CONSUMER HEALTH PERSPECTIVES

Vol. 5, No. 7 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. '72 Published Jan. 1979

Using the National Guidelines For Health Planning: A Consumers' Guide

With the passage of the National Health Planning and Resources Development Act of 1974 (the Act), health planning in the United States became the responsibility of a three-level system: the local Health Systems Agencies (HSAs); the State Health Coordinating Council (SHCC) *via* the State Health Planning and Development Agency (SHPDA); and the National Council on Health Planning and Development (National Council).

In order to help the local and state agencies formulate and fulfill their health planning objectives, the Act required that the Secretary of Health, Education and Welfare issue a series of "National Guidelines," that is, specific standards dealing with the organization and distribution of health resources (such as hospitals and major diagnostic and treatment technology) as well as with other subjects pertinent to achieving the national goal of "equal access to quality health care at reasonable cost."

In developing these guidelines, the Secretary was instructed to take into consideration the "ten national health priorities" which were identified in the Act as the major goals of the American health system:

1—the provision of primary care services for medically underserved populations

2—the development of multi-institutional systems for coordination or consolidation of institutional health services

3—the development of medical group practices, HMOs and other organized systems of providing health care

4—the training and increased utilization of physicians' assistants, especially nurse clinicians

5—the development of multi-institutional arrangements for sharing necessary institutional support services

6—the promotion of activities concerned with improving the quality of health service, including those identified by PSROs

7—the development of health service institutions able to provide various levels of care (including intensive, acute and extended care) on a geographically integrated basis

8—the promotion of activities for the prevention of disease

9—the adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions

10—the development of public education programs on proper personal health care (including preventive care).

Because of the very broad scope of the Priorities, the development and publication of National Guidelines will be a long-term, ongoing process requiring constant evaluation by those involved in health planning and delivery at all levels. Future issuances of the guidelines will deal not only with the distribution and use of physical resources and equipment, but with such subjects as equal access to services, health status of the population and development of primary and preventive services.

THE FIRST SET OF GUIDELINES*

The first set of guidelines were written in response to some of the immediate and pressing problems in the health system as cited by Congress when declaring its purpose in passing the Act. Of primary concern was the rapid inflation in the price of hospitalization, despite voluntary efforts by the private sector to control costs. The average hospital stay which cost $350 in 1965 now costs $1300. This figure, if inflation continues at the present rate, is expected to double in five years and to re-double in ten years.

An excess of hospital capacity in many regions (accompanied by low occupancy) has been identified as one of the factors in the sharp hospital cost increases. A boom in the acquisition and use of highly expensive and complex medical technology (e.g., intensive care and special surgery units, radiation therapy and dialysis equipment, computerized x-ray technology) have also increased the basic costs of treatment.

*Consumers should read the March 28, 1978 issue of the *Federal Register* for a full explanation of the process of drafting, public commentary and revision which resulted in the issuance of the Guidelines.

Written in pursuance of contract #PLD 0639478
DHEW, PHS, HRA

Some of the factors identified with the high cost of health care have also been implicated as causes of poor quality medical treatment. The presence of excessive hospital beds can create an incentive for hospitals and medical staff to admit patients whose need for hospitalization may be questionable. Similarly, where there is an overabundance of diagnostic and treatment equipment, too many tests can be ordered, too much (or inappropriate) treatment given.

Other non-cost related problems in the system were also addressed by Congress in the health planning legislation. Increasing specialization by physicians has meant that the public has less access to general, primary care; while migration of medical personnel away from both inner cities and rural areas has also adversely affected availability and quality of care in many communities.

The first set of standards present some immediate opportunities to address a number of these highly visible problems and to achieve improvements in quality, costs and efficiency in the short run. They set standards for the use and distribution of the following resources:

1. *General Hospital Occupancy Rates and Bed Supply*
   Standards setting a maximum ratio of hospital beds per thousand people and a minimum occupancy rate. (These standards do not apply to nursing home, long-term psychiatric facilities, or Veterans Administration hospital beds, nor to tuberculosis facilities.)
2. *Obstetrical inpatient care*
   A standard for consolidating maternity hospitalization services in a planning area, setting a figure for how many births hospitals providing these services should be able to accommodate.
3. *Neonatal Special Care Units*
   A standard for the optimal size and patient load of a unit providing intensive care to the low birthweight infants in a health service region.
4. *Pediatric inpatient facilities*
   A standard for the desired minimum occupancy rate in hospital departments caring for children other than infants.
5. *Open-Heart Surgery*
   For heart surgery requiring the use of a heart-lung bypass machine, a standard is set for the number of procedures a surgical unit should perform to keep up skills and keep down costs of maintaining the special technology and staff.
6. *Cardiac Catheterization Units*
   A standard for how many procedures should be performed per year to obtain economic regional utilization of this highly complex diagnostic procedure for x-ray visualization of the heart.
7. *Radiation Therapy*
   A standard for how many megavoltage radiation units are needed to treat cancer cases in a planning region.
8. *Computed Tomographic Scanners* (CT Scanners, CAT Scanners)
   A standard for judging how many scanners are needed to efficiently serve a planning region.
9. *End Stage Renal Disease Facilities*
   A standard to judge how kidney dialysis services can most efficiently be provided to those who need them in a given service area.

