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President's Message

A Bit of History¹

by **John Steen**

The time seems right for a bit of reflection on the history of health planning. What led me to this subject is the passing of Dr. Henrik Blum, who is known at Berkeley as "The Father of Health Planning" and was surely its most devoted mentor. Along with Dr. Herman Hilleboe, Dr. Leonard S. Rosenfeld, Robert M. Sigmond and others, he first outlined the principles and methods we know as health planning some forty years ago.

Dr. Henrik L. Blum, professor emeritus of health administration and planning at the University of California, Berkeley, and a champion of public health as social justice, died on January 3, 2006 at his home in Oakland, California at the age of 90. Among his contributions is that of using community organizing skills along with social and economic concepts in the development and implementation of health care delivery and health policy.

From 1950 to 1966, he served as Health Officer of the Contra Costa County (California) Health Department. There he learned principles, novel to planning at the time, that he taught

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A Bit of History

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concurrently as a lecturer at UC Berkeley: effective health planning requires a thorough knowledge of the many environmental, social, cultural, economic, and educational forces that shape a community, and the community's participation is essential to the resolution of its problems. He believed that health services should be located where most needed so as to best



Henrik L. Blum, M.D., M..P.H.

serve as resources in those communities, and among those he helped to establish there are vision screening in schools, community mental health, and genetic counseling. Concurrently, he published on subjects such as diabetes detection, genetic counseling, school lunch programs, mental health,

vision screening, safety education, and fluoridation of water. Public health practice at the time took a medical perspective on communities, seeking primarily to eradicate and prevent the spread of infectious diseases. His approach was to see the community itself as his patient.

It was in 1966, when he joined the faculty of Berkeley's School of Public Health as a clinical professor, that Blum foresaw the development of a national health system, one that would involve consumers and providers in shaping health care policy and health care delivery. In 1968, Blum became a professor of community health planning. In 1970, he established the school's Program in Planning and Policy, chairing the program until his retirement in 1984. In 1985, he was given the American Health Planning Association's Schlesinger Award.

An example of his influence in health planning is the Orange County Health Planning Council, which was the designated Health Systems Agency for Orange County, California under Public Law 93-641 (1974). Several members of the Council staff were his student graduates, and Dr. Blum's planning concepts were incorporated into much of its work. Its publications served, in turn, as teaching materials for his classes in health planning. He was also one of the founders of the Western Center for Health Planning, in San Francisco.

He was the author of three seminal texts focusing on the health needs of communities: *Public Administration: A Public Health Viewpoint* (1963), *Planning for Health: Development and Application of Social Change Theory* (1974), and *Health Planning; Notes on Comprehensive Planning for Health* (1968), which was the first set of readings ever published on health planning, and a landmark in its field.

Antecedents

It is well to be reminded that health planning arose out of communities with its roots both in public health and in medicine. And to find its antecedents, we need to go to Rochester, NY, where a form of health planning can be traced back to 1918, when its Community Chest Plan was established. In the 1920s, the Plan's executive committee reviewed requests for hospital capital fund drives. In the 1930s, administrators of six local hospitals began to meet formally to discuss problems. In 1936, The Community Chest commissioned a series of studies of health care in Rochester. In 1939, the Rochester Hospital Council was incorporated by the six local hospitals.

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Health Service Ownership and Operations For-profit vs Nonprofit

by D. Montgomery

Does the ownership of health care services matter? Is ownership a factor worthy of consideration in planning for health care services? A recent *Health Affairs* article reviews the body of evidence on the differences between non-profit and for-profit health care.

The authors found quality, cost and access differences between non-profits and for-profits for all services studied, that the effects of ownership vary considerably by service and setting, and that the effects of ownership “manifest in different ways for different services.” It is noteworthy that a subset of four characteristics appears to be related to ownership:

- For-profits mark up prices more aggressively and are more likely to maximize revenue than nonprofits;
- Non-profits are less likely to make misleading claims or to treat vulnerable patients differently than are for-profits;
- Nonprofits are more likely to be incubators of innovation in service delivery than for-profits; and
- Nonprofits react slower to change than for-profits, thus are less likely to expand capacity quickly or to eliminate services if profitability decreases.

These findings are consistent with, and reinforce, those reported earlier by a number of investigators, especially those examining ownership differences among acute care community hospitals. Principal differences reported in those studies are summarized below.

