

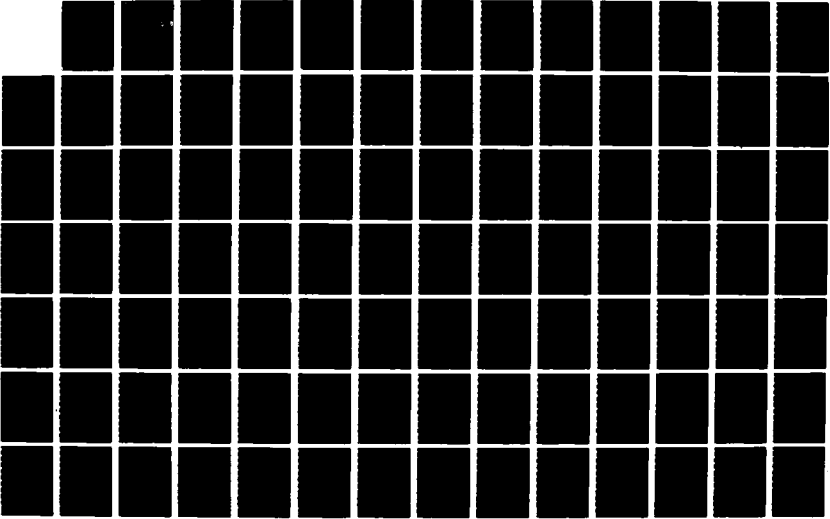
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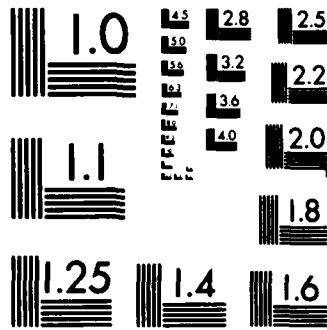
HOW DO WE TURN THIS THING OFF? A STUDY TO DETERMINE AN
APPROACH FOR MAKIN (U) ACADEMY OF HEALTH SCIENCES
(ARMY) FORT SAM HOUSTON TX HEALTH C C E MAXWELL
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HOW DO WE TURN THIS THING OFF?

A STUDY TO DETERMINE AN
APPROACH FOR MAKING CURTAILMENT OF
SERVICE AND CLOSURE DECISIONS IN
HEALTH CARE FACILITIES

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A PROBLEM SOLVING PROJECT
SUBMITTED TO THE
FACULTY OF THE U.S. ARMY-BAYLOR
UNIVERSITY PROGRAM IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE
OF
MASTER OF HEALTH ADMINISTRATION

BY

CLARENCE E. MAXWELL
CAPTAIN, MSC

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The level within DoD at which decisions should be made is addressed as is the scope of analysis for various potential decisions.

→ A key factor which is pointed out in this project is the difference which exists between the civilian health care sector and the military health care system. These differences, especially the wartime mission of the military, make applications of proposed civilian techniques such as appropriateness review in its pure form somewhat unacceptable to the military health care settings.) Unlike the civilian hospital which can be addressed and analyzed as an isolated element or an element of a community health care scheme, the military hospital, its programs and services, must be viewed as an integral part of the larger military health care system. A proposal to curtail services at a single installation or to close a facility must be evaluated for its effect on the larger system.

→ A holistic, system approach is envisioned and proposed which analyzes the capabilities of the various hospitals, the needs of the larger military health care system and the situation at the specific hospital(s) in question. An overview to this proposed approach to decision making is provided in a conceptual model. ←

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ABSTRACT

"How Do We Turn This Thing Off" is a problem solving project to determine an approach for making curtailment of service and closure decisions for Department of Defense hospitals. The need for curtailing services or closing hospitals has been precipitated in both the civilian and military health care setting by numerous factors. These factors are reviewed and it is determined that in the future it is probable that fewer military resources will be available to meet increasing demands for services.

The future environments for conditions associated with and precipitating this problem are considered and discussion is provided concerning governmental controls of health care planning, sizing of hospitals, sharing services, and competition for resources. In analysis, it is decided that the above factors, together with the ongoing problems of physician shortages and base realignments, combine to dictate that in the future there will be a need to consider curtailing hospital services or possibly closing hospitals. Because of this, it would appear that an approach to decision making for curtailing or closing hospitals should be developed. This project accomplishes exactly this requirement.

The level within DoD at which decisions should be made is addressed as is the scope of analysis for various potential decisions.

A key factor which is pointed out in this project is the differences which exist between the civilian health care sector and the military health care system. These differences, especially the wartime mission of the military, make applications of proposed civilian techniques such as appropriateness review in its pure form somewhat unacceptable to the

military health care setting. Unlike the civilian hospital which can be addressed and analyzed as an isolated element or an element of a community health care scheme, the military hospital, its programs and services, must be viewed as an integral part of the larger military health care system. A proposal to curtail services at a single installation or to close a facility must be evaluated for its effect on the larger system.

A holistic, systems approach is envisioned and proposed which analyzes the capabilities of the various hospitals, the needs of the larger military health care system and the situation at the specific hospital(s) in question. An overview to this proposed approach to decision making is provided in a conceptual model.

INTRODUCTION
SYMPTOMS OF NEED

Dear Colleague,

The finite fiscal resources of the state have resulted in chronic underfunding of our existing hospital system. After careful study of the options available, the Hospital Association is convinced that in order to maintain quality in light of the current fiscal realities, a shrinkage of our hospital system is necessary. Through such a shrinkage our limited funds can more effectively be utilized to produce the best patient care possible.... 1/

The quotation above from Irvin G. Wilmot, Chairman of the Board of Trustees of the Hospital Association of New York State (HANYS), is indicative of a problem faced within numerous hospital associations and even on the national level. The public and various advocates representing the public's interest have become alarmed at the growth in the cost of health care. In 1960, 5.2 percent of the gross national product went to health care expenditures. 2/ In 1976, 8.64 percent or \$139.3 billion, of the gross national product went to health care expenditures. By fiscal year 1980, HEW estimates, expenditures will total \$227.5 billion, or 8.9 percent of the gross national product. 3/

The concerns for the cost of health care have crossed numerous boundaries, exhibiting themselves in both the private and public sector and at local, state and national levels. Concern is also felt at Department of Defense. Within the Department of the Army, a headquarters level

study is presently being undertaken to project the long term cost of the Army's health care programs. Concern has been expressed that the Army may not be able to afford its Medical Department in the future. 4/

Given the clear concern for the existing and future cost of health care, the thrust toward cost containment are almost inevitable. As Edmund D. Pellegrino points out;

The phrase 'cost containment' now seasons the exhortations of health planners, economists, legislators, and physicians. Both friend and foe of the present system use these words to cajole, threaten, warn, or promise. Can anything so well intentioned, and so enshrined with the aura of 'good' economics, be anything but enthusiastically supported? 5/

The problem of cost containment may appear simple to the layman, however the impact of decisions made under the auspices of containing health care cost may reach much further than a balance sheet. By there very nature reductions, or the capping of expenditures, may necessitate changes in the existing patterns of health care.

WHAT IS NEEDED

To facilitate these changes there will be a very real need for effective planning. This planning will be somewhat unique to the health care area because its thrust is in a direction opposite that historically traveled by health care planners. As W. Henry Lambright points out;

In many ways, termination strategies are innovative, untested means for policy makers. Extensive research on processes of innovation has been conducted. However, much of this research has been oriented to more 'positive' forms of innovation, e.g., the adoption of new practices and the expansion of programs. ^{6/}

Lambright's statement is substantiated by a review of publications on the subject of hospital planning. As is the case with Allen and Von Karolyi's Hospital Planning Handbook, the pattern of the planning effort leads to the hiring of an architect and the development of a construction program.

While in some underserved areas there may be a need for more health resources, this is the exception as indicated by the finding of an excess of more than 100,000 hospital beds nationwide.^{7/} Health planners for the foreseeable future must make an about-face and tighten the belt of the health care industry. Colonel Jack O. Lanier, the Director of the US Army-Baylor University Graduate Program in Health Care Administration, in a speech to the 35th Annual Meeting of the Association of Military Surgeons of the United States, noted that the successful health care administrator of the future would be the one who was able to make decisions which would reduce our health care system.^{8/} What appears to be needed is a methodology for coming to grips the very difficult problems of deciding how to bear down without doing irreparable damage.

PROBLEM STATEMENT

The problem addressed in this project is to determine an optimal, feasible approach to be used by the Department of Defense in making and implementing decisions to curtail the services of a health care institution, or to close a hospital. A key term in this problem statement is the word "approach." In this project, approach will define a logical sequence of steps based on factors which must be considered to make a decision, the appropriate scope of analysis and identification of the appropriate level for decision making within the Department of Defense.

LIMITATIONS
OF THE PROJECT

The scope of this project must be acknowledged to be extremely broad. The project could be viewed in part as the complement to a 1977 study titled "Comparative Health Facility Acquisition Methodology Study." The acquisition study was accomplished by an association of four health facility planning, consulting firms under contract to the Department of Defense. The project scope of this paper will not, by necessity, be nearly as comprehensive as the acquisition study. The recommendations of this project are to be taken as recommendations limited to health facility planning within Department of Defense.

It must be recognized that discussions of curtailments of services or closure of facilities touch on extremely sensitive issues. This project will not address itself to any specific DoD health care facility, but will instead view the generic problem of curtailments of health care services or closures of health care facilities.

ASSUMPTIONS

While it is understood that any decision to curtail services at any specific DoD health care facility can be overridden in the political arena of the Executive Branch or the Congress, the influences from these political spheres is difficult to quantify or control and do not lend themselves to the framework of rational decision making at the operator/manager level. These political influencing factors will be assumed as beyond the purview of this project, and while it is understood that these influencing factors are key to the success of any specific recommendation to close a facility, they will not enter into the design of the decision making approach.

A second assumption of this project is that the existing Army framework for the management of reduction and realignment actions will not significantly change and therefore proposals for management of health facility reductions and realignments must be compatible. This project will not change the requirements for actions as described in Army Regulation 5-10, titled Reduction and Realignment Actions. It is hoped that this project will augment the existing reduction and realignment technique with medical specific considerations.

CRITERIA

The term "optimal feasible approach" as used in the problem statement is defined in this project as the approach which maximizes the following:

1. Number of cogent factors which should influence any decision to curtail a health care service or to close a health care facility.
2. The feasibility for implementation of any decision by maximizing the acceptance of parties involved and affected.
3. The appropriateness of the decision making level.
4. The appropriateness of the scope of analysis.
5. The feasibility of implementation of any decision given the resources available and the constraints which exist for DoD operation.

PLAN OF ANALYSIS

The following areas have been researched and analyzed to develop potentially viable recommendations applicable to the problem addressed:

1. A search for and review of articles, studies, books and other publications germane to the problem as stated. A bibliography is attached.
2. A review of hospital sizing models presently applicable or being discussed within DoD and a review of any sizing guidance produced by external (to DoD) health planning bodies.
3. A review of publications, articles, and HEW working papers on the subject of appropriateness review. Interviews with Department of Health, Education and Welfare personnel who are working or are knowledgeable in the area of appropriateness review.
4. An analysis of actions by DoD to consolidate health care facilities in the San Francisco Bay Area, paying particular attention to the factors being considered in decision making.
5. A review of DoD directives concerning health service curtailments, base closure and associated analyses, necessary for such closures.
6. A review of service curtailments within Health Services Command (HSC) facilities.
7. An analysis of the circumstances surrounding the closure and leasing of the United States Navy Hospital in New Orleans.
8. A review and analysis of curtailments and closures within the public sector, the causes of these actions, the impacts of these actions and the future of civilian hospital closures.
9. Review of public laws dealing with health facility planning and proposal which may change the law in this area.

THE EXISTING SITUATION

In the past ten years a number of factors have brought about actual curtailments in the medical services provided by US Army health care treatment facilities. In a few cases actual closure of a hospital (cessation of inpatient care) has occurred. The single factor which has historically brought about most of the reductions of services offered is a shortage of physicians with specialty training to staff a particular service. Other factors which have precipitated curtailments or closures includes regionalization of military medical facilities and base realignments within the Army.

PHYSICIAN SHORTAGE

In 1969 there were over 15,500 physicians on active duty in DOD. By 1977 this number has reduced to below 11,000 physicians.^{9/} Within the Army actual Medical Corps end strength has gradually declined from 4,398 at the end of fiscal year 1976 to 4,140 at the end of fiscal year 1978.^{10/} Before the Subcommittee on Personnel of the Committee on Armed Services, Lieutenant General Charles C. Pixley, The Surgeon General, stated on February 16, 1979, that approximately 5,856 military physicians are required to staff the Army's tactical medical units as well as the Army's fixed medical treatment facilities and research activities with the requisite number of physicians. It is recognized that many physicians in tactical units would have little patient care responsibility that is professionally satisfying. Therefore, it has been determined, that during peacetime, the Army can, with acceptable risk, set its military physician requirement at 5,273.^{11/} For fiscal year 1979 and 1980, physician end strength authorizations are projected to be 4,173 and 4,349 respectively. ^{12/}

The problem of specialty shortages is a subportion of the larger physician shortage issue and is causing the majority of military hospital service curtailments. The manifestations of the problem in the past two years have exhibited themselves predominately in the Army's community hospitals (MEDDACs). Between January 1977 and October 1978, twenty-three MEDDACs reduced or curtailed completely some service to their authorized beneficiaries.^{13/} A chart depicting services reductions is provided at appendix A. The Army's graduate medical education program has been expanded to address this problem and if this together with other physician procurement and retention action, is allowed to stand, then the specialty problem should be alleviated. Additionally, if the actions outlined by The Army Surgeon General to the Subcommittee on Personnel of the Committee on Armed Services are pursued, there is hope for resolving the Army's physician shortage problem.

The planning which results in curtailments of services because of physician shortages appears on the surface to be haphazard. According to Lieutenant General Pixley:

"The problem as to which specialty services may have to be curtailed and to whom, has been addressed on a specialty by specialty basis at each medical treatment facility." ^{14/}

Therefore, the medical treatment facility commander must make the decision to exclude some portion of his consumer population, normally the retired or dependents of retired. Of course the local commander may not have control of his most needed resource, physicians. Because of the separation or permanent change of station of an orthopedic surgeon the medical treatment facility commander may have little choice but to reduce services. The efforts at higher head-

quarters to identify the departures of physicians and decide which physicians to replace based on the demand for health care at the various locations is not apparent. The ability of a commander to get a replacement is often a function of timing, or the assignment desires of potential replacements. There is a method to the distribution of physician resources, although this methodology does not seem to be centrally published nor widely understood, especially outside of the Army. When documented this process of resource allocation could demonstrate to the private health sector and to governmental overview agencies that Army health resources planning occurs in considerable detail and with a thoroughness that in most cases surpasses that which is only now proposed for the civilian sector.

The services to be provided at a specific Army hospital are detailed in what is known as the mission template. This forms the basis of determining the types of resources which should be provided to the medical treatment facility and also establishes boundaries for health care services. The local hospital cannot assume missions outside of its mission template without the approval of its higher headquarters, Health Services Command, and a change in the mission template. This is an important concept of resources control which does not have an effective counterpart in the civilian community. The approval for the addition of a new service must also be approved by The Office of The Surgeon General and the Department of Defense Health Council.^{15/} It should be recognized that the mission template should be arrived at based on careful consideration of local health care requirements, Army resources available to meet these requirements, teaching or training needs of the Army Medical Department and the specific location needs for field medical support.