HOW ARE THE GUIDELINES TO BE APPLIED?

The Health Planning Act instructs the HSAs to give "appropriate consideration" to the National Guidelines in the development of their regional five-year Health Systems Plans (HSPs). The HSPs must be consistent with relevant standards set in the guidelines respecting supply, distribution and organization of health resources. In other words, the target goals which an HSA sets for its planning area must not exceed the maximums or fall below the minimum levels set in the Guidelines. Exceptions can be made, however, when justified by local conditions. For instance, the first standard, pertaining to general hospital beds, sets a maximum of 4.0 general hospital beds per thousand people. However, if a region has an especially large proportion of elderly persons (more than 12% of its population), it may be able to demonstrate that its bed needs are greater than the maximum set in the standard, since its older population uses hospitals at a higher than average rate. In such cases, adjustments to local health plans can be made, subject to the final approval of the State Health Coordinating Council (SHCC). Other special considerations have also been recognized in the guidelines—such as seasonal fluctuations in population, remote or rural location and presence of high-risk patient populations. In addition to those exceptions specifically mentioned, a general provision recognizes that there may be other special local conditions requiring plan adjustment. This is an aspect of applying the guidelines in which consumers should be involved. When HSPs are submitted to the SHCC and SHPDA for inclusion in the State Health Plan (SHP), all departures from the national standards must be accompanied by thoroughly analyzed support data.

Once goals have been established in the local HSP and the SHP, the next step is to use the guidelines in the individual decisions made in the planning process. It is anticipated that the guidelines, by setting quantitative target levels, will assist health planners and HSA members in evaluating the necessity for new or expanded services, technology and facilities. Since uninformed decisions to expand services may result in unnecessary duplication of resources or inefficient use of already constructed facilities, good guidelines are instrumental in producing educated decisions which will lead to high quality care and equitable distribution of available resources throughout the region.

The principal usefulness of a numerical standard set in the guidelines is that it can serve as an objective criterion, a standard of comparison against which local conditions can be evaluated. HSAs, sub-area councils, SHPDA and SHCCs can use the guidelines as reference points in many of their functions, including:

1. *Development of the Health Systems Plan (HSP)*
   The HSP is a statement of a region's general five-year goals for its health system. Arrangement of resources, encouragement of new programs and campaigns to improve health status are based on the HSA's estimate of current and future health needs of its population. In determining local need and in establishing local goals, the guidelines can and should be used as criteria with which local conditions can be compared and from which deviations in need of adjustment will become apparent.

For example: Based on the number of high-risk births, and maternal and infant mortality rates, the HSP may identify as a goal the development of neonatal and high-risk maternal services for its region. In determining the type and amount of services needed, reference would be made to the standards on neonatal care which indicate the number of beds or bassinets usually needed to serve a population with a given birth rate and other regional services such as obstetrics, which should be coordinated with such a unit, as well as the sort of facility in which such units might be best located.

2. *Development of the Annual Implementation Plan (AIP)*
   The AIP contains the HSA's yearly planning objectives and the specific means by which the agency plans to achieve them. As with the HSP, the guidelines and standards can be used as a basis for determining how resources can be created and distributed to meet the area's health needs.

For example: The national standard for hospital bed supply states that the maximum ratio under normal circumstances is 4.0 general hospital beds per thousand people. If a region has 5.8 beds per thousand and has no exceptional demographic circumstances which justify this high ratio, its AIP should reflect that as many health needs as possible will be met via the renovation and conversion of existing hospital space. Attention to the standards would alert planners that new inpatient construction as a means of meeting needs should be approached with extreme caution.

3. *Certification of Need (C/N) or 1122 review*
   Permanently designated HSAs have the function of reviewing institutions' applications to make capital expenditures of more than $150,000 (for equipment purchase, building or renovation or any other purpose). This project review process is called Certification of Need (where state law is operative) or 1122 review (where there is no state law and Section 1122 of the federal Social Security law is operative).