Quality Differences

Quality differences among hospitals, as measured by mortality rates, have been examined for more than two decades. The most notable recent statement on mortality differences between non-profit and for-profit hospitals came from Canadian researchers in May 2002. They undertook a systematic identification and analysis of the studies published on the question. More than 8,000 citations were identified. Examination of all of these articles resulted in the identification

of more than 800 publications that were subjected to full review by at least two separate research teams. Applying strict eligibility criteria, 13 publications containing 15 studies were identified that contained sufficient comparable data to permit the information to be pooled for a meta-analysis of the comparative mortality experiences of for-profit and nonprofit community hospitals.

Data in these studies were collected over more than a decade, between 1982 and 1995, and all of the studies were performed in U.S. hospitals. The patient population base was more than 38 million. All of the studies were based on administrative (discharge) data, and most were of Medicare patient treatment outcomes. They include both in-hospital and post-hospital mortality. Of the studies included in the meta-analysis, 14 had shown independently a higher mortality risk among for-profit hospitals, and one a higher mortality risk among nonprofit hospitals. (See box below.)

The researchers summarized their findings clearly and succinctly:

“Our systematic review identified 15 observational studies that compared private for-profit

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| Risk-Adjusted Hospital Mortality Nonprofit vs For-profit Hospitals <u>Meta-Analysis</u> | |
|---|---|
| Lit. Citations Screened | 8,665 |
| Publications Examined | 805 |
| Hospitals (multiple years) | 26,399 |
| Patients | 36,402,558 |
| Studies Pooled | 14 |
| Study Years | 1982 - 1995 |
| Indicator, Measure | Hospital Mortality (Inpatient, 30-Day) |
| For-Profit Hospitals Increased Mortality Risk | 1.02 (higher relative risk of for-profits) |
| Confidence Interval (95%) | 1.003 - 1.038 |
| Source: <i>CMAJ</i> , May 28, 2002, p. 1399. | |

Health Services Ownership and Operations

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with private not-for-profit hospital mortality. These studies uniformly met quality criteria regarding adjustment for potential confounders, in particular, patients' severity of illness or surrogate markers of severity of illness, and complete accounting of deaths. Our pooled analysis of the adult population studies demonstrated that private for-profit hospitals were associated with a statistically significant increase in the risk of death.”

Payer Mix Differences

Many studies report that nonprofit community hospitals provide more charity care and serve larger numbers of uninsured patients and larger numbers of Medicaid patients than do for-profit hospitals. They document that for-profit hospitals admit and serve disproportionately large numbers of Medicare patients and other relatively well-insured patients, whereas non-profit hospitals have disproportionately large Medicaid caseloads. This pattern has held for many years.

Service Mix Differences

Nonprofit community hospitals provide a wider array of services, including services on which the hospital incurs operating losses, than for-profit hospitals. Investor-owned system hospitals offer fewer unprofitable services than nonprofit system hospitals. This pattern holds for hospitals that are sole community providers, with the differences more pronounced in markets with limited competition.

Economic Operations Differences

There is substantial evidence that, on average, for-profit hospitals have higher operating costs than community nonprofit hospitals. Although nonprofit hospitals usually have higher numbers of full-time equivalent (FTE) employees per bed and somewhat longer average lengths of inpatient stays, average costs and charges and operating margins are usually higher in for-profit hospitals.

Some studies suggest that much of the difference in economic performance between nonprofit and for-profit hospitals is attributable to higher administrative costs among for-profits. One widely reported multi-variate study concluded that for-profit hospitals have

23% higher administrative costs than comparable non-profit hospitals. An associated analysis found that for-profits have higher total costs per inpatient day and per discharge, and that higher administrative costs accounted for most of the difference.

Regardless of the measurement, the weight of the evidence indicates that, in general, for-profit hospitals are more risky, more costly, more profitable, and provide less charity care than nonprofit facilities.

These findings and those just published in *Health Affairs* are a timely reminder, if any were needed, that planners and others trying to meet the health care needs of a community should consider ownership and all that it may entail.

¹M. Schlesinger and B.H. Gray, “How Nonprofits Matter in American Medicine, and What To Do About It,” *Health Affairs* 25 (2006): w287-w303 (published online 20 June 2006; 10.1377/hlthaff.25.w287).

²*Ibid.*

³It should be noted that the researchers also identified a number of other publications that dealt with the question of comparative mortality in nonprofit and for-profit hospitals, but did not contain sufficient data that met the necessarily strict eligibility for inclusion in the meta-analysis. They note that all of these studies report favorable findings for not-for-profit hospitals. 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.” *CMAJ*, 166 (11), (May 28, 2002), p. 1401.

⁴Devereaux, et. al., “A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals.” *CMAJ*, 166 (11), p. 1402.