While the need and the mission may exist the resources to support the mission may be scarce. The process which results in the assignment of an adequate number of physician specialists to meet the specific demand for a particular type of health care is complex and often unresponsive. Each hospital is surveyed every two to four years by what is known as a manpower survey team. This team reviews the workload which exists and through the application of staffing yardsticks published in a staffing guide or through individuals studies of nontypical situations, makes recommendation concerning the number of individuals which should be provided to accomplish the mission at the workload level historically experienced with some recognition of projections.

This survey identifies what is referred to as recognized requirements in every area of the hospital from the number of physicians in the surgery clinic to the number of housekeepers on the first floor of the facility. At Health Services Command the survey is reviewed, changed as required and a specific number of positions are identified as authorized staffing positions.

This is the number of positions which the hospital should be able to fill. Funds will be provided for the civilian employees authorized.

The military personnel assignment system will place people on orders to fill the military authorized positions. The positions which are filled result in what is known as the actual manpower. Naturally some difference can be expected between the authorized and actual strength figures. This difference is reflected in lower actual numbers than authorized due to hiring lags in the civilian positions. On the military position side the shortages of physicians has resulted in sometimes marked differences between authorized and actual figures. Because of the shortages in various specialties and the

criticality of the physician resource to the Army, yet another level of personnel resource review is superimposed. Annually The Surgeon General of the Army sponsors and chairs a conference which reviews the physician requirements of each hospital by specialty taking into account the needs of the Army at each installation, the needs of the Army Medical Department for such things as staff, residents, and fellows in graduate medical education programs and the desires of the individual physician who is available for assignment. A major issue in this balancing of resources is the long-term impact of decisions on the future physician specialty requirements of the Army and the ability of the Army to retain physicians on active duty. Short-term problems may go unresolved in hopes of developing sound long-term solutions.

The system described above is modeled at appendix B. There are deficiencies with the approach that has been described. The mission template has historically reflected little more than the existing situation concerning services of the Army hospitals. It does not reflect a comparison of the needs of various hospitals nor has it reflected the true needs of the various communities for health care resources.

The system of physician allocation is extremely aggravated by the physician shortage. The demand driven manpower survey system is heavily dependent on historical workload to document the need for personnel resources. If the physician does not exist in a clinic to accomplish the workload then the physician's position theoretically may never be filled.

Finally the overall system which establishes available physician aggregate numbers is not clearly related to the character of the existing peacetime demand for physicians. This is because the total number of physicians on active duty is in part dictated by the wartime physician needs of the Army.

DEMAND INFLUENCED CURTAILMENTS

Clear incidences of curtailments or closures of medical services associated with a drop in the need for services are not numerous. Examples of such occurrence exist at Aberdeen Proving Grounds and Carlisle Barracks where hospitals have been reduced in services to clinics because of reductions in the active duty population supported.

EXISTING DECISION MAKING FOR CLOSURE OR CURTAILMENTS

As previously indicated, the local medical treatment facility commander is responsible within the Army for making a decision to curtail medical services within his hospital. All decision of this nature to date have been labeled as temporary. For consideration of closure of a hospital (cessation of inpatient services) individual studies have occurred normally centering at the major command level, Health Services Command. There is a requirement that Department of Defense, Office of the Secretary of Defense (Health Affairs), be advised in advance of any curtailment or closure action. This requirement has been generally ignored. There is a study underway concerning Letterman Army Medical Center which will be discussed later.

THE EXISTING SITUATION IN THE CIVILIAN SECTOR

During 1975, 1976 and 1977, 231 American Hospital Association (AHA) registered U.S. Hospitals closed.^{17/} A survey conducted by the AHA reveals that there were twenty-six reasons for these closures. There are seven reasons which are most frequently cited for closing.

Financial- Twenty-seven percent of the hospital surveyed encountered troubles of an economic nature. In several of these situations these hospitals had to file for bankruptcy.

New Facility Built - Twenty three percent of the hospitals surveyed indicated that closure was caused through replacement by a new facility. In part of these cases the new hospital was specifically built to replace the old facility. In other cases a new hospital was built in the area of the old hospital and the older hospital could not compete for physician staff or patients.

Low Census - Fourteen percent of the hospitals surveyed indicated that their census had dropped because they were unable to provide the services needed.

Outdated Facility - Thirteen percent of the hospitals surveyed indicated that they closed because of outdated facilities which resulted in license problems, health and safety codes violations or lack of modern facilities conducive to good patient care.

Lack of Medical Staff - Ten percent of the hospitals surveyed stated that they had been forced to close because of a lack of physicians to staff the hospital.

Policy Changes - Six percent of the hospitals surveyed indicated that some state policy change resulted in their closure. This applies typically to specialty hospitals like mental hospitals. When the states decides that mental patients should be returned to the community then the state mental hospital closes.

Mergers - Four percent of the hospitals surveyed stated that they had closed because of mergers.

It is interesting to note that the facilities of 8.7 percent of the hospitals which closed are now being used for outpatient clinics.

Much has been written in recent months about shrinking the number of hospital beds. It would appear that excess hospital beds do exist. On the national level Walter McClure, Ph.D. prepared a document for HEW in 1976 that recommends a cut of 5 to 10 percent in U.S. bed capacity.^{19/} The Hospital Association of New York State regards a 5,000 bed shrinkage as necessary.^{20/} The Blue Cross and Blue Shield estimate that the Washington metropolitan area will have an excess of 1,700 beds by the end of 1980.^{21/}

THE LOCAL IMPACTS OF HOSPITAL CLOSURES

The effects of a civilian hospital closure or other civilian hospitals in close geographic proximity to the hospital which is closed has not been studied in much depth. The only published study of this nature was accomplished by the American Hospital Association in 1978 and studied hospitals which closed in 1975.^{22/} A total of 46 hospitals were identified as having closed in such a fashion as to generate potential impacts, that is to say they closed and did not relocate or consolidate with other hospitals. The study identified 89 hospitals which were effected by the closures. A control group of 51 hospitals were identified to provide a comparison with the affected hospitals.

A total of ten indicators were identified to measure any shifts in utilization. These indicators included surgical operations, emergency visits, outpatient visits, births, full-time equivalent employees, inpatient days, average daily census, admissions, number of beds and occupancy rates. Although there were some irregular variations, the data showed that the affected hospitals experienced a relative increase in demand following a nearby hospital closure. The authors of this study conditioned their findings by stating that the

magnitude of the increases varied widely and that the permanence of any increase has not been established.^{23/} It was further noted that the effects of a hospital closure depend to a great extent on the characteristics of the surrounding hospitals and on the features of the surrounding area.^{24/}

A finding of some interest, given the nature of many Army post locations, was that small hospitals in rural areas absorb the greatest proportional impact of a nearby closure.^{25/}

Within the military services the impact of curtailments or hospital closures on civilian hospitals have not been evaluated. Data would appear to be available on the economic impacts of such actions through Civilian Health and Medical Program of the Uniform Services (CHAMPUS).

This is an area which is recommended for further study. It is recommended that data available through CHAMPUS be augmented with other information from the sites of military medical service curtailments.

SUMMARY OF THE EXISTING SITUATION

Historically within the civilian sector, closure or curtailment of hospital services have been traced to causes which, for the most part, are local to the affected hospital and usually deal with the competition, supply and demand for health care at the specific hospital site. In many situations the local problem can be traced to a generating factor of national impact. For example, a lack of physicians in underserved rural areas or inadequate facilities in the light of stricter Joint Commission on Accreditation of Hospitals (JCAH) standards may have been the precipitating factors in causing a closure. The underlying factor which would appear to be common to almost all of these causal elements is a lack of monetary resources to purchase services, correct facility deficiencies or attract specialty skills.

Within the Army, present and past curtailments or closures of medical services have been generated, for the most part, by the shortage of physicians or by base/post realignment actions.

COMPARING THE CIVILIAN
AND MILITARY HEALTH CARE SYSTEMS

It must be recognized that there are inherent differences in the civilian health care system and the military health care system which must be highlighted to place any comparisons into perspective. A very basic difference between the military health system and the civilian health care sector is the basic mission of the military and its health care providers;

The primary mission of the Army Medical Department is to plan, prepare for and provide medical, dental, and veterinary support for military operations in accordance with approved planning scenarios. During peacetime, the military health care system, supplemented by CHAMPUS will provide health care to the soldier and other eligible beneficiaries. 26/

The requirement to maintain an ability to provide wartime health care capability is a fact that must never be overlooked or underplayed in any comparison of the military and civilian health care systems or any attempt to apply civilian sector management or control techniques to the military.

Numerous other significant differences exist. It is the character of the civilian hospital to be responsive to the local needs of local physicians and patients. The military hospital responds to local health care needs within the constraints of mission statements and resources provided. Typically the medical staff of a civilian hospital is not salaried by the hospital but is a stable user of the hospital. The physician practicing in a military hospital is salaried or contracted and is typically moved between hospitals on a three year cycle. The typical

civilian hospital is not centrally controlled as one of a group of hospitals, but is instead locally managed and operated. The military hospital is a military unit within a larger organization which centrally establishes policies and provides resources. Civilian hospitals are reimbursed for services to individual patients. Military hospitals are funded to accomplish a mission which includes providing health care services. In the civilian sector physicians can influence where their patients will be hospitalized. Military physicians are usually not provided with choices of hospitals. There is generally freedom of entry and exit between various hospitals for civilian patients and physicians. This freedom does not exist in the military. Although it may be changing, typically the civilian hospital is not a location for both inpatient and outpatient care. The military hospital is designed to provide both inpatient and outpatient care. Finally the patient in the civilian hospital must have some method of reimbursing the hospital, either from his own resources or through some third party. Also the civilian patient is not typically enrolled as a potential patient who is authorized care in a specific hospital. The military health care beneficiary is enrolled or specifically authorized care which he does not pay for.

The military organization of health care does resemble somewhat a health maintenance organization (HMO), however the typical HMO often does not operate its own hospitals and rarely is an HMO an element of a larger health care organization with many hospitals and personnel who are routinely transferred between hospitals. Additionally there is no HMO with a wartime preparedness mission. Civilian HMOs are generally

contracted with to provide services to a group and no known HMO is a subordinate element of a larger non-health care organization which it supports.

THE REAL PROBLEM

The single problem which underlies the issue of curtailments and closures in both the civilian and military health care system is the issue of resources' cost for health care. Most of the civilian closures which were noted could have been avoided if the hospitals had had the dollars to pay debts, attract physicians or rebuild facilities. Similarly the Army could have avoided curtailing services at many locations if the funds were made available to attract and ~~retain~~ retain adequate numbers of physicians. The increasing cost of health care to both the nation and the individual has caused a stretching of available resources and an unwillingness to provide continued increases in resources.

FUTURE ENVIRONMENT

Governmental Controls Influence National Health Care Planning

At the national level concern about the increasing cost of health care has grown and various alternatives have been proposed to control the growth of this cost. Hospital associations have embarked on what is known as a voluntary effort at cost control while the Department of Health, Education, and Welfare, various Congressmen and White House policy makers have proposed numerous measures aimed at controlling health care cost. Many of these measures have been aimed at the hospitals and often they are targetted to get rid of excess hospital bed capability.

HEW published National Guidelines for Health Planning in the Federal Register, March 28, 1978. Those guidelines include national health planning goals and standards respecting the supply, distribution and organization of health resources. A chart reflecting the specific standards is provided at Appendix C. These standards are to be used by local and state health planning agencies in the development of plans and in review of proposals by health care institutions. Included in these standards are such goals as four beds per 1,000 people supported, and 80 percent average annual occupancy rates for all short-stay hospital beds. Standards are also provided for obstetrical services, neonatal special care units, pediatric inpatient services, open heart surgery services, cardiac catheterization, radiation therapy, computer tomographic scanners and end-stage renal disease.

The application of the national guidelines to federal health care facilities is unclear. As it presently stands, federal facilities

would appear to be outside of the application of these guidelines. The military hospital is also outside of the jurisdiction of state health planning mechanisms established under Public Law 93-641. There is however a requirement to provide state and local governments with information on projected Federal development so as to facilitate coordination. This requirement was published by the Office of Management and Budget in the Federal Register on January 13, 1976. Specifically, Federal agencies having responsibility for the planning and construction of Federal buildings will establish procedures for:

Providing, through the appropriate clearinghouses, Health Systems Agencies and State Health Planning and Development Agencies designated pursuant to the National Health Planning and Resources Development Act of 1974 with adequate opportunity to review Federal projects for construction and/or equipment involving capital expenditures exceeding \$200,000 for modernization, conversion and expansion of Federal inpatient care facilities, which alter the bed capacity or modify the primary function of the facility as well as plans for provision of major new medical care services. 28/

The question which arises is one of authority to influence. There is no clear understanding of what is meant by OMB's requirement to "coordinate." It can be anticipated that the local and state health planning agencies will incorporate the national guidelines into their plans and reviews. Where the Army's hospital services exceed the standards of the national guidelines, this will likely be pointed out, and will, in all likelihood, have to be explained to approving authorities.

A comparing of the controls imposed by the government on civilian health care institutions with those controls imposed on federally

operated facility is natural. Mr. Sam Styles of HEW, in a recent interview, commented that much of the public correspondence recently received on standards and appropriateness review questions the exclusion of the federal hospitals. ^{28/}

APPROPRIATENESS REVIEW

The National Health Planning and Resources Development Act of 1974 requires that health systems agencies (HSAs) and State Agencies (SHPDA's) review the appropriateness of existing institutional health services. This review process is required by Section 1513(g), 1523(a) (b) and 1523(b)(3). One of the DHEW's publications, Health Planning Information Series; Guide to the Collection and Use of Health Expenditures and Utilization Data for Health Planning Agencies states that appropriateness reviews help indicate gross inefficiencies on the part of service providers by focusing attention on total expenditures in relation to the number of patients served and/or service units delivered. ^{30/} Appropriateness reviews can be conducted on two different levels: areawide and institution-specific. Areawide reviews results in findings or recommendations regarding the appropriateness of a specific service in the aggregate, as it is provided by all institutions in the area or State. Institution-specific reviews result in findings or recommendations regarding the appropriateness of that service in a particular institution. ^{31/} The DHEW contracted with the Orkand Corporation to study the problems of conducting appropriateness reviews. This corporation produced a three volume report with a conceptual overview of appropriateness review (Appendix D).

Local and state health planning agencies will not perform institution-specific appropriateness reviews of federal hospitals, however the area reviews may have some impact on Army hospitals. It is probable that the results of appropriateness review will be reflected in the area health plan and in the coordination review comments when project proposals are submitted. It is also possible that OMB or DoD guidance will require The Surgeon General to compare hospital services with the appropriateness standards in the community where the hospital exist.

The future potential impact of appropriateness review on the private and public sector is as yet unclear. Presently the only sanction associated with inappropriate finding is public disclosure. The effect of this disclosure is unknown. This situation may change. A bill to encourage service curtailments and closure of inappropriate services has been drafted (Appendix E). If passed this bill could result in popularity for hospital service curtailments.