For example: In considering a hospital's application for purchase of a $500,000 CT scanner, the national standards on utilization levels of this x-ray technology should be consulted. If, for instance, there are other CT scanners in the immediate vicinity which are not being used at the level set in the guidelines (2,500 medically necessary procedures performed per year), the application for a new scanner may be rejected on that basis, and inter-institutional sharing arrangements should be considered.

THE VALUE OF THE GUIDELINES

The Guidelines provide an objective backdrop for the whole planning process and a vital technical aid for consumers in particular. The major advantages to formulating numerically specific, broadly applicable national standards can be outlined as follows:

Strengthening Consumer Participation on HSAs: To appreciate the potential value of the National Guidelines, especially for consumers, it must be briefly mentioned that the standards were issued partly in response to consumer experience with the previous federal health planning legislation. Before 1975, health planning in the United States had been conducted by regional boards which were created by the Comprehensive Health Planning Act of 1966 (CHPA). Like the current health planning Act, the CHPA strongly emphasized the concepts of consumer participation and region-wide cooperative planning of health services.

However, effective consumer participation in the CHPA system was hampered by consumers' relative lack of technical background in health planning and by the absence of sanctions to back any CHPA council decisions which might be regarded with disfavor in the provider sector. As a result, CHPA councils very rarely denied any institution's requests for construction, expansion or acquisition of equipment, so that the CHPA planning process did virtually nothing to control the explosion and intensification of the health services industry which was going on in the 1960s and early 1970s. Consumers had no objective standards against which they could evaluate the applications for new services which came before them, and they were without the technical capability to arrive at alternate plans of their own.

Therefore, in the legislative debates which preceded the passage of the 1974 health planning Act, consumers who had experience on CHPA boards were among those who testified most strongly to the need for clearly delineated National Guidelines.

Measuring HSA Progress. By clearly defining the goals and objectives for a planning region, HSA progress toward long-term goals can be objectively measured. For example, if an HSA determines that hospitals in its region are overbedded and under-occupied (using the national figures of 4.0 beds per thousand people and 80% occupancy rate as standards), it may seek to limit its hospital capacity over the long run. Progress toward this goal can be easily monitored, and any failure of the HSA to regulate additional hospital construction will be evident.

Achieving Public Accountability and Public Interest Advocacy. The setting of numerical standards and goals heightens the visibility of planning agency achievements and failures. Provider and consumer HSA board members can more easily be held accountable to the public for their decisions when the public has specific expectations of the HSP and AIP.

The requirement that local conditions be measured by the National Guidelines and geared to the goals of the Priorities will mean that deficiencies or inequities in the health system will become conspicuous. The attention which is drawn to medically underserved communities or to poor quality services should provide a basis for public interest advocacy.

When gaps or problems in the health system are uncovered in this way, consumers on HSA boards can encourage health institutions in the affected communities to submit applications for programs and facilities which will supply the needed services. Those institutions conducting health needs studies in their community, based on which they are developing plans for appropriate services, especially primary, preventive and home care services, and which have effective quality assessment/control/assurance programs, should be sought out and supported.

Improving Quality of Care. Since the Guidelines require planning agencies to make the most effective and appropriate use of limited resources, we should be motivated to carefully examine the quality of our delivery system. Many modes of delivering care have gone unquestioned for decades or longer. Discussion of how best to improve health status or access to health services may be stimulated by the guidelines' incentive to better organize services. In order for the HSAs to make such decisions responsibly, they must focus increased time on community health needs and determine the quality of existing services.

In seeking to meet national goals, the HSA can be a vehicle for promotion of alternatives in service delivery. Ambulatory care, shared and regionalized services, health maintenance organizations are all encouraged by the National Priorities.

Improving Decision-Making on HSAs. The existence of the guidelines can serve to improve the health planning process itself. The need to comply with maximum and minimum levels of service may force planning agencies to review all proposals more thoroughly and with increased awareness of region-wide needs.

Cooperation. The presence of national goals and standards may ultimately encourage greater cooperation between consumers and providers on HSAs. Although providers and consumers often have different ideas about the purposes of the health care system, under the National Guidelines, they must work to achieve a common set of goals.

(Continued on page 6)

A FICTIONAL EXAMPLE*

The following fictionalized example was constructed to illustrate how consumer members of an HSA might make use of the National Guidelines and Priorities in planning positively and cost-consciously for their regions and communities, making the project review process one which is responsive to consumer priorities.

North Calitucky Regional Health Organization, a mythical HSA, is responsible for health planning in a service area which encompasses one major city and several suburban counties. Health consumers in North Calitucky, although they hold a majority of seats on the HSA board (as they did on the CHPA board which preceded it), have failed to make an impact on the way health services are organized in the area. The economic needs of individual institutions and the interests of the medical profession have been the principal factors determining the types of health programs and facilities proposed and established. As mandated, the HSA has reviewed all applications for institutional expansion; but, until recently, these applications have been almost routinely approved without challenge by consumer board members, who had no technical basis on which to evaluate them.