⁵Arrington, B and Haddock, CC. “Who Really Profits from Non-Profits?” *Health Services Research*, (June 1990): 291-304. ♦



Primary PCI in Maryland Hospitals Without On-site Cardiac Surgery

by Paul E. Parker

Debate and discussion surrounding the utility of Certificate of Need-style regulation of medical care facilities and services over the last decade has often touched on the potential for using something akin to facilities licensure as an alternative to CON. In general, this is usually described as an alternative to traditional CON regulation, allowing for less restricted levels of market entry to establish new clinical service programs. This alternative involves the use of an ongoing process of monitoring how programs are functioning to assure quality of care, rather than relying on more direct limitations on the number of programs, à la CON, to achieve higher volumes of service and, thus, a greater likelihood of skillful and consistent service provision.

Recent developments in the regulation of primary or emergency angioplasty under Maryland's CON program can be viewed as providing some insights on how one regulated service sector, interventional cardiology, may be evolving in this direction.

In 1996, Maryland hospitals participating in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) received a waiver from the requirement in Maryland CON regulation, identical to that found in many states, that percutaneous coronary intervention (PCI) only be performed in hospitals with on-site cardiac surgical backup. Clinical evidence from C-PORT and other research, and work with a cardiac advisory committee, led to the adoption in Maryland of a waiver program for Maryland hospitals without on-site cardiac surgery to establish "primary" PCI programs, i.e., PCI performed on an emergency basis for specific types of patients presenting to a hospital with acute myocardial infarction. In May 2006, the first group of seven hospital applications for this waiver

were reviewed by the Maryland Health Care Commission, which, among other things, is the state's CON agency. All were Baltimore-area facilities that had participated in C-PORT.

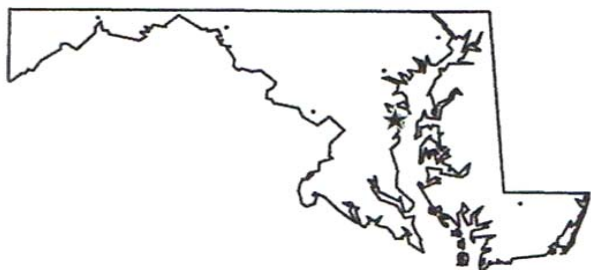
Obtaining a waiver requires demonstrating compliance with a number of requirements touching on the areas of institutional resources, physician resources, minimum volumes of appropriate patients and minimum volumes of primary PCI provision. Among these requirements are:

- The availability of primary PCI as routine treatment of choice for all appropriate patients 24 hours per day, seven days per week;
- Provision of primary PCI as soon as possible and not to exceed 120 minutes "door to balloon," for 80% of patients;
- Formal, written agreement with an advanced cardiac life support EMS provider that guarantees arrival of the air or ground ambulance within 30 minutes of the primary PCI hospital request;
- A minimum of 75 PCI cases for all physicians performing primary PCI (consistent with ACC/AHA criteria for competency); and
- Performance by the hospital of a minimum of 36 and, optimally, 49 primary PCI procedures annually. The lower volume applies to areas of the state where access to high volume programs is not readily available.

Additionally, all hospitals obtaining a waiver must participate in supplying information to an ongoing PCI data base that will be used to monitor process and outcome measures.

Only one of the seven hospitals in the first round of waiver application reviews obtained an unconditional two-year waiver based on full compliance with the requirements. The other six all exhibited some level of non-compliance with the requirements and received conditional, one-year waivers. Failure to meet the standard "door-to-balloon" time of 120 minutes or less for at least 80% of primary PCI patients was a defect in all

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Response to Review of *The U.S. Healthcare Certificate of Need Sourcebook*

by Robert James Cimasi

In the AHPA's 4th Quarter, 2005 issue of this newsletter, an anonymous article on *The U.S. Healthcare Certificate of Need Sourcebook* was published. While as an AHPA member and author of this book I was both taken aback and extremely disappointed in reading the unwarranted *ad hominem* attack couched as a critique of the work, I am always willing to accept constructive criticism and suggestions to improve my work going forward. However, I am not willing to sit back and accept the anonymous author's outright defamation and libelous attack on my character and integrity and the false characterization of my work as "chicanery." The following is my response to the anonymous article's allegations and criticisms.

The *Sourcebook* is the result of over two years of dedicated, focused research resulting in a comprehensive reference manual and sourcebook encompassing elements of the statutory, regulatory, administrative, and legal aspects of Certificate of Need (CON) regulation, from its inception to the present. Hundreds of hours of independent research, review, and analysis were performed in the development and production of this one-of-a-kind work.