GAO Sizing Model

As in the civilian sector, the closest scrutiny of a hospital occurs when major construction is proposed. Because of the high dollar cost associated with hospital construction, careful analysis of the requirements for services is undergone. If any of the construction funding is tied to the inpatient area then the hospital is sized. Presently the General Accounting Office (GAO) sizing model is used to determine the number of beds which should be built into a military hospital. Very briefly the model works this way. Data is

accumulated nationally by the Commission on Professional and Hospital Activities in a Professional Activity Survey which reflects the average length of stay in the civilian sector by individual diagnosis (IPDS). The Biostatistics Agency of the Army Medical Department gathers similar data for each Army hospital including the total numbers of patients treated per year and the diagnosis of each patient at each Army hospital. Through a computer program the Army hospital's specific data on incidences of cases is adjusted by the civilian length of stay to produce a requirement for beds in the hospital. This is accomplished by types of beneficiary and the hospital is sized based on the beds required to support the health care needs of the active duty population and the dependents of the active duty. For a teaching hospital this base number of beds can be increased by ten percent to support retired military and their dependents. For non-teaching hospitals an increase of only five percent is allowed to provide beds for retired military and their dependents. A factor of 1.25 is applied to final bed figures to allow for dispersion (80% occupancy). The model also adjusts in the Army's favor for length of stays where the patient dies, is transferred or stays in the hospital for more than 100 days. Where the bed requirements of the active duty military based on the Army experienced length of stay exceed the PAS dictated beds, the Army can program light care beds.

In cases where the GAO sizing model has been applied it shows the need for a hospital significantly smaller than is presently being operated. This can generally be attributed to the lack of beds provided for retired military and dependents of retired military.

The Army can recapture the retired and their dependents' beds if it can be proven that it is more economical to build for and provide health care to this beneficiary within the Army hospital than it is to send this group out to CHAMPUS. This entails an extensive justification process.

The GAO sizing model has never been applied to an Army medical center construction project which has been built and no curtailments have occurred to date as a result of its application. In criticism of this sizing model it should be pointed out that it assumes: (1) the civilian length of stay is appropriate, (2) that the Army hospital can be planned in isolation and without affecting other Army hospitals and (3) that historical workload on incidences of health care need can reflect future health care needs of a community.

The future application of the GAO sizing model can result in service curtailments, especially for the retired community. Recently GAO has decided to make certain improvements to its model which will enable DoD to calculate the appropriate size of each medical specialty service within the hospital ^{32/}. This constitutes a new threat to the management of military hospitals. The future application of an improved GAO model may dictate specialty curtailments in yet to be constructed, replaced or modified Army hospitals.

Office of the Assistant Secretary of Defense (Health Affairs) has also developed a sizing model for hospitals which basically applies a straight line regression analysis to the historical workload data for active duty personnel and their dependents. This model has never been applied outside of the testing situation and it is doubtful that it will replace the GAO model. The GAO model has gained Congressional interest and approval.

HOSPITAL CLOSURE AT THE
NAVY HOSPITAL, NEW ORLEANS

The circumstances surrounding the closure and leasing of the Navy hospital in New Orleans are unique and serve rather poorly as an example of planning. The Navy originally requested a twenty-five bed facility, but due to the influence of a Congressman from Louisiana, built a facility with over 200 beds.^{33/} It was anticipated that certain Navy units would be restationed into the New Orleans area and would bolster the demand for health care at this hospital. This restationing never occurred and the hospital became a public issue of excessive construction and under utilization. The planning that went into the Navy's phase down to an outpatient clinic is not an example of forward thinking and planning but a study in reaction to public exposure. The decision was made to lease the hospital to a hospital service chain but a question concerning the certificate of need arose. The administrators of civilian hospitals in the New Orleans area wrote to the local Health System Agency, the state, HEW and DoD complaining that the need for more civilian beds was not evident and in fact the HSA had determined that New Orleans is an over-bedded area. The director of the HSA took up the issue and made a trip to Washington, DC, in early 1979 to discuss the question at HEW and with some members of Congress.^{34/} The leasing hospital corporation, Westbank Medical Center, rallied political support and when the HEW appropriation bill came before Congress the issue was resolved rather quickly with the HSA voicing no further objection to the lease agreement.^{35/} The Navy now operates a health clinic in a portion of the new building and Westbank Medical

Center operates a hospital in the remainder of the building. A review of the Congressional records shows very little discussion of the original need for the hospital and no discussion of leasing it out. It is curious however that from beginning to end the fate of this facility was decided at the Congressional level.

SAN FRANCISCO BAY AREA STUDY

In the San Francisco Bay area a study is ongoing to determine whether the Department of Defense needs to operate three hospitals within a forty mile radius. The item which originally generated the study was a change in the seismic criteria in California and the realization that neither Letterman Army Medical Center nor Oakland Navy Regional Medical Center meet the new requirements for earthquake resistance. The need for seismic upgrade at both locations and the cost of such construction gained the interest of personnel at the Department of Defense level and the San Francisco Bay Area Study was begun. It should be noted that the requirement for construction served as the leverage which allowed DoD to begin study of the Bay Area needs for military health care facilities. The study is being accomplished by a team of individuals headed by personnel from the US Army Health Services Command. The Navy and the Air Force provides data to this team. At the Surgeons General level there exist an ad hoc inter-service working group to oversee the study. At DoD level there is

an OSD Steering Group composed of the three Surgeons General, and representatives of the Offices of the Assistant Secretaries of Defense for Health Affairs, Manpower, Reserve Affairs and Logistics and Comptroller. The principle Deputy Assistant Secretary of Defense for Health Affairs chairs the steering group.

To date no conclusions have been reached or released from the study. The issue of seismic upgrade has ceased to be of much importance. Presently it appears that distrust and inter-service rivalry mark the tenor of the ongoing study. The alternatives which exist include: (a) maintaining the status quo and seismic upgrading both facilities, (b) closing Letterman and shifting workload to the Navy operated Oakland facility (c) closing Oakland and shifting workload to the Army operated Letterman facility, (d) closing Oakland, shifting the workload to Letterman and letting the Navy operate Letterman as a Navy facility.

It is estimated that this study will be completed in the summer of 1979. ^{36/}

The problem with making closure or curtailment decisions as they are being made in the San Francisco Bay Area Study are:

(1) the study lacks a holistic approach in that it ignores the effects which alternatives have on the overall military system of hospitals (2) the vested interests of the services are allowed to overly influence the study group.

SHARING

The concept of sharing services has gained considerable press in the civilian sector with hospitals joining in group purchasing and sharing such elements as medical maintenance or ambulance services. Sharing within the network of federal health care facilities may become a greater issue in the future. The General Accounting Office published on June 14, 1978, a report to Congress titled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." A digest of this report is provided at appendix F. If the recommendations of the report are acted upon by the Congress and if the Congress does have the stated desire for greater sharing of the nation's medical resources then it is possible that some health care facilities will curtail and shift their workloads to other facilities to meet sharing obligations.

COMPETITION FOR RESOURCES

The continued national inflation and the desire to contain cost and government spending have made budgeting an exercise of greater challenge. At the root of almost all of the future challenges which can potentially result in closure or curtailments is the pressure to spend less and within the government to budget less. These pressures have resulted in greater competition for available dollars for operation, maintenance, and construction. At the Headquarters level of the Army there is a perception that the dollars for medical activities must be fought for and justified more strongly than ever before. ^{37/}

In the past the Medical Department has been able to justify its requirements based on the uniqueness and life-saving nature of its mission. The need to maintain JCAH accreditation has been used liberally in the past to justify construction requirements with very little questioning from the rest of the Army Staff. These days may well have past. The Army Staff appears to be growing weary of the accreditation failure threat and the high price tag associated with medical facility construction. If medical facility construction funding does become extremely austere the probability of non-accreditation of an Army hospital is very real given present accreditation status, Appendix G. Accreditation failure could bring about service curtailment, especially if it occurs at a teaching hospital.

THE FUTURE IN SUMMARY

A number of factors have been identified which potentially can act alone or in unison to result in curtailment or closure pressure at a DoD hospital. These factors may vary from government actions in the civilian sector to control hospital cost to action within the Department of Defense which would result in fewer resources for the medical departments of the Services. The probability of one or more of these factors resulting in serious impact to close a hospital or curtail health care services is considered high.

FUTURE SYSTEM, WHAT SHOULD IT DO?

Given that there will be a future need to make decisions, there are three basic questions which must be resolved to properly address the issue of military medical facility service curtailment or facility closure. These questions are:

1. Who should make the decisions?
2. What scope of analysis is desirable?
3. What factors should be considered and what importance should be attached to these factors?

More specifically the optimal approach for decisions making will:

- a. Maintain decision making at the lowest level which is practical and effective.
- b. Be effective and not easily subverted.
- c. Minimize inter-service rivalry.
- d. Consider ^{the} military health care system as a whole and not inappropriately address facilities in an isolated fashion.
- e. Appropriately consider ~~ed~~ a maximum number of germane factors which influence the decision making process.
- f. Reflect DoD health care system comparability to the civilian sector health care system.

WHAT SHOULD THE DECISION APPROACH TAKE INTO ACCOUNT

A survey of commanders and executive officers of both Army and Air Force medical treatment facilities was conducted to provide background information for this paper. A copy of the survey questionnaire is provided at Appendix H.

In part this survey attempted to identify the importance of various factors which potentially should be considered in any proposed decision making approach. Interestingly, the respondents did not seem to feel that factors which are required to be considered under provisions of AR 5-10, "Reduction and Realignment Actions" are important for making decisions in the health care area. One notable exception to this is the status of the active duty population, which is of highest importance to both the AR 5-10 proponents and the health care providers. Issues such as community economic impact and community employment impact were not deemed important by the people surveyed.

The health care providers placed emphasis on maintaining graduate medical education programs, providing varied patient populations and treating the dependents of active duty personnel. There is generally high recognition for the importance of resources availability.

While there appears to be a fairly strong perception that a moral obligation exist to provide medical care to the retired military member and his dependents or survivors, the demand for health care by the same group was rated lower as a factors to be considered in decision making.

The physical conditions of the facility which is considered for closure was given fair weight as a factor to consider in decision making, however the conditions of facilities or facility associated JCAH problems were not judged to be a serious problem for the future by any hospital commander or executive officer. In a related response, the DoD facilities were judged, by most respondents, to be better than civilian health care facilities.

Factors which appear to have relatively less importance for decision making include: the reputation of the medical treatment facility; ties to local institutions; community impact; and comparability with the civilian community medical facilities under provisions of Public Law 93-641 and service appropriateness review.

The majority of respondents placed graduate medical education on the same level of importance as providing health care to the peacetime active duty Army. The respondents also expressed a strong desire to maintain or expand medical education programs and resist any resource reductions. There is a fairly strong perception that DoD's thrust to curtail or close health care facilities is predominantly motivated by reasons of budget economies, without regard to the needs of the services. No respondent felt that DoD personnel should initiate closure or curtailment initiatives. Respondents indicated that final decision making authority should rest at either the Surgeon General level or at DoD level. This is interesting since it is perceived that DoD personnel do not possess a good grasp of the problems faced by the medical departments of the services. The personnel in The Surgeon General's Office are

judged to possess an adequate appreciation for the needs of the hospitals and their problems, in most areas.

It is perceived that resources for health care will decrease in the next five years. The most important factor causing curtailments or closure of the future is judged to be decreases in the number of health care providers in the military. Budget reductions are judged to be the second most important single factor causing curtailments and closures.

Overwhelmingly the respondents seemed to think that there is a need for the existing number of medical centers.

Some interesting differences appeared between the groups surveyed. The medical center commander generally scored everything as more important a factor of consideration than the other groups. This may reflect a greater appreciation for the complexity of the problem. Both groups of physicians placed higher emphasis on graduate medical education, varied patient populations and providing care to the retired military and their dependents.

The administrative groups, executive officers, scored questions concerning resource limitations as more important than the physician groups did. MEDDAC executive officers gave greater importance to the physical conditions of hospitals and the productivity of the hospitals in question.

Medical center commanders give DoD personnel more credit for problem understanding than the other groups surveyed. MEDDAC Commanders prefer to see closure or curtailment initiatives start at the hospital level while the other groups favor initiatives starting at the Surgeon

General level. Medical Center commanders and executive officers desire that final decisions on closure or curtailment occur at the Surgeon General level while MEDDAC groups prefer to see decision made at the DoD level. MEDDAC commanders were the only group that seem to believe that resources for military health care will increase over the next five years.

DESIGN
ALTERNATIVES

Given the questions which must be resolved of who should make the decision for curtailment or closure and what approach should be used to arrive at a decision, two series of alternatives exist, each of which must be analyzed. The alternative decision levels include:

1. A Department of Defense Steering Committee overseeing the analysis work of a consultant firm and/or the analysis work of the three services.
2. A tri-service panel composed of non-medical representatives of each of the services. This panel would oversee and steer the analysis of subordinate working groups.
3. A tri-service panel composed of the three Surgeons General. This panel would oversee and steer the analysis of subordinate working groups.
4. A single service panel composed of predominately non-medical representative from the department. *Justification?*
5. A single service panel composed of personnel from the medical department and chaired by The Surgeon General or his representative.
6. The major command of several hospitals (Health Services Command).
7. The medical treatment facility.

The alternatives which exist for scope of analysis of decision making are:

1. Holistic to the DOD health care system. Analysis under this alternative must encompass the impact of any proposed action at a specific location on the other elements of the DOD health care system.

2. Holistic to the military services (Army, Navy or Air Force) health care system. Analysis under this alternative must encompass the impact of any proposed action at a specific location to the impact on the other element of that services health care system.

3. Isolated to the geographic area of the specific medical treatment facility in question and those other medical treatment facilities in geographic proximity which may be affected by a curtailment or closure.

4. Isolated to the specific medical treatment facility in question. The impact of proposed actions will not be evaluated by the reactions of other elements of the health care system.

ALTERNATIVE ANALYSIS AS A TECHNIQUE

Aside from the questions of who and by what overall conceptual approach, some method of developing and evaluating alternatives using reasonable criteria must be developed. The approach of an economic analysis is most reasonable and increasingly required to justify any major initiatives at the Department of the Army level. If major construction requirements become a by-product of the curtailment/closure decision making process, then an economic analysis is required. This approach requires a minimum of three alternative proposals for problem solution and a clear quantification and comparison of the costs, brought to the same point in time. Experience with economic analysis to date applied to the military health care system indicates that the application of this technique generally ignores the larger questions of individual alternative impacts on the broader health care system, but instead dwells on the narrower cost identified at a specific location. Additionally there appears to be a seductive rigor associated

with the quantified dollar figures of an economic analysis. The attempt is too often made to bring every variable of each alternative to a dollar figure and to make decisions based on cost comparisons. Non-cost data needs to be brought into the decision making arena. This data needs to be appropriately weighted and balanced against the quantifiable cost data. For these reasons an approach of alternative analysis as opposed to economic analysis is preferred. An alternative analysis would by nature have the same trappings of an economic analysis, that is a minimum of three alternatives, but would bring non-quantifiable factors into the decision making process. The weighting of these factors, as opposed to cost factors, should be decided in advance of data quantification.

FACTORS TO REPORT AND CONSIDER

For the final decision makers, the present and future status of the following factors should be enumerated for each alternative solution:

1. Beneficiary Numbers
 - a. Active Duty
 - b. Dependents of Active Duty
 - c. Retired
 - d. Dependents and survivors of retired
2. Location specific and service system (AMEDD) impact on graduate medical education (GME). Curtailment of a single residency can have system impact (Appendix J).
3. Location specific and service system impact on education and training programs outside of GME programs.
4. Existing and resultant patient population mixes.
5. Location specific and service system impact on unique services of the facility in question (burn units, etc.)