The publication of the National Guidelines for Health Planning armed North Calitucky HSA consumers with standards of comparison against which local services could be assessed. As a result, they began to take a more active role in formulating the region's Health Systems Plan (HSP) and in reviewing provider applications.

North Calitucky's Health Systems Plan (HSP): In its Health Systems Plan, North Calitucky identified the following five-year goals for its area:

1) *regional consolidation and cooperative development of specialized services,* such as neonatal intensive care, high-risk maternity, cardiac catheterization and open heart surgery.

2) increased availability of *primary medical care* (physician, nurse and paraprofessional outpatient services) *for its inner city population.* There is only one physician for every 4500 people in some urban districts of North Calitucky's major city, and the outpatient clinics of its only municipal hospital are badly overcrowded.

3) development of *modern alternatives in baby delivery,* e.g., more facilities and programs for natural childbirth, and settings which will accommodate the presence of fathers or other supporting persons whom the mother wishes to be present at delivery. There has been much demand for these less mechanized birth environments in N. Calitucky, but existing maternity facilities do not offer alternative programs nor do they permit fathers in delivery rooms.

4) establishment of specialized, *coordinated units for high-risk deliveries and neonatal intensive care.*

5) where possible, without detriment to services, *elimination of superfluous general hospital beds.* A high priority is the identification, conversion or retirement of poorly utilized inpatient services, since maintaining these extra, unused beds is costly.

North Calitucky has 5.0 general hospital beds per thousand people, 25 percent above the nationally set maximum ratio of 4:1000. Taken as a whole, the region does not have an especially large proportion of elderly or poor citizens, nor any other factor which might justify maintaining an exceptional hospital capacity. Average hospital occupancy (75%) in the area is also below the desired minimum (80%) set in the National Guidelines.

INSTITUTIONAL APPLICATIONS AND HSA DECISIONS

Four applications are submitted by North Calitucky hospitals to the HSA. Wishing to contain costs while working affirmatively to fill service gaps, the project review committee approved and disapproved institutional applications by examining local needs in the context of national standards and goals:

Application One: Calitucky University Medical Center (400 beds) applies to the HSA for permission to add 40 beds to accommodate a high-risk maternity service, a neonatal intensive care unit and for unspecified "general expansion."

Background: University of Calitucky Medical Center is a large teaching institution, respected for its residency programs in cardiology, pediatrics and OB-GYN. There is at present no organized program in the region for special care of high-risk pregnancies and births, or for neonates with severe medical problems. Overall occupancy rate at the university medical center is 75%.

The HSA Decision: Basing its judgment on the national priorities, national guidelines and the region's own HSP, the project review committee decided to reject the University's application for expansion.

Although there is need in North Calitucky for intensive neonatal and high-risk maternity services, and although such services would be appropriately delivered by a specialized teaching institution, the project review committee reasoned that no new construction was necessary to provide the needed units. The university hospital, typical of the North Calitucky region, has an occupancy rate of 75%, slightly lower than the national minimum, and amounting to an unused capacity of 100 beds. For this reason the HSA called into question the "general" expansion for which need was not specifically demonstrated.

The committee met with the applicant on this matter, informing the hospital administration that a new application would be considered provided that it *a)* deliver these needed services in converted and remodeled (rather than new) space, and *b)* reduce the hospital's overall bed complement by 10%, to 360 beds. A new proposal along these lines won later approval by the HSA. Using this planning strategy, the

* in which an HSA uses the National Guidelines in project review.

HSA managed to obtain needed services for its region using existing space and facilities at a lower total cost to the delivery system.

Application Two: North Calitucky Urban Community Hospital wishes to undertake a major renovation of its under-occupied maternity ward by breaking it down into private and semi-private rooms.

Background: The falling birth rate in the N. Calitucky region has meant that this hospital's 30-bed maternity service has a very low rate of occupancy (50%). Another side effect of the decline in births has been an under-occupied pediatric service. The administration and medical staff of Urban Community hope by the renovations to increase maternity admissions at their facility.

The HSA's Decision: The HSA rejected this application because there was insufficient evidence that occupancy in the refurbished facilities would be appreciably increased. According to HSA analysis there were two major unmet obstetrical needs in the community: 1) natural childbirth programs and facilities, and 2) improved prenatal care, as evidenced by the area's high infant and neonatal mortality rates. Therefore, the HSA sought ways to elicit a proposal which would be responsive to some of the needs which were identified in the HSP.