The *Sourcebook* provides detailed descriptions, on a state-by-state basis, of significant elements of CON regulatory requirements, including such items as application thresholds, contact information and utilization data. Comprehensive bibliographies are also included: listings of thousands of published monographs; serials; professional and trade journal (as well as general press) articles; research studies; published case law; and law review and bar journal coverage of CON related topics. The work also includes compendiums of internet-based and other data resources, a thorough glossary of CON terminology, and contact information for various research organizations and health care economists who have contributed to CON research. The *Sourcebook* is indexed, and supplemented with numerous schedules.

While the anonymous article asserts several general colorful (however petty and unsupported) criticisms of the *Sourcebook*, such as, the "509 page, 2 ½ pound blunderbuss is largely a book of redundant lists and a source of much nonsense, though amusing nonsense in

places," and "exotic nonsense" [emphasis added], I believe that such comments are not deserving of a response in this forum. However, the anonymous article also makes two serious false and defamatory accusations regarding the academic integrity of the *Sourcebook* (as well as my character, as author) that need to be specifically addressed. First, the anonymous article states on page 6 that:

"The information is presented clumsily, and there appears to have been generous borrowing from AHPA sources, especially, the *National Directory of Health Planning, Policy, and Regulatory Agencies*. This section, too, is replete with errors and misinformation. Many of the errors appear to result from misinterpreting data and information gleaned from state CON program websites and the *AHPA Directory*. For example, the entry for the State of Virginia indicates that linear accelerators are not subject to CON review, but radiation therapy services are. A substantial part of the information presented is inaccurate or misleading." [emphasis added]

Data related to the specific elements of the various states' CON regulations and programs was independently researched utilizing a thorough analysis of each state's CON statutes and regulations, as well as other published sources. It is presented in a straightforward and logical organization allowing for quick reference. No information was plagiarized from any source, and the anonymous author of the *Health Planning Today* article has gone beyond the bounds of legitimate criticism in writing and publishing such a false and defamatory characterization of the *Sourcebook* in accusing me of plagiarism, and any assertion to the contrary is false and intolerable.

The only alleged error specifically referenced by the anonymous author concerns the source of the data related to the status of linear accelerator regulation in Virginia. The anonymous article asserts, "[f]or example, the entry for the State of Virginia indicates that linear accelerators are not subject to CON review, but radiation therapy services are. A substantial part of the information presented is inaccurate or

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POLICY PERSPECTIVE

By John Steen

Certificate of Need

In Pennsylvania, State Rep. Phyllis Mundy, D-Kingston, has introduced a bill that would re-establish a certificate of need program for the state. Her efforts toward that end in last year's legislative session failed to receive enough support to succeed, but the state's business sector has expressed renewed interest in cost containment measures over the past year, and state regulation is one of those measures. The escalating cost of health care, coupled with the significant increase in ambulatory surgical centers, diagnostic imaging, and other specialty services, has revived the debate about renewing the program. "The goal is to rein in the technological arms race we are engaged in here in Northeastern Pennsylvania," Ms. Mundy said, and she continued:

"It is more clear than ever that we must restore the certificate of need law that expired in 1996. There is plenty of unneeded duplication that is driving up the cost of health care for families and businesses. For example, the number of MRI units in Pennsylvania increased 47 percent from 1999 to 2001. Each one of these units costs an average of \$2 million to buy and \$800,000 per year to run. The Pennsylvania Health Care Cost Containment Council reports that the number of MRI scans increased from 9.3 million to 13.5 million between 1999 and 2001. This 45 percent increase is estimated to have cost \$3.4 billion, according to the Blue Cross Blue Shield Association."

Mundy's bill (H.B. 2618) would re-enact the certificate of need program as it existed before its sunset in 1996 with a number of particularly progressive additions and changes. The bill would:

- Create local review committees to review certificate of need applications and make recommendations to the Department of Health. The local review committees would be made up of local or regional groups of consumers, business, labor, health care providers, payors or other affected interests.
- Require applicants to submit a data-based cost analysis showing that there is not a more appropriate, less costly or more effective alternative of providing the proposed services and

that the proposed service will not have an inappropriate adverse impact on health care expenditures.

- Require the Pennsylvania Health Care Cost Containment Council to assist the Department of Health in the application review process.
- Create a "look back" provision to require the Department of Health to monitor quality of a facility one year after a certificate has been issued by requesting data from PHC4, including mortality rates and the number of procedures performed.
- Ban physicians from referring patients to any facility in which they have a financial interest. (In the case of scanning facilities, for example, self-referring physicians order two to eight times as many scans as do other doctors, according to HealthHelp, a radiologist management company.)