6. Location specific to the DOD health care facilities in geographic proximity and system wide impacts which result in a necessary shift of workload, programs or resources.
7. The ability of the civilian sector at the specific location in question to absorb workload which would be transferred under any proposed alternatives.
8. The health care cost of transferring workload either within the DOD system or to the civilian sector.
9. The cost to beneficiaries of each alternative.
10. Other government incurred cost associated with transferring workload to include transportation, and construction cost at a receiving DOD health care facility.
11. Compatability of each alternative to DOD health care resource trends to include operation dollars, construction dollars, and personnel assets.
12. The productivity of the facility or facilities in question and the impact of the alternatives on this productivity.
13. The effect of each alternative on civilian employees of the health care facilities impacted by alternatives. This is a more important element of AR 5-10 required data.
14. The availability of civilian employees (nurses, technicians, etc.) where workload increases will transfer to other facilities.
15. The physical conditions of facilities impacted by alternatives to include the need for modification as a result of alternatives, the known and projected need for modification to meet JCAH requirements, and the need for modification of facilities to improve efficiency and modernize or expand existing assets.

16. The assignment desirability of the medical treatment facility or facilities in question and the impact of the alternative on the ability of the service to meet these assignment desires.
17. The minimum workload comparability of services provided at the DoD facility and civilian health care facilities. More specifically, insure that the alternatives will not result in the provision of service at workload levels below the national guidelines published by HEW.
18. The over or under bedded status of the civilian community(ies) impacted by each alternative.

SYSTEMS IMPACT
CAPABILITY PLANNING

To be able to accomplish valid analysis and have worthwhile data to report a new approach is needed. A deficiency of most approaches for making decisions concerning closure or curtailment of a health care activity is the lack of analysis of overall system impact. The recommendation that a specific facility be closed needs to be made with an analysis of where certain functions can be reasonably relocated. For example, if it is proposed that a medical center be closed or phased down to the point of no longer providing graduate medical education programs, and there exist⁵ a need in the service to continue to train physicians in the same number, then an alternative teaching site ^{should} must be selected.

Within the Army Medical Department there is data available concerning the expanded capability of AMEDD hospitals. This data reflects expansion under wartime conditions but does not depict reasonable expansion

capability to meet potential expanded peacetime needs. This type of planning is needed if effective planning is to occur and if any methodology of closure/curtailment decision making is to be based on full evaluation of alternatives.

Capability planning should be applied to each Army hospital and identify the restraining factors and cost associated with incrementally increasing the workload or teaching/training capability of the facility. As the mission of a facility increases or is expanded then a number of factors should be analyzed. At some point the ability for expanding the capabilities of the facility become limited by either cost factors, physical limitations or training materials. At a minimum four levels of expanded ~~dd~~ capability should be identified: (1) low or no cost expansion which can be accomplished with the resource presently available on site (note commanders should be discouraged from any "can do" statements as mission increases should be considered long term and overworking the existing staff is not encouraged) (2) expansion which can occur without construction or modification of facilities but with the assignment or hiring of additional personnel, (3) expansion which can occur within minor construction or exigent minor construction limitations and the assignment and hiring of additional staff, (4) expansion which can occur with Military Construction, Army appropriation for facility modification or expansion and with the assignment or hiring of additional personnel.

Each of the expanded capability levels should be analyzed under two assumptions: (1) that additional workload will be generated by an increased post mission and additional active duty personnel will be

assigned to the post and (2) that no measurable addition will be made to the active duty population to be supported. Additional workload should be identified from unmet needs which exist in the community supported. It may be possible, for example, to effectively use an additional orthopedic surgeon or to open or expand an obstetrics service. For the larger MEDDACs the potential for graduate medical education programs should be recognized within the framework of capability planning. Where MCA construction is judged to be required the GAO sizing model should be applied to ascertain the practicality of justifying facility expansion.

An essential characteristic of capability planning is its ability to identify those factors which constrain expansion. It may be that the projected patient population is a limiting factor of expansion. Possibly operating rooms, delivery rooms, clinic space, office space, or beds available are the constraining factors which limit expanded capabilities. Other factors external to the hospital may pose problems. An overbedded condition in the civilian community may create problems if expansion proposals are based on recapturing CHAMPUS workload. This should be recognized.

The merit of capability planning is sound and this type of planning is already required for installation master planning by AR 210-23. This requirement addresses expanded missions due to an increased post mission and usually, increased numbers of active duty personnel. What is being proposed here is to expand this planning effort to identify additional capabilities to maximize AMEDD resource application.

SELECTING WHO SHOULD MAKE THE DECISION

A listing of eight worst potential decision results is provided at Appendix K.

It is the potential decision result that should dictate the level where the decision should be made. Seven levels of decision making have been identified (Appendix L). To determine the decision level in a given worst potential decision result situation the seven levels of decision making should be evaluated against three criteria. These criteria are: (1) the appropriateness of the decision level based on ability of personnel at that level to grasp the totality of the situation, (2) the acceptability and implementation potential of a decision made at this level within the effected service(s), (3) the appropriateness of the decision making level with respect to keeping decision making at the lowest reasonable level. Where service rivalry may be an issue, a criteria to evaluate unbiasedness is added. An example of an evaluation to decide at which level a decision should be made is provided at Appendix M.

SELECTING THE SCOPE OF ANALYSIS

Once the decision level has been established the methodology scope for problem analysis should be selected. Four analysis scopes have been identified: (1) a holistic analysis of alternative solution based upon the entire DoD health care system. (2) a holistic analysis of alternative solutions based upon the service (Army, Navy or Air Force) effected. (3) an analysis isolated to the geographic area of the health care facility effected (4) an analysis isolated to the health care facility under study.

Three criteria are identified for evaluation of the best conceptual method of analysis. Those criteria include: (1) minimizes inter-service rivalry; (2) consider the health care system effected in an appropriate scope; (3) minimizes unnecessary data collection. An evaluation of alternative analysis scopes is provided at Appendix N.

ANALYSIS PROCESS

Given the decision level and the conceptual methodology which should be used a study group should be formed. This group will vary in composition with the decision making level selected. The study group, which can be contracted, should use the alternative analysis technique previously described and develop a minimum of three alternatives to address the perceived problem. The curtailment of services at the local hospital level should be excluded from alternative analysis if the impact of a decision does not effect other medical treatment facilities.

Given the data obtained from capability planning the decision makers will be able to recognize alternative trade-off which should offset undersirable effects of certain closure or curtailment proposals. For example if a potential exists for curtailment of several graduate medical education programs at one medical center, then the impact on the service-wide teaching program can be assessed. It may be possible to shift resource to another or other medical centers and thereby maintain the total number of physicians in graduate medical education by specialty. To the knowledge of this researcher this type of data is not presently available to decision makers.

Criteria for evaluation of closure and curtailment alternatives should be agreed to early on in the evaluation process. The weighting of this criteria should also be agreed to prior to the evaluation of alternatives. Care will have to be taken to insure that meaningful criteria for evaluating alternatives is identified. Criteria which invites debate must be avoided. If quality of health care is proposed as a

criteria for evaluating alternatives, the method of quantifying the quality of health care under each alternative must be agreed to.

When alternatives and criteria for evaluation have been identified then the evaluation process should proceed drawing on the capability planning data and specific studies for the information necessary to quantify, evaluate and rank order alternatives in each criteria area. The decision maker can then make reasonable, informed decisions. Because of the potential requirement for analysis under provisions of AR 5-10 the decisions based on health care system impact analysis may require recycling, encompassing the documentation required by Congress and DoD when civilian community impact thresholds are surpassed.

COST AND BENEFIT OF ALTERNATIVES APPROACHES

As pointed out previously, the problem of making a decision to curtail medical services or to close a hospital (cease inpatient services) is an extremely complex problem. The multiple situations which present themselves as causal agents for considering a curtailment or closure together with the multiple circumstances which exist at the various medical treatment facilities and within the military health care system as a whole, resist any single best alternative decision making approach. Instead a process of ~~taylor~~^{TAILORING}ing the problem solving approach to the problem presenting itself must be pursued. The benefits of alternative levels of problem solving and scopes of analysis vary with the situation. Because a specific case and a

single final solution arrived at through a set methodology is not appropriate, the cost benefits of alternative approaches is not of importance. It can be assumed that decision making at a high level within DoD is more expensive than decision making at the medical treatment facility or facilities in question, but the burden of this cost is essential if effective decisions which can be implemented are to be reached.

The true benefit of the alternatives is that they are judged appropriate for the situation encountered. Criteria is established which dictates the level of decision making and the scope of analysis. The benefit to be realized by applying this criteria in selection of alternatives is a resultant decision which addresses all important factors in its analysis process and which has improved potential for implementation.

THE OPTIMAL FEASIBLE SOLUTION

No single alternative methodology can be judged as an optimal feasible solution to the problem of making decisions to curtail medical service or to close a hospital. The approach to decision making which is optimal varies with the situation encountered. The basic methodology has certain similarities. Alternatives should be developed and analyzed against appropriate consideration factors. Of key importance the impact of each alternative must be evaluated against its impact on the military health care system as a whole, both at the DoD system level and at the individual services levels. The merit of capability planning is deemed to be essential to any approach to decision making.

It is unfortunate that this type of information has not been gathered to date for studies which have occurred or are occurring on the subject of military health facility service curtailments, closures or relocations.

The technique of economic analysis has possibly been over emphasized in recent years. An economic analysis is clearly of value but should be considered only a portion of a larger alternative analysis which weighs non-cost items as well as costed items and displays this information to the decision makers.

IMPLEMENTATION ACTIONS INDICATED

To implement the problem solving approaches outlined and judged to be desirable by this project, actions must be taken at various levels of the DoD health care system. These actions include:

(a) use of capability planning as a data gathering tool for future decision making and (b) development of DoD instructions in the area of decision making concerned with health care service curtailments, hospital closures and health service relocations. These DoD instructions should follow the problem solving approach outlined in this project and must be staffed with the three Surgeons General.

MEASURING PERFORMANCE

The DoD Health Council should accept responsibility for measuring the performance of the decision making approach. Measurement should occur in the areas of: (1) insuring that the appropriate decision making level is used, (2) insuring that the correct analysis scope for each situation is used and (3) insuring that all appropriate factors are considered when evaluating alternatives specific to a hospital or system problem.

CORRECTIVE ACTIONS

The DoD Health Council should modify sections of the problem solving approach by (1) altering the criteria for selection of decision making

levels as required. (b) altering the criteria for selection of analysis scope as required and (c) by adding, deleting, and weighting those factors which should be used in evaluation of alternative decision packages.

RECOMMENDATIONS

The following recommendations are made:

1. Capability planning be applied to Army hospitals. Health Care Operation ^S within the Surgeon General's Office should be responsible for providing instructions to hospital commanders so that effective capability planning data can be gathered from MEDDACs and medical centers.
2. That this project be provided to the Deputy Director for Facilities, Office of The Assistant Secretary of Defense for Health Affairs.
3. That further study be applied to the area of appropriateness review at some future point in time. The future of appropriateness review is not yet clearly definable in the civilian sector, however its implementation appears to be forthcoming in some form.

*why not get
time in time?*

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- 2 Harold M. Goldstein and Morris A. Horowitz, Health Personnel: Meeting the Explosive Demand for Medical Care (Germantown, MD.: Aspen Systems Corporation, 1977), p. 26.
- 3 John K. Iglehart, "And Now It's Carter's Turn to Try to Control Health Costs" National Journal 10 (April 9, 1977), p. 551.
- 4 William Lucas, Statement Made at The Surgeon General's Installation Planning Board Meeting, HQDA, Washington, D.C., 6 February 1979.
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- 6 W. Henry Lambright, Grant Application, NCHSR Solicitation, "Achieving Effective and Equitable Service Cutbacks" Syracuse Research Corporation, Syracuse, New York (November, 1978).
- 7 Advanced Notice of Proposed Rule Making. "National Guidelines for Health Planning" Federal Register 42 (September 23, 1977) p. 48502.
- 8 Jack O. Lanier, COL, MSC, Director of US Army, Baylor University Graduate Program in Health Care Administration, Speech to 85th Annual Meeting of the Association of Military Surgeons of the U.S., Washington, D.C. (November 29, 1970).
- 9 John E. Murphy "Health Issues in the Federal Sector" Office of the Assistant Secretary of Defense - Health Affairs (November 29, 1978) p. 3
- 10 Charles C. Pixley, LTG., MC, USA, "United States Army Medical Department: Progress and Plans" Military Medicine 144 (February, 1979) p. 94.
- 11 Charles C. Pixley, Statement by Lieutenant General Charles C. Pixley MC The Surgeon General, Department of the Army, Before the Subcommittee on Personnel of the Committee on Armed Services, U.S. House of Representatives 96th Congress. (February 16, 1979) p. 7.
- 12 Ibid.
- 13 Health Services Command (HSOP-S) Letter, subject: "Reduction of Professional Services" dated 13 October 1978.
- 14 Pixley, p. 94.

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REDUCTIONS IN SERVICES PROVIDED
AT MEDDACS
(Between Jan. 1977 and Oct. 1978)

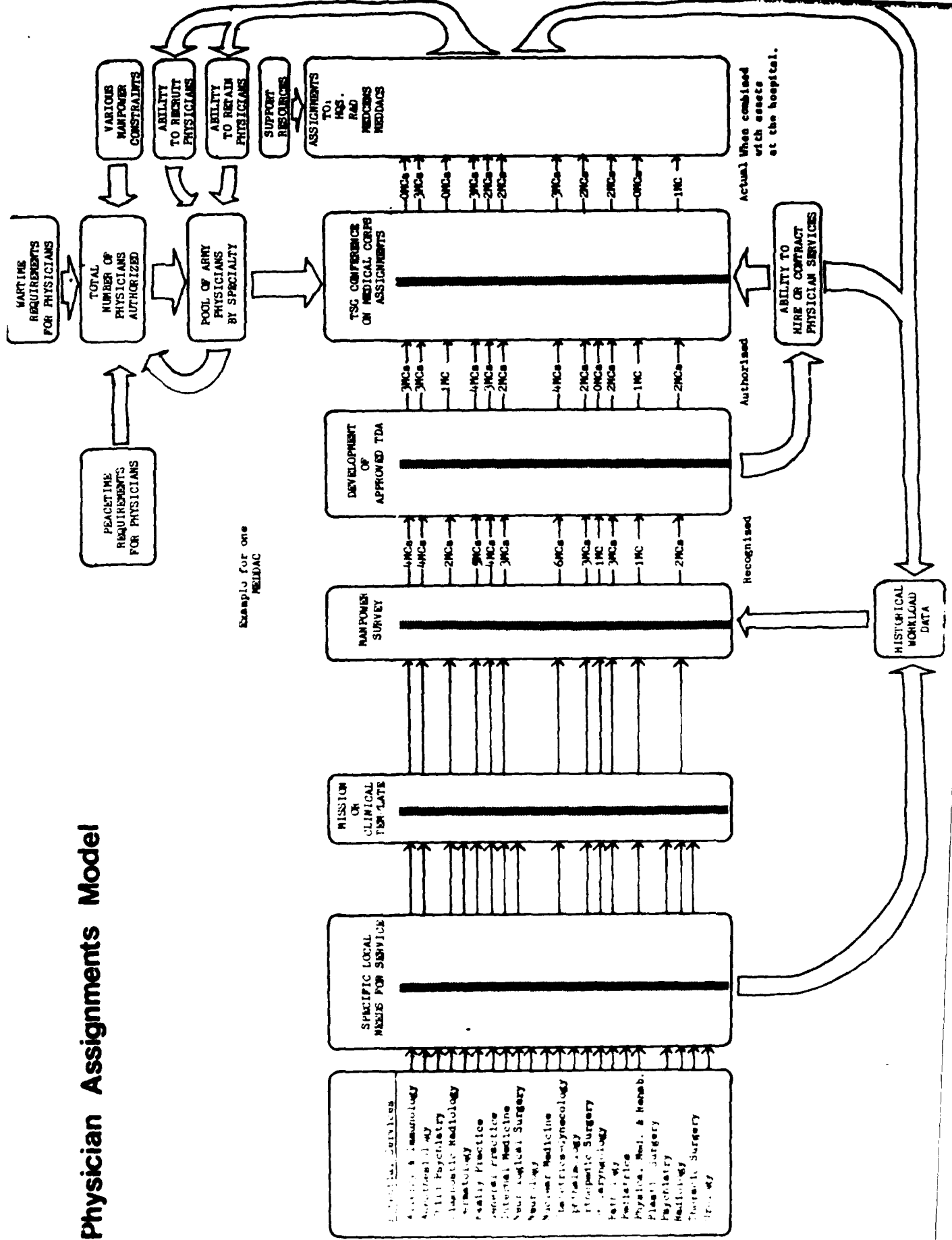
<u>SPECIALITY SERVICE</u>	NO. OF MEDDACS CURTAILING SVC. AVAILABILITY	NO. OF MEDDACS DROPPING SVC. COMPLETELY
Orthopedic	13	4
Optometry	10	0
Ophthalmology	3	6
Obsetrics	5	6
Gynecology	3	3
Internal Medicine	3	0
Physical Examination	3	0
Psychiatry	3	2
ENT	6	5
Dermatology	5	1
Podiatry	2	0
Neurology	1	4
Urology	0	3
Cardiology	4	0
Gastroenterology	1	1
Allergy	1	2
Nuclear Medicine	2	0
Social Work	2	0
Family Practice	2	0
Community Health	1	0

A total of 23 MEDDACS have reduced services in one or both of the above methods.