Meetings between the applicant institution and the HSA resulted in a new proposal from Urban Community in which only two-thirds of the original number of beds would be renovated into private and semiprivate rooms and one-third of the pediatric bed capacity would be converted into facilities for natural childbirth. In response to HSA suggestions and community need the hospital agreed to develop a nurse practitioner outreach program for prenatal care in the surrounding area and to provide an option for midwife deliveries.

Application Three: Municipal Hospital wished to build a free-standing outpatient health center on its grounds in the inner city. The center is to be staffed by physicians who are full-time employees of the Municipal Hospital who will be assisted by nurse practitioners and physicians' assistants.

Background: There is only one physician for every 4500 people in North Calitucky's inner city. The existing outpatient clinics at the Municipal Hospital are overcrowded and are oriented toward specialty categories of care, e.g., dermatology, ob-gyn, neurology, etc. This mode of organizing outpatient care has resulted in the patients' making multiple visits to an ever-changing spectrum of physicians, residents and interns. Waiting periods are typically long, from one to four hours.

The HSA Decision: Municipal Hospital's application is accepted, provided that the hospital (in conjunction with the university medical school) develop a residency program in Family Practice and organize the center along Family Practice lines (that is, to assign each family to one primary care doctor who coordinates and supervises all their care at the health center).

Although the construction of the health center is a major capital expenditure, the project review committee of the HSA reasoned that this project was needed to provide a critically important health service to a severely underserved group.

In endorsing the Municipal hospital's proposal, the HSA was also moving affirmatively to fulfill three "National Health Priorities": increasing access to care for the underserved; developing more organized forms of care; and making use of paraprofessional medical workers for community outreach and follow-up.

Application Four: Suburban Community Hospital wishes to establish an open-heart surgery unit and a cardiac catheterization facility for the suburban counties.

Background: Suburban Hospital is a large and attractive new facility which has the potential of drawing a larger specialist staff could it amass resources competitive with the university hospital. Suburban hospital argued that physicians and patients did not wish to travel to the inner city for open-heart surgery.

Decision of the HSA: Suburban Hospital's application to establish an open-heart and cardiac catheterization unit is turned down by the HSA on the grounds that the open-heart and catheterization units at the university medical center are not yet operating at the minimum level suggested by the federal guidelines (200 operations and 300 catheterizations per year). In addition, the HSP goal of regionalization and consolidating specialized services does not argue for having two such specialized departments in the same service area.

SUMMARY

Before the National Guidelines were available to health planning bodies, consumers reviewed provider applications piecemeal, without reference to any official regional health plan. There were no objective standards by which the consumer could assess the medical necessity or economic feasibility of new services or facilities. Had four such project reviews taken place without reference to National Guidelines, it is likely that each application would have been approved as written. The region would have been saddled with a superfluous open-heart unit and an extra catheterization facility; it may have felt the consequences in quality and costs if these units were either under-used or inappropriately over-used.

Using the Guidelines, the consumer majority of an HSA can critically assess the adequacy and efficiency of proposed services and their relevance to regional needs. As illustrated, the project review process can be used not only to control the size and distribution of physical resources (construction of facilities, purchase of major technology) but also to influence the type and quality of health services available in the community (family practice, outreach programs, midwifery, preventive screening).

Impact on Costs. Quantifying needs and goals is a first step in being able to make an impact on containing the costs of health care. Once specific regional goals have been set, comparisons may be made among the various ways of delivering a given amount of services at the same (or better) level of quality. When cost-effective alternatives have been studied and adopted, consumers may more easily press their case to assure that the region's resources can be channeled into the areas of greatest need.

Using the Guidelines in Conjunction with the National Priorities

It must be kept in mind that the national guidelines are not ends in themselves, but means to achieve the overall goals for the nation's health services which are set out in the ten National Health Priorities. HSA decisions making the most effective use of the guidelines must also take the purposes of the Priorities into consideration.

The extent to which health facilities are fulfilling these priorities is a valid criterion on which to base decisions to convert or retire facilities, to reduce bed capacity and to approve proposals for modernization or establishment of needed new services. Institutions which provide primary care service for underserved populations in economically depressed areas, those with outreach and home care services (using nurse clinicians, etc.), with appropriately categorized and utilized emergency departments with walk-in services for episodic, non-acute ambulatory care, those which share certain high cost specialty support services, which participate in programs to regionalize tertiary services, which operate a group practice, HMO, or a community health center, are those facilities which should not be retired and should be favored for improvements and modernization programs. Conversely, hospitals not providing such services or participating in such programs may be rated vulnerable for conversion or retirement and ineligible for modernization programs.