Dr. Ioana Popescu, from the University of Iowa Hospitals and Clinics in Iowa City, and two colleagues evaluated the relationship between CON regulations and outcomes of acute myocardial infarction (MI) in more than one million elderly Medicare beneficiaries admitted to 4,587 U.S. hospitals between 2000 and 2003.¹ The team found that rates of coronary revascularization 30 days after admission were lower in states with CON regulations than in states without such regulations. In states with CON regulations, patients with acute MI were 15% less likely to undergo revascularization during the first two days after hospital admission, and they were more likely to be transferred to another hospital for revascularization. They found no adverse effect on mortality for patients in states with CON despite the decreased utilization. According to Dr. Popescu, "by promoting development of high-quality clinical programs, these regulatory efforts may be important in creating centers of excellence and regionalizing health care delivery."

It is interesting to a policy analyst to hypothesize about what might be responsible for this. Might it be that:

- The higher patient volumes at hospitals in states with CON regulations result in greater

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Policy Perspective

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effectiveness and efficiency in care; and/or that

- The revascularization procedures themselves increase mortality?

And might this suggest some sort of congruence between the medical and regulatory cultures in CON states?

Quality of Care

The Institute of Medicine has concluded that problems with the quality of care are widespread and systemic and require a system-wide approach.² A new study³ confirms that, noting how much better the Veterans Affairs health system performs:

“Our previous study of the quality of care delivered in the Veterans Affairs health system illustrates some of the potential for improvement. In that system, with one of the country's most mature electronic medical-record systems, decision-support tools at the point of care, automated order entry, routine measurement of and reporting on quality, and financial incentives for performance, we found that participants received 67 percent of recommended care, a considerably better rate than the 55 percent observed in the current study.”⁴

None of the nation's other health systems have achieved the VA system's compliance rates for recommended care, rates such as a pneumonia vaccination rate of 94 percent, and a cervical cancer screening rate of 91 percent (both in 2005).

Uncompensated Care

On March 5, the CBS news program *60 Minutes* included a story about how most of the nation's hospitals charge their “highest prices, by far, to those who can afford it least — the 46 million Americans who don't have health insurance.” The program reported:

“Hospitals charge uninsured patients two, three, four or more times what an insurance company would pay for the same treatment. And, when the uninsured can't pay, they often find themselves the target of collection agencies or in bankruptcy court.”

As the growing numbers of uninsured (and underinsured) Americans have gained media attention, so has the uncompensated and charity care (“community benefits”) provided by hospitals. In a growing number of

states, the attorneys general have addressed the public welfare obligations of hospitals, even to the extent of taking legal action (or threatening same) against those that have been anything but compassionate in their billing of the medically indigent.

There is good reason why this resonated loudly in New York State, which has had no legislation requiring hospitals to provide financial assistance to patients and has suffered the travesties detailed by *60 Minutes*.



(Between 1971 and 1997, when New York set hospital rates, hospitals could not charge private pay patients more than 30 percent above *costs*.) In neighboring states like Massachusetts and New Jersey, hospitals are required by law to provide substantial discounts to patients who cannot afford to pay their hospital bills. All that could change now that New York State has just passed landmark legislation, awaiting the governor's signature, under which individuals with incomes at or below the federal poverty level (\$9,800 for one person) will only be subject to a nominal payment, while bills for patients between 100 percent and 250 percent of the poverty level will be based on a sliding fee scale. In addition, hospitals will be not be able to charge uninsured patients under 300 percent of poverty more than the rates they charge their largest group payor.

As progressive as this legislation is, it still fails to require a hospital's accountability to its community, the true standard of the communitarian ethic that guides health planning. Hospital governing boards should be required to review and approve all collection policies activated by the delivery of their hospital's services, and they as well as the state should review the amount of patient financial assistance provided on an annual basis. That assistance should be denominated in terms of hospital costs, not charges, independent of “bad debt” and shortfalls attributable to government and private third-party payors.

¹Ioana Popescu, MD, M.S. Vaughan-Sarrazin, PhD, G.E. Rosenthal, PhD, “Certificate of need regulations and use of coronary revascularization after acute myocardial infarction.” *JAMA* 2006; 295:2141-2147. <http://jama.ama-assn.org/cgi/content/abstract/295/18/2141>. Also see E.L. Hannan's editorial in which he suggests new research to answer some

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Response to Review

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misleading.” The anonymous article then immediately refers (in Footnote 3) to the second accusation of plagiarism in attacking the academic integrity of the *Sourcebook*, which states:

“As with most chicanery, there is a lesson to be learned here. If come exam time one finds it necessary to peak at a fellow student’s paper, craftiness and seat selection are critical. For reasons that preclude explication here, the AHPA *National Directory* has incorrectly reported a moratorium on development of long-term care beds in Virginia for nearly a decade. Serendipitously, *Source* reports the same stealth moratorium. The moratorium, imposed in 1987, was lifted 1995.”