NOTE: The duration of all curtailments or drops of service are stated to be indefinite.

SOURCE: Data compiled based on information obtained from Health Services Command, Health Care Operations in a letter HSOP-S, dated 13 October 1978.

Physician Assignments Model



NATIONAL GUIDELINES
FOR
HEALTH PLANNING

<u>Planning Item:</u>	<u>National Guideline:</u>	<u>DoD Planning Guidance</u>
Beds per population served	There should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area except under extraordinary circumstances.	The DoD planning of hospital beds is based in historical workload and civilian length of stays. The GAO sizing model is applied. Results approach 3 beds per 1,000 population supported.
General hospitals Occupancy Rate	There should be an average annual occupancy rate for medically necessary hospital care of at least 80 percent for all non-Federal, short-stay hospital beds considered together in a health service area, except under extraordinary circumstance.	DoD hospitals are planned with a dispersion factor for beds of 80%. This should insure an average of 80% occupancy.
Obstetrical services	Hospitals providing care for complicated obstetrical problems (Levels II and III) should have at least 1,500 births annually. There should be an average annual occupancy rate of at least 75 percent in each unit with more than 1,500 births per year.	Obstetrical inpatient facilities are provided for all military hospitals with 360 or more deliveries per year.
Neonatal special care units	The total number of neonatal intensive and intermediate care beds should not exceed 4 per 1,000 live births per year in a defined neonatal service area. A single neonatal special care unit (Level II or III) should contain a minimum of 15 beds. "Bed" includes incubators or other heated units for specialized care and bassinets.	Regional, teaching and obstetrical centers nursery facilities are provided where deliveries exceed 2160 per year (deliveries/month). No lower limit of births is established for such hospitals with less than 2160 births per month. The mission of the specific hospital dictates.

Planning Item:	National Guidelines:	DoD Planning Guidance
Pediatric inpatient services	<p>There should be a minimum of 20 beds in a pediatric unit in urbanized areas.</p> <p>For a facility with 20-39 pediatric beds, the average annual occupancy rate should be at least 65%; for a facility with 40-79 pediatric beds, the rate should be at least 70%; for facilities with 80 or more pediatric beds, the rate should be at least 75%.</p>	Facilities provided based on mission of hospital
Open heart surgery	<p>There should be a minimum of 200 open heart procedures performed annually, within three years after initiation, in any institution in which open heart surgery is performed for adults.</p>	Individual study
Cardiac catheterization	<p>There should be a minimum of 300 cardiac catheterizations, of which at least 200 should be intracardiac or coronary artery catheterizations, performed annually in any adult cardiac catheterization unit within three years after initiation.</p> <p>There should be no new cardiac catheterization unit opened in a facility not performing open heart surgery.</p>	Individual study
Radiation therapy	<p>A megavoltage radiation therapy should serve a population of at least 150,000 persons and treat at least 300 cancer cases annually within three years after initiation.</p>	Individual study
Computed Tomographic Scanners	<p>A Computed Tomographic Scanner (head and body) should operate at a minimum of 2,500 medically necessary patient procedures per year, for the second year of its operation and thereafter.</p>	Individual study

SOURCES: National Guidelines from the Federal Register, Vol. 43, No. 60 (March 28, 1978). DoD criteria from DoD Hospital Space Planning Criteria.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Non D/D Item 1623
(Revised)

DRAFT

The Honorable Thomas P. O'Neill
Speaker of the House of
Representatives
Washington, D. C. 20510

Dear Mr. Speaker:

Enclosed for consideration by the Congress is a draft bill "To amend title XV of the Public Health Service Act to revise and extend the authorities and requirements under that title for health planning, to provide for assistance to hospitals in discontinuing inappropriate services, and for other purposes."

An appropriate health planning system is a cornerstone for the provision of quality health care and for the control of excessive health care costs. The National Health Planning and Resources Development Act of 1974 established the framework for such a system. We intend to continue our implementation of the program in this important area. The enclosed draft bill would materially assist our implementation by authorizing needed appropriations through fiscal year 1982 and by making certain improvements in current authorities.

Of particular importance in controlling unnecessary health costs is the elimination of unneeded hospital inpatient services. The draft bill would provide for grants for fiscal year 1980 to hospitals to assist them in eliminating inappropriate services. We estimate that this program would save more than two dollars in unnecessary costs for every dollar spent for the grants.

Assistance is needed for medical facilities having difficulties with safety hazards or accreditation. In addition, there are medically underserved populations which need outpatient medical facilities constructed or modernized. The draft bill would authorize appropriations of "such sums as may be necessary" for such projects for fiscal years 1981 and 1982.

The Honorable Thomas P. O'Neill

2

The Administration is not requesting an extension of the other health resources development authorities in title XVI of the Public Health Service Act. There are currently more acute inpatient facilities than are needed, and most of these facilities can usually raise funds for capital expenses without federal assistance. To control ever increasing health care costs we need to discourage additional unneeded construction. We intend to assist in developing needed health resources in areas with inadequate health care systems through such activities as the National Health Service Corps, community health centers, and health maintenance organizations.

A table of appropriation authorizations appears at Tab A, and a summary of the draft bill at Tab B.

We urge that the Congress give the draft bill its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

Secretary

Enclosures

2

APPROPRIATION AUTHORIZATIONS

(in thousands of dollars)

	FY 1980	FY 1981	FY 1982
HSA grants	\$115,400		
SHPDA grants	30,000		
Rate regulation	2,000	"such sums as may be necessary"	
Discontinuation of inappropriate hospital services	30,000	--	--
Medical facilities construction and modernization special projects	--	"such sums as may be necessary"	
Total	\$177,400		

SUMMARY OF DRAFT BILL

TITLE I

Section 101 would authorize appropriations for fiscal years 1980, 1981, and 1982 for health planning activities (see Tab A).

TITLE II

Section 201 would authorize the Secretary of Health, Education, and Welfare to change the boundary of a health service area if another boundary would be more suitable. The Secretary may now change the boundary only if the existing boundary ceases to meet statutory requirements.

Section 202 would expand the authority of a public regional planning body or unit of general local government that serves as a health systems agency (HSA), in relation to the authority of the separate governing body for health planning. The parent body would be empowered to approve the budget of the separate governing body for health planning, the health systems plan, and the annual implementation plan. The parent body could also remove for cause members of the separate governing body for health planning.

Section 203 would exempt personnel records from the requirement that HSAs, State health planning and development agencies (SHPDAs), and Statewide health coordinating councils (SHCCs) make their records available to the public.

Section 204 would permit individuals to serve as consumer representatives on HSAs although they had been classified as "indirect providers" during the immediately preceding year (often because they had served as members of a health institution's governing board), and would remove redundant terminology.

Section 205 would permit certain "providers" to serve on HSAs as "provider" representatives although they do not fall into one of five currently specified classes.

Section 206 would require nonmetropolitan representation on HSAs at least equal to the proportion of nonmetropolitan residents in the health service area. Currently the representation must be equal to the proportion of those residents in the health service area.

Section 207 would provide for the review of health systems plans and State health plans on at least a biennial, rather than an annual, basis.

Section 208 would permit the Secretary to specify those institutional health services which must be reviewed on an institution by institution basis as part of a SHPDA's appropriateness review activities.

Section 209 would permit the Secretary to return to conditional status for not more than 24 months an HSA which was experiencing difficulty in meeting all the requirements applicable to HSAs.

Section 210 would permit HSAs and SHPDAs to use funds granted in a fiscal year in the following fiscal year.

Section 211 would replace the present allocation of grants to HSAs on a formula basis with grants whose amounts would be determined by the Secretary.

Section 212 would permit the Secretary to continue beyond 36 months the conditional status of a SHPDA which had not yet met all the requirements applicable to SHPDAs, if the Secretary found that the SHPDA was making a good faith effort to meet those requirements.

Section 213 would permit the Secretary to return to conditional status for not more than 24 months a SHPDA which was experiencing difficulty in meeting all the requirements applicable to SHPDAs.

Section 214 would give the Secretary the discretion to determine the extent to which Federal funding under the Public Health Service Act and related laws should be reduced for States that by the end of fiscal year 1980 have not met all the Federal requirements for health planning activities in the State. Current law requires the Secretary to eliminate all such funds to States not in compliance.

Section 215 would require State certificate of need programs to determine the need for major medical equipment, whether or not located in a medical institution, but would eliminate the requirement that those programs determine the need for the establishment of health maintenance organizations.

Section 216 would delete a redundant requirement for State review of new institutional health services.

Section 217 would provide for representation of HSAs on SHCCs based on the population in each HSA's area, rather than on the current basis of equal representation for each HSA.

Section 218 would permit the Governor of a State to appoint the chairman of the SHCC; currently the SHCC members always choose their own chairman.

Section 219 would permit the Governor of a State to modify the State health plan developed by the SHCC, as long as the Governor consulted with the SHCC before making modifications and publicly stated his reasons for the modifications.

Section 220 would authorize the Secretary to make grants to SHPDAs for planning, evaluating, or carrying out programs to decertify health care facilities providing health services that are not appropriate. Up to 15 percent of the funds appropriated for State health planning and development could be used by the Secretary for this specific purpose.

Section 221 would permit HSAs and SHPDAs, in conducting reviews of proposed health system changes, to utilize, in relation to health maintenance organizations, only those criteria specified by the Secretary.

Section 222 would permit the Governor of a State which consists of one health service area to eliminate the HSA and have the SHPDA carry out the HSA's functions.

Section 223 would enact minor and technical amendments.

Section 224 would provide for effective date.

TITLE III

Section 301 would permit the Secretary to make grants to public or nonprofit private hospitals to assist them in discontinuing inappropriate inpatient hospital services. The Secretary could provide grant funds to assist in liquidating the outstanding debt of a hospital that was closing, converting part of a hospital from use for inpatient care to other health care uses, and meeting other costs associated with the discontinuation of the inappropriate services.

Section 302 would authorize the Secretary to provide technical assistance to hospitals to assist them in discontinuing inappropriate inpatient hospital services.

Section 303 would authorize appropriations of 30 million dollars for fiscal year 1980 for sections 301 and 302.

Section 304 would expand the medical facilities special projects authority. Current language authorizes grants for projects designed to prevent or eliminate safety hazards in public medical facilities, or to avoid noncompliance by such facilities with licensure or accreditation standards. Section 304 would authorize such grants for private non-profit facilities. The section would also permit the Secretary to make grants for other construction or modernization projects for outpatient medical facilities serving medically underserved populations. Section 304 would authorize appropriations of "such sums as may be necessary" for fiscal years 1981 and 1982 for special project grants.

DRAFT

A B I L L

To amend title XV of the Public Health Service Act to revise and extend the authorities and requirements under that title for health planning, to provide for assistance to hospitals in discontinuing inappropriate services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Short Title and References in Act

Section 1. (a) This Act may be cited as the "Health Planning Amendments of 1979".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I -- THREE YEAR AUTHORIZATION EXTENSIONS

Three Year Authorization Extensions

Sec. 101. (a) Section 1516(c)(1) is amended by striking out "and" after "1976," and by inserting before the period ", \$115,400,000 for the fiscal year ending September 30, 1980, and such sums as may be necessary for the two succeeding fiscal years".

(b) Section 1525(c) is amended by striking out "and" after "1976," and by inserting before the period ", \$30,000,0

for the fiscal year ending September 30, 1980, and such sums as may be necessary for the two succeeding fiscal years".

(c) Section 1526(e) is amended by striking out "and" after "1976," and by inserting before the period ", \$2,000,000 for the fiscal year ending September 30, 1980, and such sums as may be necessary for the two succeeding fiscal years".

TITLE II -- AMENDMENTS TO HEALTH PLANNING AUTHORITIES

Revision of Boundaries of Health Service Areas

Sec. 201. The first sentence of section 1511(b)(4) is amended by inserting after "the requirements of subsection (a)" the following: "or a change in the boundary of such area would result in a health service area which better meets the requirements of such subsection".

Improved Coordination Between Governing Bodies For Health Planning and Their Public Regional Planning Bodies or Units of General Local Government

Sec. 202. (a) Section 1512(b)(3)(A) is amended by striking out the first sentence and inserting instead the following: "A health systems agency which is a public regional planning body or unit of general local government shall establish a separate governing body for health planning in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 1513 except as otherwise provided in subparagraph (B) of this paragraph. The public regional planning body or unit of general local

government may remove for cause members of the governing body for health planning."

(b) Section 1512(c)(3)(B)(i) is amended by inserting immediately before the semicolon ", but the budget of a health systems agency described in clause (B) or (C) of paragraph (1) of this subsection shall be subject to approval by the public regional planning body or unit of general local government".

(c) Section 1512(b)(3)(B)(ii) is amended by inserting immediately before the semicolon ", but both plans (and amendments to those plans) in the case of a health systems agency described in clause (B) or (C) of paragraph (1) of this subsection shall be subject to approval by the public regional planning body or unit of general local government".

Confidentiality of Personnel Records

Sec. 203. (a) Section 1512(b)(3)(B)(viii) is amended (1) by striking out "business meetings" and inserting instead "business meetings (other than those parts of meetings that involve personnel matters)", and (2) by striking out "records and data" and inserting instead "records and data (other than records and data on the personnel of the health systems agency)".

(b) Section 1522(b)(6) is amended (1) by striking out "business meetings" and inserting instead "business meetings (other than those parts of meetings that involve personnel matters)", and (2) by striking out "records

and data" and inserting instead "records and data (other than records and data on the personnel of the State Agency)".

(c) Section 1524(b)(3) is amended by striking out "business meetings" and inserting instead "business meetings (other than those parts of meetings that involve personnel matters)".

Consumer Members of the Governing Body of
a Health Systems Agency

Sec. 204. (a) Section 1512(b)(3)(C)(i) is amended by striking out "who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care" and inserting instead "who are not providers of health care and have not within the twelve months preceding appointment been direct providers of health care (as defined in section 1531(3)(A))".

(b) Section 1512(b)(3)(C)(iii)(I) is amended by striking out "(either through consumer or provider members)" and inserting instead "(either through members who are providers of health care or through members who are not such providers)".