For instance, in reviewing a hospital's application to purchase a CT scanner, an HSA can do much more than to consult the relevant national standard for CT scanner utilization. It can also focus its inquiry on the larger questions of whether alternate solutions are possible (e.g., can a mobile scanner be shared between two hospitals?), or whether the applicant hospital has a record of supplying high-quality, needed services to the community or region. If two hospitals are competing for permission to supply a single needed health service, the HSA's choice may be based upon the extent to which the facility promotes the goals of the National Priorities. If the specific standards of the guidelines are put into the general context of the priorities, the planning process should be a balanced one.

LIMITATIONS AND POTENTIAL MISUSES OF THE GUIDELINES

A frequently encountered objection to the National Guidelines is that they usurp local initiative by requiring HSAs and SHCCs to conform with nationally set standards. Although it is not true that any federal agency has the power to decide which facilities shall (and shall not) be planned locally, a real danger to local consumers does exist if the guidelines are formulated without feedback from the local level or with an overattention to cost containment at the expense of public health needs.

To assure that the guidelines are workable at the local level and relevant to actual health needs, HSA consumers must make optimal use of the public hearings and periods of public commentary which precede the final writing of the guidelines.

Rather than being a drawback to local initiative, good guidelines (which have been set with due consideration to local conditions, public need and economic possibilities) should be extremely useful to communities in providing a means by which their own needs can be identified and met.

Although the guidelines are important tools for the HSAs, there remains a potential for misapplication of the standards and for using them to justify planning decisions which affect services adversely. Consumers must be vigilant lest planning decisions made in the name of achieving the national goals hurt regional service quality by:

1. *perpetuating what already exists and impeding the development or growth of alternate or more socially responsive health institutions.* For example, as a result of attempting to maintain a maximum bed-to-population ratio of 4:1000 averaged over the service area, the HSA may deny applications for needed expansion while tolerating the presence of underoccupied or low quality facilities or those offering costly underused services and technology which might be more appropriately located elsewhere in the service area.
2. *disapproving the applications of those institutions most vulnerable to political pressure.* County and municipal hospitals, for example, may (actually or potentially) fill many community needs, yet they often have little power on the HSA compared with prestigious, private institutions. Services in such hospitals could suffer through rigid application of the guidelines. Again, applying the guidelines in the context of the National Priorities should prevent misapplication of the numerical standards.
3. *inadvertently creating an incentive for providers to swell admission rates and prolong stays in order to live up to mandated occupancy rates.* It has been demonstrated that, to some degree, excess beds influence hospitals and staff to admit patients who do not need hospital care or to keep patients in the hospital longer than is needed. Unchecked, this hidden side effect of enforcing a minimum occupancy rate can end up inflating costs rather than holding them down.

Making the Guidelines Work for Consumers

Active and aware consumer participation in health planning at the local and state levels is needed to insure that the guidelines are implemented in the light of public health needs.

If consumers are to use the guidelines as an effective instrument for health planning, they must undertake several major tasks:

1. It is critical that consumers familiarize themselves with the guidelines, their goals and provisions. Consumers can require that HSA staff be directed to hold educational sessions for central board and sub-area council members to explain and discuss the guidelines and Priorities.
2. As representatives of their communities and majority members of HSA governing boards, consumer board members of HSAs are responsible to insure that the HSA professional staff:
   a) undertake a review of the current status of the community's health system (inventory, demand levels, needs/problems), not only those items specifically addressed in the guidelines (e.g., beds, CT Scanners, etc.) but also relevant aspects of the Priorities (ambulatory care facilities, preventive services, etc.).
   b) develop a method to analyse the fiscal impact of institutional expansion or contraction, and the impact of totally new services. Potential cost savings and increases will be identified and quantified.
3. Consumer board members of HSAs should insure that there is a full and open discussion of the guidelines, Priorities and the standards. Public hearings should be called to:
   a) explain the National Guidelines and the Priorities to the community, including their relationship to each other and the possible impacts on the community of bringing local health services and facilities into conformity with national standards.

b) inform the community of proposed local goals and objectives as contained in a working draft of the HSP and AIP, specifically how national goals and priorities will be achieved or why the area is requesting an exemption from consistency with the guidelines. The projected impact of the plan on the community—establishment of new services or facilities, the retirement of existing ones, redistribution of resources—should be fully discussed.

c) solicit comments concerning gaps and/or weaknesses in the guidelines and the process by which they are developed and/or implemented, to be forwarded to the National Council for consideration in the revising of old and devising of new National Guidelines and Priorities. An active solicitation of written and oral comments should accompany these hearings. Task forces composed of consumers, providers, government and HSA staff should be established to work on specific projects, reporting to the public of their progress and recommendations at these hearings. Consumers who are members of the HSA governing board must insure that the work of these task forces is supported and seriously considered by the HSA. The more involved the whole community is in the planning process, the more likely it is that meaningful and realistic plans will be developed and implemented. In addition, since the community is the constituency of HSA consumer members, the more knowledgeable, vocal and involved the community is, the more powerful and effective consumers can be in the HSA process.