Notwithstanding that the Maryland Health Care Commission reported in its October 25, 2000 publication *Certificate of Need Regulation of Nursing Home Services in the United States*¹ that Virginia had a moratorium on nursing homes between 1966-2000 (the year the report was issued) based in part on AHPA information, which the anonymous article asserts is incorrect, this snide and negligent allegation of plagiarism is both unfounded and defamatory. While Chapter 901 of the 1996 General Assembly of Virginia did amend and reenact Section 32.1-102.3.:3 of the Code of Virginia, relating to a moratorium on the issuance of certificates of public need for nursing home beds, to provide for applications for increases in nursing home beds in response to Requests for Applications, this amendment and reenactment (of note, approved *April 10, 1996*, not 1995 as asserted in the article’s Footnote 3) did not *repeal* the existing moratorium on nursing home beds, but rather, created a regulatory cap (limitation) on the number of beds granted CON approval and maintained a de facto moratorium.² The de facto moratorium depended upon the publication of Request for Applications (RFAs) by the Commissioner of Health. In specific, the state’s COPN Rules and Regulations contains a description in Section 12 VAC 5-220-345, “Limitation on acceptance of nursing home bed applications,” of the de facto moratorium on long-term care beds through the annual allocation of beds available for CON applicants within each of the “planning districts” by the State Health Commissioner, stating: “Applications for projects which would result in an increase in the number of beds in which nursing facility or extended care services are provided (see 12VAC5-22-325) shall only be accepted

for review when properly filed in response to an RFA.”³

Additionally, while the anonymous article falsely accuses the *Sourcebook* of “borrowing” information from the AHPA *National Directory*⁴ in reporting that there is a long-term care moratorium in Virginia, it simultaneously criticizes the *Sourcebook*’s entry for Virginia that indicates that linear accelerators are not subject to CON review despite the fact that radiation therapy is a covered service.

Linear accelerators and radiation therapy are listed separately in the *Sourcebook* as they are not synonymous. Radiation therapy is a service which may be provided using linear accelerators or other means. Because the Virginia Code did not specifically list “linear accelerators” as subject to CON, and referenced “radiation therapy” only,⁵ the *Sourcebook*, in contrast to the 2004 AHPA *National Directory*, which stated sixty-two (62) linear accelerators were currently regulated as of “Fall and Winter, 2003,” did not report that linear accelerators were specifically covered as equipment used to provide radiation therapy in Virginia. Thus, the anonymous article falsely asserts that the *Sourcebook* “borrowed” information from the AHPA *National Directory* pertaining to long-term care in Virginia and appears to suggest the *Sourcebook* at the same time ignored information from the AHPA *National Directory* pertaining to linear accelerators. Despite the seriousness of these false assertions, the anonymous article presents no other details on other alleged misleading inaccuracies or “errors and misinformation” in support of its defamatory and libelous attack on the academic integrity of the *Sourcebook* and my character as its author.

In addition to these egregious claims accusing the *Sourcebook* of chicanery and plagiarism, the anonymous article also spends much of its attack engaging in a capricious stylistic review of such insignificant issues as the font chosen for the main headings, as well as, the stylistic arrangement of the book and article bibliographies contained in the *Sourcebook*. In doing so, the anonymous article moves from the outrageous (defamation and libel) to the ridiculous nitpicking on font and layout in asserting:

“It is debatable whether the majority of the “books” listed are actually books. For example, 16 of the 126 are working papers developed by the

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Maryland Health Care Commission that have been posted on the Commission's website. The full list is a hodgepodge of monographs, planning documents, CON task force reports, CON review criteria and standards, and similar documents. The lengthier "article bibliography," with more than 2,000 listings, is even more idiosyncratic. It looks and reads like a hastily arranged computer search dump, with citations ranging from the sublime to the ridiculous. Some are outright duplications."