Provider Members of the Governing Body
of a Health Systems Agency

Sec. 205. Section 1512(b)(3)(C)(ii) is amended by striking out "who represent" and inserting instead "shall include representatives of".

Nonmetropolitan Members of the Governing Body
of a Health Systems Agency

Sec. 206. Section 1512(b)(3)(C)(iii)(II) is amended by inserting "at least" before "equal".

Biennial Review of Health Systems Plans and State
Health Plans

Sec. 207. (a) The first sentence of section 1513(b)(2), the first sentence of section 1523(a)(2), and the first sentence of section 1524(c)(2)(A) are each amended by striking out "annually" and inserting instead "biennially".

(b) Section 1524(c)(1) is amended by striking out "annual and coordinate the HSP and AIP" and inserting instead "and coordinate at least biennially the HSP and annually the AIP".

(c) The third sentence of section 1524(c)(2)(A) is amended by striking out "for each year".

Specification by the Secretary of Services for Appropriateness
Review on an Institution by Institution Basis

Sec. 208. Sections 1513(g)(1) and 1523(a)(6) are each amended by inserting "(and on an institution by institution basis those institutional health services specified by the Secretary)" after "health services".

Return of Health Systems Agency to Conditional Status

Sec. 209. Section 1515(c)(3) is amended by adding at the end the following: "If an agreement under this subsection is not renewed by the Secretary, he may enter into an agreement under subsection (b) with the entity for a period of conditional designation which may not exceed 24 months, if the Secretary finds that the period

of conditional designation should enable the entity to qualify again for designation under this subsection, and that the period of conditional designation will assist in carrying out the purposes of this title."

Carry-Over of Grant Funds

Sec. 210. (a)(1) The second sentence of section 1516(a) is amended (A) by inserting "and" after "appropriate," and (B) by striking out ", and shall be available for obligation" and all that follows in that sentence and inserting instead a period.

(2) Section 1516(a) is amended by inserting after the second sentence the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to an agency may be obligated in any period in which a designation agreement is not in effect for that agency, except that such funds shall be available for obligation for such additional period as the Secretary determines such entity will require to satisfactorily terminate its activities."

(b) The second sentence of section 1525(a) is amended to read as follows: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds

under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for that State Agency."

(c) Section 1526(c) is amended (1) by striking out "(1) such a grant" and all that follows through "(2)", and (2) by adding at the end the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for that State Agency."

Grants to Health Systems Agencies

Sec. 211. (a) Section 1516(b) is amended to read as follows:

"(b) The amount of any grant under subsection (a) to a health systems agency designated under subsection (b) or (c) of section 1515 shall be determined by the Secretary."

(b) Section 1516(c) is amended (1) by repealing paragraph (2), and (2) by striking out the paragraph designation "(1)".

Extended Period for Conditional Designation of a State Health Planning and Development Agency

Sec. 212. The first sentence of section 1521(b)(2)(B) amended by inserting ", except that the Secretary may extend the period for such additional time as he finds appropriate

if he finds that the designated State Agency is making a good faith effort to comply with the requirements of section 1523" before the period.

Return of State Health Planning and Development Agency
to Conditional Status

Sec. 213. Section 1521(b)(4) is amended by adding at the end the following: "If an agreement under paragraph (3) is not renewed by the Secretary, he may enter into an agreement under paragraph (2) with the Governor for a period of conditional designation which may not exceed 24 months, if the Secretary finds that the period of conditional designation should enable the agency to qualify again for designation under paragraph (3), and that the period of conditional designation will assist in carrying out the purposes of this title."

Secretarial Discretion in Withholding Funding

Sec. 214. Section 1521(d) is amended by striking out "may not make" and inserting instead "may decline to provide any portion of".

Major Medical Equipment and Health Maintenance Organizations
Under a State Certificate of Need Program

Sec. 215. (a) The first sentence of section 1523(a)(4) is amended by inserting "and new major medical equipment" after "new institutional health services".

(b) The second sentence of section 1523(a)(4) is amended by striking out "organizations" each place it occurs and inserting "in lieu thereof "equipment".

(c) Section 1531(5) is amended by striking out "and health maintenance organizations" and "and organizations".

(d) Section 1531 is amended by adding after clause (5) the following:

"(6) The term 'major medical equipment' means equipment which is used in the provision of health care and whose cost or fair market value (whichever is greater) exceeds \$150,000."

Review of New Institutional Health Services

Sec. 216. (a) Paragraph (5) of section 1523(a) is repealed, and paragraph (6) is renumbered as (5).

(b) Section 1513(f) is amended by striking out "paragraphs (4) and (5)" and inserting instead "paragraph (4)"

(c) Section 1522(b)(13) is amended by striking out "(5), or (6)" and inserting instead "or (5)".

(d) Section 1523(c) is amended by striking out "(4), (5), or (6)" and inserting instead "(4) or (5)".

Proportional Representation of Health Systems Agencies on Statewide Health Coordinating Councils

Sec. 217. (a) Section 1524(b)(1)(A) is amended (1) by striking out clause (ii) and by redesignating clause (iii) as clause (ii), and (2) by amending the first sentence of clause (ii) (as so redesignated) to read as follows: "The number of representatives on the SHCC to which a health systems agency is entitled shall be proportional to the share of the State's population in the agency's health servi

area, except that each agency shall be entitled to at least one representative on the SHCC."

(b) Section 1524(b)(1)(A)(i) is amended (1) by striking out "at least five ", and (2) by adding at the end the following: "Each agency shall submit a number of nominees to the Governor which is at least twice the number of representatives on the SHCC to which the agency is entitled."

Selection by Governor of Chairman of the
Statewide Health Coordinating Council

Sec. 218. Section 1524(b)(2) is amended to read as follows:

"(2) The Governor of the State shall either select from among the members of the SHCC a chairman, or direct the SHCC to select from among its members a chairman."

Modification of State Health Plan by Governor

Sec. 219. (a) Section 1524(c)(2) is amended by adding at the end the following:

"(C) The SHCC shall submit the State health plan to the Governor. The Governor may, within sixty days of the submission of the plan to him, make such modifications to the plan (and to the HSP's) as he finds to be advisable, provided that he (i) consults with the SHCC before he makes the modifications, and (ii) publicly states the reasons for making those modifications."

(b) The heading to section 1524 is amended by adding at the end "and Modification of State Health Plan by Governor".

Grants for Decertification Programs

Sec. 220. (a) Title XV is amended by inserting after section 1526 the following section:

"Grants for Decertification Programs

"Sec. 1527. (a) The Secretary may make grants to State health planning and development agencies for planning, evaluating, or carrying out programs to decertify health care facilities providing health services that are not appropriate. Grants under this section shall be made on such terms and conditions as the Secretary may prescribe.

"(b) The Secretary may use up to 15 percent of the sums appropriated for a fiscal year under section 1525 for grants under this section."

(b) Section 1525(c) is amended by inserting "and under section 1527 (to the extent provided under section 1527(b)), after "subsection (a),".

**Reviews of Proposed Health System Changes
in Relation to Health Maintenance Organizations**

Sec. 221. (a) Section 1532(c) is amended--

(1) in the matter preceding paragraph (1), by striking out "Criteria" and inserting instead "Except as provided in subsection (d), criteria",

(2) by striking out paragraph (8),

- (3) by renumbering paragraph (9) as (8), and
(4) by striking out the last sentence.

(b) Section 1532 is amended by adding at the end the following:

"(d) Criteria required by subsection (a) for health systems agency and State agency review, in relation to health maintenance organizations (as defined in section 1301), shall include only those criteria specified by the Secretary, and shall be consistent with the standards and procedures established by the Secretary under section 1306(c).".

Elimination of Health Systems Agencies in States Which
Consist of One Health Service Area

Sec. 222. Section 1536 is amended by adding at the end the following subsection:

"(c) At the request of the Governor of any State (other than a State under subsection (a)) which consists of one health service area, (1) no health systems agency shall be designated for the health service area, and (2) the State Agency designated for the State under section 1521 shall, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by section 1516.".

Minor and Technical Amendments

Sec. 223. (a) Section 1512(b)(3)(B)(iv) is amended by striking out the comma after "(h)".

(b) Section 1512(b)(3)(B)(vi) is amended by striking out "reimburse" and by inserting in lieu thereof "reimburse (or when appropriate make advances to)".

(c) Section 1513(e)(1)(A)(i) is amended (1) by inserting a comma after "Community Mental Health Centers Act", and (2) by striking out the second comma after "Drug Abuse Office and Treatment Act".

(d) Section 1513(e)(1)(A)(i) is amended by striking out "sections 409 and 410" and inserting instead "section 410".

(e) Section 1513(e)(1)(A)(i) is amended by inserting "of 1972" after "Drug Abuse Office and Treatment Act".

(f) Section 1513(e)(1)(B) is amended by striking out "under titles IV, VII, or VIII of this Act" and inserting instead "for research or training".

(g) The last sentence of section 1532(a) is amended by striking out "States" and inserting instead "State".

Effective Dates

Sec. 224. (a) Sections 202, 217, 219, and 221 of this title, and section 215 of this title with respect to major medical equipment, are effective 180 days after the date of its enactment.

(b) Section 211 of this title is effective with respect to grants made from funds appropriated for fiscal years beginning after September 30, 1979.

(c) The remainder of this title is effective on the date of its enactment.

TITLE III -- HEALTH RESOURCES

Grants to Hospitals to Assist in Discontinuing
Inappropriate Inpatient Hospital Services

Sec. 301. (a) The Secretary may make grants to public or private nonprofit hospitals to assist them in discontinuing inpatient hospital services that the Secretary determines are inappropriate.

(b) An application of a hospital for a grant under this section shall be in such form, submitted to the Secretary in such manner, and contain such information and assurances, as the Secretary may prescribe.

(c) The Secretary may make a grant under this section only if he determines--

(1) that the hospital would not be able to discontinue the services with respect to which the application is submitted without the grant, and

(2) that the hospital will comply with such conditions as the Secretary determines are appropriate.

(d) The amount of any grant under this section shall be determined by the Secretary. A grant under this section may include amounts--

(1) in the case of the closure of the entire hospital, to liquidate the net outstanding debt of the hospital,

(2) in the case of the conversion of part of the hospital from use for inpatient care to another health care use, to pay for the costs of that conversion, including costs of construction, and

(3) that the Secretary determines are otherwise needed to assist in discontinuing inappropriate inpatient hospital services.

(e) The Secretary may make payments under this section in advance or by way of reimbursement, and at such intervals and on such conditions as he finds necessary.

(f) Each hospital which receives a grant under this section shall (1) establish and maintain such records, and arrange to have performed such audits, as the Secretary may require, and (2) make available those records to the Secretary and the Comptroller General of the United States for examination, copying, and mechanical reproduction.

Technical Assistance

Sec. 302. The Secretary may provide technical assistance to hospitals to assist them in discontinuing inappropriate inpatient hospital services.

Appropriation Authorizations

Sec. 303. For the purposes of making grants and providing technical assistance under sections 301 and 302, there are authorized to be appropriated \$30,000,000 for fiscal year 1980.

Construction and Modernization Special Projects

Sec. 304. (a) Section 1625(a) is amended --

(1) by striking out the last sentence,

(2) by inserting "(1)" after the subsection

designation "(a)", and

(3) by adding at the end the following paragraph:

"(2) The Secretary may make grants for construction or modernization projects for outpatient medical facilities serving medically underserved populations."

(b) Section 1625(c) is amended by striking out "subsection (a)" and inserting instead "subsection (a)(1)".

(c) Section 1625(d) is amended to read as follows:

"(d) There are authorized to be appropriated such sums as may be necessary for fiscal years 1981 and 1982 for grants under subsection (a)."

(d) Section 1601 is amended by inserting before the period the following: ", and for construction and modernization projects for outpatient medical facilities serving medically underserved populations".

(e) The third sentence of section 1604(a) is amended by striking out "Except as provided in section 1625, the" and inserting instead "The".

Conceptual Overview of Appropriateness Review

	TASK NUMBER	HSA	SHCC Participates if Necessary	SHPDA
Formulation of the Appropriateness Review Work Program (6-9 months-Once Every Five Years)	1	Develop System-Wide Screening Criteria	Advise on Development of System-Wide Screening Criteria	Guide MSAs in Development of System-Wide Screening Criteria.
	2	Conduct System-Wide Screening.		
	3		Advise SHPDA on System-Wide Screening	Conduct System-wide Screening Based on MSA Recommendations
	4	←————→	Establish and Adopt General Criteria, Procedures and Data Needs for Areawide Reviews	←————→
	5	←————→	Set Schedule for Areawide Reviews by Service	←————→
Areawide Review of a Service Repeated for Each Service; Estimated 12 months for review of four Services)	6	←————→	Establish Service-Specific Criteria and Standards for Areawide and Service-Institution Specific Review	←————→
	7	Conduct Areawide Screening and Formulate Preliminary Areawide Recommendations		
	8*	Review Selected Institutional Providers of the Service Identified in Areawide Screening		
	9	Issue Recommendations on Areawide Appropriateness of Service, Including Individual Providers of the Service.		
	10		Advise SHPDA on Formulation of State-wide Findings on the Service	

* Task not always performed.

AD-A184 676

HOW DO WE TURN THIS THING OFF? A STUDY TO DETERMINE AN
APPROACH FOR MAKIN (U) ACADEMY OF HEALTH SCIENCES
(ARMY) FORT SAM HOUSTON TX HEALTH C C E MAXWELL

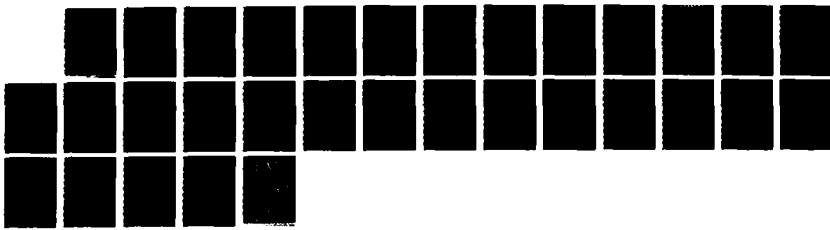
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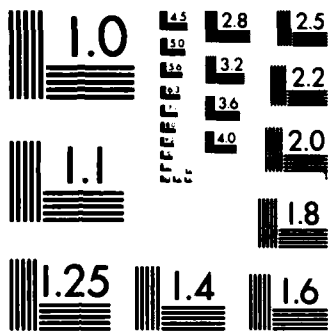
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COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

LEGISLATION NEEDED TO ENCOURAGE
BETTER USE OF FEDERAL MEDICAL
RESOURCES AND REMOVE OBSTACLES
TO INTERAGENCY SHARING

D I G E S T

The Congress has expressed its desire for greater sharing of the Nation's medical resources by enacting several laws to encourage regional cooperation in the health care community. However, Federal agencies' participation in regional health planning groups established as a result of these laws has, for the most part, been only advisory.

No interaction is required between Federal agencies responsible for the direct delivery of health care. Moreover, no laws clearly require Federal interagency sharing, although several permit Federal health facilities to share their capabilities with other agencies.

GAO studied the direct health care delivery activities of the Department of Defense (DOD), the Veterans Administration (VA), and the Department of Health, Education, and Welfare's (HEW's) Public Health Service to identify (1) opportunities for Federal health care providers to share their resources and (2) legislative, administrative, and other obstacles which preclude or inhibit sharing. Each is responsible for providing medical care to specified categories of beneficiaries.

The Office of Management and Budget works with the agencies to improve the planning and coordination of Federal health programs, most often through its annual budget reviews.