4. Consumers should see to it that guidelines for acceptable project application are developed by their HSA which provide that all proposals contain a thorough demand, need and impact analysis of the project with respect to furthering the National Guidelines and achieving the goals set forth in the National Priorities.

5. Consumers should insure that the HSA has developed criteria and instituted procedures to address exceptional situations and conditions.

6. Consumers should inform and clarify for the SHCC and SHPDA and for the Federal Regional Health Director any problems and conflicts that they may have with these agencies.

FUTURE GUIDELINE DEVELOPMENT

In the near future, the Secretary of HEW will be issuing another set of National Guidelines relating to health status, health promotion and access to care. This, in turn, will be followed by other, still undefined, topics. It is the concern of the consumer that any further guidelines promulgated relate to the ten National Priorities identified in the Act. The initial set of guidelines addressed only a very limited number of these priorities. In addition, current guidelines will be reviewed at least every two years and revised as necessary based on further analyses and experience with their use. To insure that newly promulgated and revised National Guidelines reflect consumers' concerns and local experience, the following actions should be considered:

1. At both the local and state planning levels, a task force consisting of HSA consumers board members and other active laypersons, providers and HSA professional staff be established that will review, on a regular basis, local resources, demands and needs in light of the National Guidelines. The goal of these task forces will be to arrive at a quantifiable balance between technological and human services needs and costs which can be used in the future to develop and revise National Guidelines.

2. It is critical that the findings of these task forces be made known to the National Health Planning Council, which must be consulted in the development of the National Priorities and guidelines, and to HRA, which staffs the Council and DHEW in relation to the National Health Planning Act.

3. In reviewing and developing recommendations for future guidelines, consumers should consider such factors as:
   a. What has been the experience to-date with the implementation of the initial set of standards?
   b. Do these standards provide a realistic framework within which local decisions can be made or are they too inflexible and unworkable, too simplistic, too narrow or broad, or focused on the wrong issues?
   c. In what fashion have the guidelines been used in plans and projects under review by the HSAs and SHCCs? Are HSA's and SHCC's professional staff insuring that all plans and projects adequately use the guidelines?

4. To back up the work of the task force and to further insure the relevance of the guidelines to local conditions, HSAs should encourage the development of communications networks linking consumers on the local and state levels with consumer members of the National Council. The establishment of such a network could insure a continuous exchange of information between the local and federal level and promote cooperation between DHEW and consumers in the process of guideline formulation.

It should be noted that development of the full range of National Guidelines will be a long-term process, although time frames must be established for a progress evaluation of specific Guidelines. Indeed, there is little agreement in some areas on many issues relating to national health goals and resource standards, and there are questions as to their application to localities in an arbitrary manner.

The changes in health delivery systems implied in the National Guidelines and in other laws and regulations (Health Education Promotion Act, Social Security Act, Federal Drug Administration, etc.) will be a lengthy process; however, participation of consumers and progressive monitoring will be necessary for the orderly and effective development of workable National Guidelines for health planning policy.

GLOSSARY

Access to Care. Ability to obtain medical services from practitioners and health facilities. *Equal Access:* Ability to obtain health services regardless of geographical, ethnic, social or financial factors.

Acute Care. Care (usually in a hospital) of fairly short duration, given during the course of a single episode of illness or injury.

Ambulatory care (also called out-patient care or walk-in services). Health services given in a health care institution, but which do not require the patient to be hospitalized overnight. Clinic and health center services.

AIP (Annual Implementation Plan). The plan which HSAs must prepare annually, stating the years' workload and short-term objectives for their health planning area.

Bed Supply (Bed complement). The number of HSA- or state-approved hospital beds in a given institution or area. Usually a "bed" is the unit in which hospital size is expressed.

Bed Ratio. Number of general hospital beds per thousand population.

Cardiac catheterization. A diagnostic X-ray procedure in which a thin flexible tube is passed into the heart through a vein or artery.

Certificate of Need (C/N or CON). A certificate issued by a governmental body (usually the state or HSA) approving an institution's plans to construct or modify a facility. to change an existing service or to create a new service. This program to control capital expenditures according to public need is also administered under the authority of *Section 1122* of the Social Security Act.

CHPA. The Comprehensive Health Planning Act of 1966 (also known as "Partnership for Health," and P.L. 89-749). The federal health planning legislation which preceded the planning Act which is presently in effect. The CHPA created local and state planning agencies, mandated consumer participation in health planning and emphasized regional planning and monitoring of construction of health facilities.