In fact, the *Sourcebook* bibliography of CON-related books contains references to books and related monographs, including reports, which are bound and catalogued. While one's definition of what may be described as a "book" is in the eye of the beholder, this unique listing of these resources spanning the history of CON regulation is a valuable addition to the work. The *Sourcebook* articles bibliography, rather than "a hastily arranged computer search," is a significant development and presentation of a compendium of articles published on CON related topics and is the result of years of research spanning the full range of professional publications as well as general media sources. This compilation required sending researchers to search and identify articles at university and public libraries, the use of inter-library loans, as well as bibliographic database searching. Given the fact that there are over 2,000 article citations, there may well be a few articles which have been published in multiple places, as well as possible duplication of an article, that were not eliminated in the editing process for this first edition. Every effort is being made to correct any duplication for future editions. The value of the *Sourcebook* as a resource is significantly in its comprehensive and unique and innovative listing of related CON information for the purpose of expediting research.

I believe the *Sourcebook* is unique in its scope and has received numerous favorable reviews as to its comprehensive treatment of CON-related topics. I am proud of the significant effort and investment that went into the production of this work and stand by its utility and value as a reference work for readers (whether providers, policy makers, regulators, researchers or scholars) of all types interested in CON matters. Because significant financial investment in

searching out, obtaining, and cataloguing the industry research for the *Sourcebook* will, in light of the accepted limited audience for such a book, preclude recovering through author's royalties, I undertook and completed this project as a contribution to fulfilling a resource gap for health care planning and health care administration professions. Within this context, the anonymous article attacking the *Sourcebook* and its false and defamatory *ad hominem* assault on character, published by the AHPA, was completely unfounded, unwarranted, and far beyond the pale of acceptable criticism. I am available and would be pleased to discuss any aspect of the *Sourcebook* with any AHPA member.⁶

¹"Certificate of Need Regulation of Nursing Home Services in the United States," Maryland Health Care Commission, October 25, 2000, Appendix A, Tables A1-A21, (Source: National CON Survey AHPA/MD, June 2000; Health Care Financing Administration, *Health Care Financing Review*, Summer 1993, Fall 1995, 1995 Supplement, Fall 1999, American Health Care Association, 2000).

²Virginia Code Ann., §32.1-102.3.2(A)-(B) (2004), as enacted by Chapter 901 of the General Assembly, H1302, Approved April 10, 1996.

³"12 VAC 5-220-345. Limitation on acceptance of nursing home bed applications" in "Virginia Medicare Care Facilities Certificate of Public Need Rules and Regulations" (12 VAC 5-220), Virginia Department of Health, amended July 1, 2003, p. 29.

⁴"National Directory of Health Planning, Policy and Regulatory Agencies," compiled by the Missouri Certificate of Need Program for the American Health Planning Association, February 14, 2004.

⁵Va. Code Ann. Sec. 32.1-102.1 (2004)

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A Bit of History

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These earliest planning efforts were also taking place in those cities, like Pittsburgh and Detroit, that were centers of major industries. The Hospital Planning Council of Greater New York was the first in 1938. But only eight such hospital planning councils were formed between 1938 and 1962. In most other communities, the earliest antecedents of health planning were occasioned by the Hill-Burton Act in 1946, which mandated states to assess the needs for hospitals and to establish statewide priorities for the allocation of funds for new hospitals. Hospitals receiving Hill-Burton funds were required to provide charity care to the medically indigent. In Rochester, the Council of Rochester Regional Hospitals was formed to upgrade health care in rural hospitals.

Mature community health planning in Rochester dates from 1961. In 1959, Rochester area hospitals initiated a drive to raise more than \$30 million to finance 500 additional hospital beds. In 1960-61, Marion Folsom (Vice President of Kodak, and former Secretary of the federal Department of Health, Education and Welfare) founded the Patient Care Planning Council to plan for Rochester's health care needs. He organized a committee of consumers, hospital administrators, physicians, and business and government representatives to assess the capacity needs of Rochester's hospitals objectively. Based on this assessment, the Council reduced the hospital drive's objective from \$30 million to \$14 million, and reduced the number of additional hospital beds from 500 to 140. This was the paradigm for New York's certificate of need program in 1964, the first state regulation of capital expenditures by hospitals and nursing homes, and the earliest model for state-regional linkage of planning and regulation.²

Amendments to the Hill-Burton Act in 1962 mandated the formation of state and regional health planning agencies with federal support. A voluntary not-for-profit network of regional health planning agencies in major metropolitan areas conducted needs analyses and advised states on construction priorities in their areas. Their numbers grew from eight in 1962 to 33 in 1964 and 50 in 1965.

Through the Partnership for Health Act of 1966, the federal government established Comprehensive Health Planning Agencies, and in Rochester the fol-

lowing year, the Wadsworth Committee was formed to study inner city health care needs. It recommended creating a network of neighborhood health centers. In 1973, with business support, three HMOs were established.