In fiscal year 1977, DOD, VA, and HEW collectively spent over \$6 billion to provide medical care directly to eligible Federal beneficiaries and over \$700 million for medical care provided to eligible beneficiaries in the non-Federal sector. Recently, representatives of the three agencies met to

begin planning for increasing interagency sharing. An interagency Federal Health Resources Sharing Committee has been established. (See p. 10 and apps. II and III.)

Numerous opportunities for increased interagency sharing either were not considered as opportunities by the agencies involved, had been pursued but abandoned, or had been only partially successful. (See app. IV.)

In most instances the following obstacles precluded attempts by or discouraged local Federal officials from completing satisfactory interagency sharing arrangements.

- The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share. (See p. 11.)
- Restrictive agency regulations, policies, and procedures. (See p. 14.)
- Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries. (See p. 23.)

Attempts to share, whether started at the local Federal hospital level (including clinics) or by an interagency group at the department level, such as the Federal Health Resources Sharing Committee, will be hindered by the same obstacles.

Existing legislation is subject to various interpretations and/or permits only certain types of resources to be shared. This makes it difficult for agencies to use such legislation to increase interagency sharing. Frequently Federal officials do not know what the specific groundrules are, and little substantive direction has been provided to local Federal hospitals concerning interagency sharing problems and questions.

Eliminating legislative and administrative obstacles and implementing a structured

Federal interagency sharing program would be advantageous to both the Federal Government and its health care beneficiaries.

A key factor is enacting legislation to direct interagency sharing whenever appropriate and encourage the establishment of uniform Government-wide implementing procedures. Such legislation should encourage individual initiative without affecting any Federal agency's organizational or command structures. It should also give increased management options to local Federal medical officials to make the best use of the Nation's medical resources.

RECOMMENDATIONS TO AGENCIES

The Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs should jointly direct the Federal Health Resources Sharing Committee to expeditiously seek workable solutions to the administrative obstacles within each agency which impede sharing, and report individually on an annual basis to the congressional appropriations committees on the progress being made in implementing an effective sharing program. (See p. 30.)

The Director, Office of Management and Budget, should establish a management group within the existing Office of Management and Budget organizational structure to work with DOD, HEW, and VA to better coordinate the development of an effective Federal sharing program. The group should work closely with the Federal Health Resources Sharing Committee and with the Office of Management and Budget officials responsible for reviewing budget requests for Federal health care delivery activities in order to foster increased interagency sharing. (See p. 30.)

RECOMMENDATIONS TO THE CONGRESS

The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically this legislation should:

- Establish a Federal policy that directs interagency sharing when appropriate.
- Authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected.
- Eliminate all restrictions on the types of medical services which can be shared.
- Authorize Federal field hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government.
- Authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner.
- Establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources.
- Authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred.
- Assign to the Office of Management and Budget the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources. (See p. 30.)

AGENCY COMMENTS

DOD and HEW generally agreed with GAO's conclusions and recommendations. VA did not. The Office of Management and Budget did not take a position on the legislative recommendations, but disagreed with GAO's recommendation regarding the designation of a group to work

with the Federal agencies to coordinate the development of an effective interagency sharing program.

GAO's evaluation of the agencies' comments is on pages 31 through 38.

Tear Sheet

16 FEB 1979

ARCADE/AL/NEDGEN

SURVEY FUNDING

DATE NEXT SURVEY

LOCATION/ADDRESS	SURVEY FUNDING	DATE NEXT SURVEY	REMARKS
Wm. Beaumont Army Medical Center	Two-year	1978	
Brooke Army Medical Center	One Year	1978	
Fitzsimons Army Medical Center	One year	1978	(Single survey)
Letterman Army Medical Center	Two year	1978	(Single survey)
Madigan Army Medical Center	Two year	1977	
Walter Reed Army Medical Center	One year	1978	1979*
Dwight D. Eisenhower Medical Center	Two year	1978	1980
Tripler Army Medical Center	One year	1978	1979*
DeWitt AH, Ft Belvoir, VA	Two year	1977	
Martin AH, Ft Benning, GA	One year	1978	(Single survey)
Womack AH, Ft Bragg, NC	Two year	1977	
USAH, Ft Campbell, KY	One year	1978	(Single survey)
USAH, Ft Carson, CO	Two year	1977	
Cutler AH, Ft Devens, MA	Two year	1977	
Walson AH, Ft Dix, NJ	One year	1978	(Single survey)
McDonald AH, Ft Eustis, VA	Two year	1977	
Darnall AH, Ft Hood, TX	Two year	1977	(Single survey)
Raymond W. Bliss AH, Ft Huachuca, AZ	Two year	1977	
Honrieff AH, Ft Jackson, SC	Two year	1977	
Ireland AH, Ft Knox, KY	Two year	1978	
Carson AH, Ft Leavenworth, KS	Two year	1976	1979**
Kenner AH, Ft Lee, VA	Two year	1977	
General Leonard Wood AH, Ft Leonard Wood, MO	One year	1978	1979 *
Noble AH, Ft McClellan, AL	Two year	1976	1979 **
Kimbrough AH, Ft George G. Meade, MD	Two year	1976	1979 **
Patterson AH, Ft Monmouth, NJ	Two year	1977	
Sillas B. Hays AH, Ft Ord, CA	Two year	1978	
USAH, Ft Polk, LA	One year	1978	(Single survey)
USAH, Redstone Arsenal, AL	Two year	1978	
Urban AH, Ft Riley, KS	Two year	1977	
Lytler AH, Ft Rucker, AL	Two year	1977	
Reynolds AH, Ft Sill, OK	Two year	1978	
USAH, Ft Stewart, GA	Two year	1977	
US Military Academy, West Point, NY	One year	1978	
Bassett AH, Fairbanks, AK	Two year	1977	

* Full survey following single interim
** Postponed survey

AN OPINION SURVEY ON
SERVICE CURTAILMENTS OR CLOSURES
OF DOD HOSPITALS

The attached survey has been developed to gather research information on the subject of health services curtailments and hospital closures. For a number of reasons, future situations may dictate careful consideration of alternatives and initiatives to curtail services or close hospitals at various locations. The opinions of those individuals who are actively engaged in the application of increasing scarce resources to provide health care is considered essential to the development of a full appreciation for the implications of curtailment/closure proposals. More specifically this questionnaire is aimed at: 1) obtaining an appreciation for the relative importance of various factors which should be considered in the decision making process, 2) obtaining a feel for perceptions about the reasons for curtailment/closure initiatives, and the ability of higher headquarters to make sound decisions in this area and 3) obtaining opinions about the future with respect to curtailments and closures.

Your participation in this survey is greatly appreciated. Individual responses will not be released. However, if you would like to obtain feedback concerning the survey's results showing how total numbers of individuals responded to each part of the survey, please indicate this desire on the last question of the survey form.

PART I
BACKGROUND INFORMATION

A. I am a:

- Medical Center Commander
- MEDDAC Commander
- Medical Center Chief of Staff
- Medical Center Executive Officer
- MEDDAC Executive Officer
- Other _____

B. I am located at a hospital of:

- Above 500 beds
- 300-500 beds
- 100-300 beds
- 50-100 beds
- 10-50 beds

C. At the medical facility where I am presently assigned:

- There have been service curtailments in the past three years.
- There have been discussion of facility closure, either at this hospital or concerning this hospital at higher headquarters.
- None of the above.

PART II
DECISION MAKING FACTORS

The following is a listing of items which possibly should be considered when evaluating the merit of curtailing medical services at a DoD health care facility or closing the facility. You are requested to evaluate the importance of each of these factors. On the left of the item, please indicate by circling a number, the relative importance of the item between 1 and 5, and 1 indicating most important and 5 indicating least important.

<u>Relative Importance</u> (Most to Least)					<u>Item</u>
1	2	3	4	5	The need to provide medical care to an active duty population.
1	2	3	4	5	The need to provide medical care to dependents of active duty personnel.
1	2	3	4	5	The demand for medical care by retired and dependents of retired personnel.
1	2	3	4	5	A moral obligation to provide medical care to retired military members and their dependents.
1	2	3	4	5	A need to provide accredited graduate medical education opportunities to active duty physicians.

Relative Importance
(Most to Least)

Item

1	2	3	4	5	Item
1	2	3	4	5	The need for a varied patient population to retain physicians.
1	2	3	4	5	The need for a varied patient population to support graduate medical education programs.
1	2	3	4	5	Ties (research, teaching training, etc.) to other DoD activities in geographic proximity to the medical treatment facility in question.
1	2	3	4	5	Existing ties to local civilian health care institutions.
1	2	3	4	5	Ability to maintain the total number of graduate medical education positions (interns, residents and fellows) within the service worldwide.
1	2	3	4	5	National and local reputation enjoyed by the medical treatment facility.
1	2	3	4	5	The need to shift limited health care resources to other locations.
1	2	3	4	5	The dictates of fewer resources (dollars and personnel).
1	2	3	4	5	The ability of the civilian community to provide health care through the CHAMPUS program.
1	2	3	4	5	The ability of another DoD facility in a forty mile radius to absorb additional workload.
1	2	3	4	5	Unemployment impact of proposed actions on local community.
1	2	3	4	5	Economic impact of proposed actions on local community.
1	2	3	4	5	The productivity of the medical treatment facility in question, as compared with other DoD facilities.
1	2	3	4	5	The physical conditions of the facility and the need for a construction project to assure JCAH accreditation and efficient operation.

Relative Importance
(Most to Least)

Item

1 2 3 4 5

The need to curtail services to maintain comparability with what is deemed "appropriate" under provisions of Public Law 93-641, The National Health Planning Act, in the civilian sector.

1 2 3 4 5

Other _____

1 2 3 4 5

Other _____

PART III
PERCEPTIONS AND OPINIONS

The following questions are designed to obtain information concerning perceptions and opinions. Please check the appropriate blocks.

A. Which is more important?

- Enhancing physician retention and medical department competence for combat needs through the medical center teaching programs.
- Providing health care to the peacetime active duty force where it is located.
- Both of the above are equally important.

B. In the face of DoD resources reductions, should the services fight to maintain or expand the medical education programs?

- yes
- in some specialities
- no

C. Is the thrust at DoD to curtail or close health care facilities predominantly for budget economies, without regard to the needs of the services?

- yes
- partially true
- no

D. At what level initiatives for curtailments or closures be originated?

- at medical treatment facility
- at major command
- at The Surgeon General's Office
- at DoD

E. At what level should curtailment or closure decisions be finalized?

- at the major command
- at The Surgeon General's Office
- at DOD

F. Do personnel at DoD possess a good grasp of the problems faced by the medical departments of the services?

- yes
- only in some areas
- only some individuals
- no

G. Do personnel in The Surgeon's Office possess an adequate appreciation for the needs of the hospitals and their problems?

- yes
- in most areas
- in some area
- no

(.1. In the next five years DoD resources for health care will:

Decrease considerably

Decrease a little

Remain constant

Increase a little

Increase considerably

I. The most important probable single factor causing the curtailment/closure actions of the future will be:

A reduced budget for DoD health care.

Base realignments and closures.

Fewer health care providers on active duty.

Inability to maintain JCAH accreditation because of unfunded construction requirements.

Regionalization.

Other _____

J. Is there a need for the existing number of military teaching hospitals?

yes

no

K. Over the past five years the resources provided to other DoD programs have done what in relation to resources provided for health care associated programs?

Increased at a faster rate.

Increased at an equal rate.

Decreased at an equal rate.

Decreased at a faster rate.

.. In comparison with civilian medical treatment facilities, DoD facilities are generally:

- Much better
- Better
- About the same
- Worse
- Much worse

M. I would like to receive a copy of the consolidated results of this survey.

- yes
- no

RESULTS DISPLAY
FOR
OPINION SURVEY ON
SERVICE CURTAILMENTS
OR CLOSURES OF DOD HOSPITALS

A survey was developed to gather research information on the subject of health services curtailments and hospital closures. For a number of reasons, future situations may dictate careful consideration of alternatives and initiatives to curtail services or close hospitals at various locations. The opinions of those individuals who are actively engaged in the application of increasingly scarce resources to provide health care was considered essential to the development of a full appreciation for the implications of curtailment/closure proposals. The results of the survey follow:

PART I
BACKGROUND INFORMATION

Surveys were mailed to a total of 50 individuals and 42 responded. All of these individuals are assigned to DoD hospitals.

A. Profile of respondents:

Numbers	Type
9	Medical Center Commanders
12	Meddac Commanders
1	Medical Center Chief of Staff (responses shown with MEDCEN X.O.s)
8	Medical Center Executive Officers (X.O.s)
12	Meddac Executive Officers (X.O.s)

Responses above includes a total of six Air Force respondents.

B. Respondents by numbers of beds at hospitals where assigned:

Numbers	Size of Hospitals
11	Above 500 beds
7	300 - 499 beds
22	100 - 299 beds
2	50 - 99 beds
0	Below 49 beds

- C. 1. Twenty-six individuals stated that there have been service curtailments in the past three years at the medical facility where they are presently assigned.
2. Five individuals stated that there have been discussions of facility closure where they are presently assigned. These discussions have occurred either at their hospital or at a headquarter above them.
3. Thirteen individuals stated that there have been neither any curtailments of services in the past three years at their hospital nor any discussions of closure.

PART II
DECISION MAKING FACTORS

Individuals surveyed were asked to indicate the importance of the following items as factors for consideration when evaluating the merit of curtailing medical services of closing a DoD health care facility. The importance of the item was indicated between a numerical scale of 1 to 5. The number 1 indicates most important and the number 5 indicates least importance.