Computerized Axial Tomography. A diagnostic X-ray test which uses a computer to reconstruct images of cross sections of the head and body (also: CT scanner, CAT scanner).

End Stage Renal Disease (ESRD). A condition that usually results in the patient requiring kidney dialysis or a kidney transplant.

Extended Care Facility. Skilled nursing facility; long-term care.

Goal. In health planning, a goal is future oriented statement that specifies desired ends without setting a deadline or the actions to achieve the goal.

Group Practice. A formal association of three or more physicians or other health professionals providing services with the income pooled and redistributed to the members of the group according to some prearranged plan. Group practices vary considerably in services offered and in size.

High Risk Group. Refers to persons within a population who are much more likely to have certain health problems than the population at-large.

H.M.O. (Health maintenance organization). By definition an HMO has to have a voluntarily enrolled group of subscribers, a predetermined fixed periodic prepayment, an agreed upon set of services and an organized system for providing the services in a geographic area. The Kaiser-Permanente system in California is the most famous example of an HMO.

Health Systems Agency (HSA). Refers to agencies responsible for the planning and development responsibilities in each of the federally-designated geographic health service areas. HSAs have their functions and organizational alternatives spelled out in P.L. 93-641.

Health Systems Plan (HSP). A long-range (usually five years) health plan prepared by an HSA detailing the health goals and in accord with nationally identified priorities and in agreement with quantifiable national health planning guidelines.

Intensive Care Unit (ICU). A specialized nursing unit in a hospital which concentrates upon seriously ill patients needing constant care and observation.

Inpatient Care. Services provided in a facility which provides room, board, and continuous (overnight) health care (Hospital care, in-hospital care).

Multi-institutional. Shared, coordinated or consolidated among several health facilities.

National Council on Health Planning and Development (NCHPD). A fifteen-member advisory council is established by the National Health Planning and Development Act of 1974, which is to consult with the Secretary of Health, Education and Welfare on the National Guidelines, the Implementation of the planning law and the evaluation of needed new technology for organizing, delivering and equitable distribution of health services in the United States.

Neonatal. Relating to infants less than one month old.

Nurse Practitioner (NP). A registered nurse qualified and specially trained to provide primary care and specialty care under the general supervision of a physician. There are nurse anesthetists, nurse midwives, nurse pediatricians and others.

Occupancy rate. A way of measuring how much use is being made of a hospital's bed capacity. Percentage of available beds which are occupied at a given point in time.

Objective. In achieving a goal, one step which has a specific target date for completion.

Obstetrics. Branch of medicine dealing with childbirth.

Open Heart surgery. Any heart surgery requiring the use of a heart-lung bypass machine. Requires a specially trained staff and specially equipped surgical unit.

P.L. 93-641. The National Health Planning and Resources Development Act of 1974.

Physician's Assistant (PA). A specially trained and licensed, when required, or otherwise credentialled individual who performs tasks formerly performed only by physicians. Works under the supervision of a physician and may be called Medex, paramedic, or various types of nurse practitioners.

Primary Care. The level of care which includes preventive services and detection and treatment of non-acute commonly encountered illnesses. In our health system, primary care is usually given by physicians, PAs or nurses, in offices, outpatient clinics and health centers.

Regionalization. A system in which health institutions and resources are coordinated and linked so as to deliver primary, secondary and tertiary services (as well as medical education) to the region as a whole.

Secondary Care. Services for less common health problems that require specialized care usually available only in hospitals. Sometimes the term "secondary care" is used to denote services provided by medical specialists to whom patients have been referred from the primary source of care.

Standards. Generally, a measure set by competent authority as the rule for evaluating quality and/or quantity. Used for licensure, accreditation or payment for services. PSROs set standards for care along with norms and criteria.

Statewide Health Coordinating Council (SHCC). A state council of providers and a majority of consumers which supervises the work of the SHPDA, reviews the budgets of the HSAs, prepares a state health plan from HSA Plans and reviews applications for HSA planning and resource development assistance.

State Health Planning and Development Agency (SHPDA). A state agency selected by the governor, having the tasks of preparing a state health plan (SHP) and medical facilities plan, of administering the section 1122 and certificate of need reviews and responsibility for the state's health planning and development functions.

Tertiary Care. A level of care which refers to complex diagnostic and therapeutic services which require the highly specialized personnel and equipment usually found in major medical centers.

Utilization rate. A pattern of use for a single service or type of service, e.g., the number of admissions to a particular hospital department in a single year.

Underserved. Generally, not having enough health services, in terms of medical practitioners or facilities (or any other resources related to adequate provision of health care); technically, areas with less than one physician per 4000 population.

PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.
377 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959