The 1974 National Health Planning Law then created the most extensive system of community health planning agencies, known as Health Systems Agencies (HSAs), the nation has ever had, following a template of one HSA for every one million people, on average, in each state. One of the 205 HSAs established was the Finger Lakes Health Systems Agency, in Rochester. In 1978, local hospitals established the Rochester Area Hospitals Corporation to promote continued cooperative planning among themselves. Beginning in 1980, along with insurers and government representatives, they managed community-wide hospital revenues and improved the solvency of their hospitals through the Hospital Experimental Payments Program (HEP). Throughout the decade, HEP established a global community-wide revenue cap for hospital-based inpatient and outpatient care.

These two historical streams of health planning – personal health in Rochester, and public health in California – have since come together around their common client, the community. In March 2004, the Finger Lakes HSA adopted a revised mission statement that moves from health systems analysis to seeking community solutions to problems of the health of the community, recognizing the broadened focus of the Agency that has been operationalized for at least a decade.

For more than a decade, the Alameda County Public Health Department in California has been moving away from a "service" to a "capacity-building" approach to public health. The Department is a leading practitioner of "the new public health," strengthening communities from within to play a greater role in their own health. It actively involves residents in the planning, evaluation, and implementation of health activities in their communities. To do this it has Community Health Teams in 10 neighborhoods across Alameda County, and it has taken to training community leaders to work with their own neighbors to address common concerns. And so, the focus of "the new public health" is community organizing, and the community is the patient.

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Primary PCI in Maryland Hospitals ...

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six proposals, and three of the six also failed to demonstrate “24/7” availability of primary PCI.

Like the traditional medical facilities licensure model, this CON waiver program requires an applicant to demonstrate compliance with certain minimum requirements and to obtain renewal of its waiver status on the basis of continued compliance. Unlike traditional medical facilities licensure, and more like CON regulation, there are minimum service volume requirements. And unlike either traditional facilities licensure or CON, there are quantified performance targets that must be met, in addition to more simple structural and process measures.

Effective use of this model will require the ongoing availability of meaningful information on program performance, quality, and patient outcomes. It will also require decision makers to establish policies and procedures that differ from those typically found in CON programs. Evaluating program performance on an ongoing basis, demarcating the border lines of performance that will define continued endorsement of a program or de-authorization, and actually making decisions to disestablish an existing service, rather than merely authorizing or denying a proposal to establish a program, pose challenges not typically found in traditional models of CON regulation. ♦

Policy Perspective

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of the questions raised by this study: “Evaluating and improving the quality of care for acute myocardial infarction. Can regionalization help?” *JAMA* 2006; 295:2177-2179. <http://jama.ama-assn.org/cgi/content/extract/295/18/2177>.

²Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Washington, D.C.: National Academy Press, 2001.

³Asch SA, Kerr EA, Kessey J, et al. “Who Is at Greatest Risk of Receiving Poor-Quality Health Care?” *New England Journal of Medicine*. 354(11): 1147–1156. <http://content.nejm.org/cgi/content/full/354/11/1147>.

⁴The previous study referred to: Asch SM, McGlynn EA, Hogan MM, et al. “Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample.” *Ann Intern Med* 2004;141:938-945. ♦

A Bit of History

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And that brings me back to Dr. Henrik Blum. In 1983, he gave us this insight into the political marginalization of health planning:

“Can there be meaningful health planning when so little else is publicly planned? It is my conviction that how health planning is set up is not altogether a result of special interest forces. Its mandate is determined by such societal forces as traditions, socioeconomic political outlooks, formal governance structures, and availability of resources. A society such as ours has strong anticollective biases, fears of government expressed as endless built in checks and balances, many levels of government, and many regional differences. Thus we will surely require, but have a difficult time developing, a strong national sense of direction that is melded with powerful state if not local participation to allow for ample variation in accordance with local needs and yet falls within nationally set goals. Our planning machinery is likely to be set up in just those ways that have allowed the health sector to create the problems that upset us so. Only under truly stressful shortages of resources, major calamities, or war are major changes going to be demanded of a given sector. That is what we are seeing today, and the official health planning machinery continues very much to one side of the action.³

The very same reasoning can be used to explain why we don’t yet have a national health care system.

¹A portion of this “Message” originally appeared in the American Public Health Association’s Community Health Planning and Policy Development Section Newsletter.

²In 1971, New York State became the first to set hospital rates, greatly strengthening that linkage.

³Book Review: “*Health Planning: Lessons for the Future*, by Bonnie Lefkowitz.” *Inquiry*, 20, 390, 1983. ♦

