasonable health care delivery?

This session would bring together three active health care leaders (to be selected by July) representing states with and without CON. The format would include 20-minute presentations of individual perceptions and experiences, followed by an interactive debate and audience questions. As moderator, I would draw upon the knowledge gained from 15 years of monitoring CON programs around the United States, plus information from numerous studies and surveys. With 36 states (plus the District of Columbia) administering CON programs, the diversity of experience and varying program results are instructive. This would bring to bear the involvement of the American Health Planning Association, which has a long history of advocating sound community-based planning and implementation, as well as a new Internet "ePlanner" initiative.

Learning Objectives: After attending this session, the participants would be: 1.Aware of a number of planning methods to assure a healthy community; 2.Better prepared to assess the value of cooperative planning and regulation in their community; and 3.Able to weigh, and participate in, the debate over managed care vs. planning and regulation.

See individual abstracts for presenting author's disclosure statement and author's information.

Organizer(s): [Thomas R. Piper, BA](#)

12:30 PM: [Can government oversight assure greater value for the public's health care dollars?](#)
John W Steen, PhD

12:50 PM: [Can a reasonable balance be drawn between public planning and regulation, and private investment and innovation to achieve reasonable health care delivery?](#)
Michael K. Dexter

1:10 PM: [Outcomes of regulation versus competition: Enabling information access, assessment modeling, and outcomes evaluation with ePlanner, a community health planning tool](#)
Robert Vogel, MPA

Organized by: [Community Health Planning and Policy Development](#)

CE Credits: Health Education (CHES) 🍏

(visit www.apha.org/meetings for registration and other information)