ITEMS: WHICH POSSIBLY SHOULD BE CONSIDERED	Total Mean	CATEGORIES OF RESPONDENTS																							
		MEDCEN CDR.					MEDDAC CDR.					MEDCEN X.O.					MEDDAC X.O.								
		Group Mean	Response Frequency	Group Mean	Response Frequency	Group Mean	Response Frequency	Group Mean	Response Frequency	Group Mean	Response Frequency	Group Mean	Response Frequency												
1. The need to provide medical care to an active duty population.	1.00	1.00	9	0	0	0	0	1.00	12	0	0	0	0	1.00	9	0	0	0	0	1.00	12	0	0	0	0
2. The need to provide medical care to dependents of active duty personnel.	1.60	1.22	7	2	0	0	0	1.75	3	9	0	0	0	1.78	3	5	1	0	0	1.58	5	7	0	0	0
3. The demand for medical care by retired and dependants of retired personnel.	2.38	1.88	3	4	2	0	0	2.91	1	5	2	2	2	2.56	1	3	4	1	0	2.08	3	5	4	0	0
4. A moral obligation to provide medical care to retired military members and their dependents.	1.98	1.22	7	2	0	0	0	2.50	2	4	4	2	0	2.89	4	3	1	1	0	2.08	4	5	2	0	1
5. A need to provide accredited graduate medical education opportunities to active duty physicians.	1.83	1.00	9	0	0	0	0	2.16	5	3	2	1	1	1.78	6	1	1	0	1	2.17	3	5	3	1	0

ITEMS: WHICH POSSIBLY SHOULD BE CONSIDERED.	CATEGORIES OF RESPONDENTS																								
	MEDCEN . CDRS .					MEDDAC CDRS .					MEDCEN . X.O.s					MEDDAC X.O.s									
	Total Mean	Group Mean		Response Frequency			Group Mean	Group Mean		Response Frequency			Group Mean	Group Mean		Response Frequency									
		1	2	3	4	5		1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		
6. The need for a varied patient population to retain physicians.	1.83	2.33	3	2	3	0	1	1.42	9	1	2	0	0	1.22	7	2	0	0	0	2.33	3	3	5	1	0
7. The need for a varied patient population to support graduate medical education programs.	1.95	2.00	4	1	2	1	0	2.25	3	5	3	0	1	1.22	7	2	0	0	0	2.33	3	4	3	2	0
8. Ties (research, teaching, training, etc.) to other DoD activities in geographic proximity to the medical treatment facility.	2.67	2.22	2	3	4	0	0	3.33	0	3	5	1	3	2.11	3	3	2	1	0	2.75	2	4	2	3	1
9. Existing ties to local civilian health care institutions.	2.69	2.38	2	3	2	0	1	3.17	2	2	3	2	3	2.55	2	1	5	1	0	2.75	2	3	4	2	1
10. Ability to maintain the total number of graduate medical education positions (interns, residents and fellows) within the service worldwide.	2.02	2.67	2	3	2	0	2	1.75	8	1	2	0	1	1.33	6	3	0	0	0	2.33	3	4	4	0	1
11. National and local reputation enjoyed by the medical treatment facility.	2.71	3.00	1	3	2	1	2	2.92	2	2	5	1	2	2.00	2	5	2	0	0	2.83	2	3	4	1	2

ITEM: WHICH POSSIBLY SHOULD BE CONSIDERED.	CATEGORIES OF RESPONDENTS																							
	MEDCEN CDRS.				MEDDAC CDRS.				MEDCEN X.O.s				MEDDAC X.O.s											
	Group Mean	Response Frequency			Group Mean	Response Frequency			Group Mean	Response Frequency			Group Mean	Response Frequency										
		1	2	3		4	5	1		2	3	4		5	1	2	3	4	5					
12. The need to shift limited resources to other locations.	2.44	3	1	3	2	0	3.00	1	4	3	2	2	2.11	4	0	2	1	1	2.08	2	8	1	1	0
13. The dictates of fewer resources (dollars and personnel).	1.64	4	3	2	0	0	1.75	7	1	4	0	0	1.86	3	2	2	0	0	1.58	6	5	1	0	0
14. The ability of the civilian community to provide health care through the CHAMPUS program.	2.00	3	2	3	0	1	2.25	2	7	1	2	0	2.11	5	2	0	0	2	2.08	6	2	2	1	1
15. The ability of another DoD facility, in a forty mile radius, to absorb additional workload.	1.89	4	2	3	0	0	2.83	1	5	3	1	2	2.00	5	2	0	1	1	2.58	2	4	4	1	1
16. Unemployment impact of proposed actions on local community.	3.71	1	0	2	3	3	4.42	0	1	1	2	8	3.11	2	1	1	4	1	3.75	0	1	4	4	3
17. Economic impact of proposed actions on local community.	3.90	0	0	3	2	4	4.50	0	1	0	3	8	3.22	2	1	1	3	2	3.67	0	1	5	3	3
18. The productivity of the medical treatment facility in question, as compared with other DoD facilities.	2.33	3	1	2	3	0	3.00	3	1	2	5	1	1.89	5	1	2	1	0	1.83	3	8	1	0	0

ITEMS: WHICH POSSIBLY SHOULD BE CONSIDERED.	CATEGORIES OF RESPONDENTS																							
	MEDCEN CDRS.			MEDDAC CDRS.			MEDCEN X.O.S.			MEDDAC X.O.S.														
	Group Mean	Response Frequency		Group Mean	Response Frequency		Group Mean	Response Frequency		Group Mean	Response Frequency													
		1	2		3	4		5	1		2	3	4	5										
19. The physical con- ditions of the facility and the need for a construc- tion project to assure JCAH accred- itation and efficient operation.	2.44	2	2	4	1	0	2.42	4	2	3	3	0	2.22	4	1	2	2	0	1.67	6	4	2	0	
20. The need to curtail services to maintain comparability with what is deemed "appropriate" under provisions of Public Law 93-641, The National Health Plan- ning Act, in the civilian sector.	3.56	0	0	6	1	2	2.36	1	2	4	1	3	3.00	1	2	4	0	2	3.41	1	0	6	3	2
21. Other:																								
The retention of health professionals.	n.a.	1	0	0	0	0																		
Cost-benefit analysis- Total savings to DoD.	n.a.								0	1	0	0												
Long range plans- change to instal- lation mission.	n.a.								0	1	0	0												

PART III
PERCEPTIONS AND OPINIONS

Frequency of Responses- CATEGORIES OF RESPONDENTS				TOTALS	QUESTIONS/ANSWERS
MEDCEN CDRS	MEDDAC CDRS.	MEDCEN X.O.s	MEDDAC X.O.s		
1	1	2	1	5	Q. Which is more important? A1. Enhancing physician retention and medical department competence for combat needs through the medical center teaching programs.
1	2	0	3	6	A2. Providing health care to the peacetime active duty force where it is located.
7	9	7	8	31	A3. Both of the above are equally important.
9	10	6	10	35	Q. In the face of DoD resource reductions, should the services fight to maintain or expand the medical education programs.
0	2	3	2	7	A1. Yes
0	0	0	0	0	A2. In some specialities
					A3. No
2	7	3	6	18	Q. Is the thrust at DoD to curtail or close health facilities predominantly for budget economies, without regard to the needs of the services?
6	4	4	4	18	A1. Yes
0	1	2	2	5	A2. Partially true
					A3. No
2	6	3	4	15	Q. At what level should initiatives for curtailments or closures be originated?
2	4	1	4	11	A1. At medical treatment facility
5	2	5	4	16	A2. At major command
0	0	0	0	0	A3. At The Surgeon General's Office
					A4. At DoD

FREQUENCIES OF RESPONSES - CATEGORIES OF RESPONDENTS					TOTALS	QUESTIONS/ANSWERS
MEDCEN CDRs	MEDDAG CDRs	MEDCEN X.O.s	MEDDAG X.O.s			
1	1	3	2	7	Q. At what level should curtailment or closure decisions be finalized?	
5	7	2	3	17	A1. At the major command	
3	4	4	7	18	A2. At the Surgeon General's office	
					A3. At DoD	
1	0	1	1	3	Q. Do personnel at DoD possess a good grasp of the problems faced by the medical departments of the services?	
4	0	2	3	9	A1. Yes	
2	5	3	2	12	A2. Only in some areas	
2	7	3	5	17	A3. Only some individuals	
					A4. No	
2	4	1	2	9	Q. Do personnel in The Surgeon General's office possess an adequate appreciation for the needs of the hospitals and their problems?	
6	6	5	5	22	A1. Yes	
1	1	2	3	7	A2. In most areas	
0	0	1	2	3	A3. In some areas	
					A4. No	
3	2	1	4	10	Q. In the next five years DoD resources for health care will:	
2	1	5	4	12	A1. Decrease considerably	
0	0	1	1	2	A2. Decrease a little	
0	4	1	2	7	A3. Remain constant	
3	4	0	1	5	A4. Increase a little	
					A5. Increase considerably	
9	11	8	9	37	Q. Is there a need for the existing number of military teaching hospitals?	
0	1	1	3	5	A1. Yes	
					A2. No	

FREQUENCY OF RESPONSES - CATEGORIES OF RESPONDENTS					QUESTION/ANSWERS
MEDCEN CDRs	MEDDACC CDRs	MEDCEN X.O.s	MEDDACC X.O.s	TOTALS	
					Q. The most important probable single factor causing the curtailment/closure actions of the future will be:
2	4	4	3	13	A1. A reduced budget for DoD health care.
2	1	3	4	10	A2. Base realignments and closures.
2	6	1	5	14	A3. Fewer health care providers on active duty.
0	0	0	0	0	A4. Inability to maintain JCAH accreditation because of unfunded construction requirements.
0	0	0	0	0	A5. Regionalization.
					A6. Others
-	-	1	-	1	• All the above
-	-	1	-	1	• A desire for persons in OMB & DoD to curtail medical services and their lack of understanding for the necessity for support to contingency plans.
1	-	-	-	1	• Stupidity
2	-	-	-	2	• National Health Scheme
					Q. Over the past five years the resources provided to other DoD programs have done what in relation to resources provided for health care associated programs?
2	5	3	3	13	A1. Increased at a faster rate.
0	3	1	2	6	A2. Increased at an equal rate.
1	2	4	3	10	A3. Decreased at an equal rate.
2	2	0	3	5	A4. Decreased at a faster rate.
					Q. In comparison with civilian medical treatment facilities, DoD facilities are generally:
2	0	3	0	5	A1. Much better
4	3	4	6	17	A2. Better
1	5	1	1	8	A3. About the same
1	2	1	2	6	A4. Worse
0	2	0	2	4	A5. Much worse

MATRIX CODES

1. Approved graduate medical education program (residency) required in this specialty to gain residency program approval.
2. Ordinarily the institution providing the residency will have residency program in the specialty cited.
3. It is essential that there be expertise and facilities available in this specialty.
4. A requirement is cited for strong support service in this specialty.
5. Resident experience with patients undergoing this type of specialty care is necessary.
6. Resident's time must be spent in part in this specialty area.

NOTES

Few quantitative requirements are cited in specific terms. Instead, most requirements are couched in such phrases as, "The institution must be able to provide an adequate number and variety of ... patients. Arbitrary figures cannot reveal these considerations accurately.

- 1/ Experience and training in community medicine also required.
- 2/ It is essential that there be available expertise and facilities in such areas as allergy, cardiology, endocrinology, gastroenterology, hematology, infectious diseases, metabolism, nephrology, nuclear medicine, oncology, pulmonary diseases and rheumatology. A reasonable amount of experience is also desirable in dermatology, neurology and psychiatry.
- 3/ General requirements for all residency programs require that hospitals offering a residency program have acceptable pathology and radiology departments.

WORST POTENTIAL DECISION RESULTS

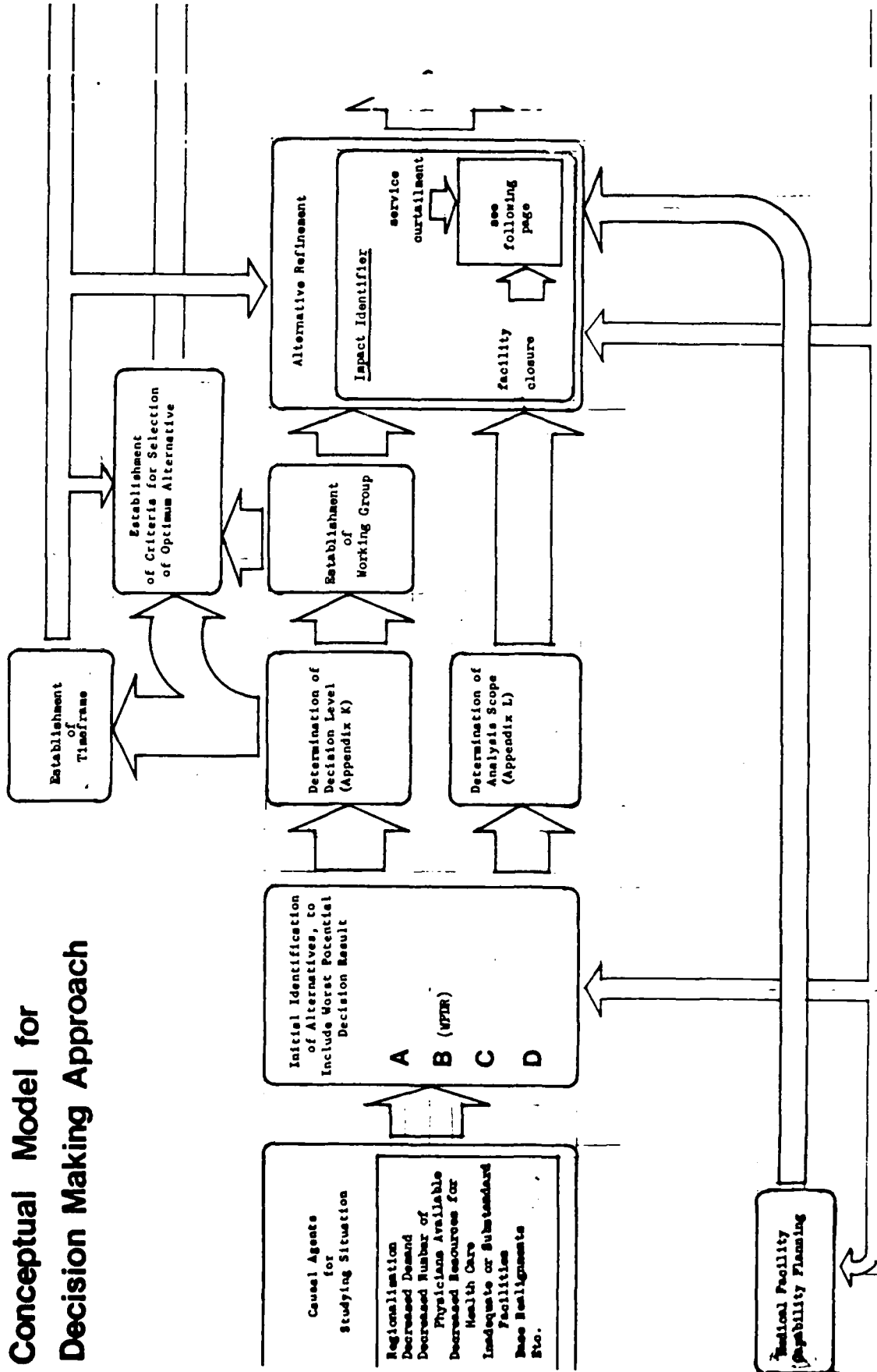
- A** The phasing down of a medical center to a MEDDAC without shifting the teaching mission or any workload to another DoD facility.
- B** The closure of a medical center, stopping inpatient services, without effecting other DoD facilities.
- C** The shift of a medical center's inpatient workload in part or totally to another DoD medical facility belonging to another service. The closing of the graduate medical education program at the same medical center.
- D** The phasing down of a medical center to a MEDDAC or outpatient facility and relocation of the teaching mission to another facility belonging to the same service. No effect is envisioned on the facilities belonging to another medical service.
- E** The phasing down, reduction to a clinic, of a MEDDAC hospital with no impact on any other DoD facility's workload.
- F** The phasing down or closure of a MEDDAC hospital with a workload shift to another or other facilities of the same service.
- G** The phasing down or closure of a MEDDAC hospital with a shift of workload to facility(ies) belong to another service.
- H** Curtailment of a service or services at a medical treatment without any effect on any other DoD facility.

LEVELS OF DECISION MAKING

1. DoD Steering Group: A steering group composed of at least the following members: The Assistant Secretary of Defense for Health Affairs, representatives of a) OASD- Comptroller, and b) OASD- Manpower, Reserve Affairs and Logistics, and The three Surgeons General.
2. Tri-service Panel: A panel of representatives of the Chiefs of Staff of the three services.
3. Committee of the Three Surgeons General: In this situation the committee may have to make a decision which will be acted upon at a higher level.
4. Chief of Staff of Single Service: The Chief of Staff of the service involved can appoint an individual or group to make recommendations to him for a decision.
5. The Surgeon General of a Single Service: The Surgeon General can make a decision based on a study made by subordinates.
6. Major Command (HSC): A decision may have to be approved at a higher level.
7. Medical Treatment Facility: A decision may have to be approved at a higher level.

NOTE: Decisions made at levels below DoD will still have to be approved up the chain of command to the DoD Health Council. Where thresholds set forth in AR 5-10 are exceeded the requirements for analysis and decision making dictated by the Army Regulation and DoD instructions must be met.

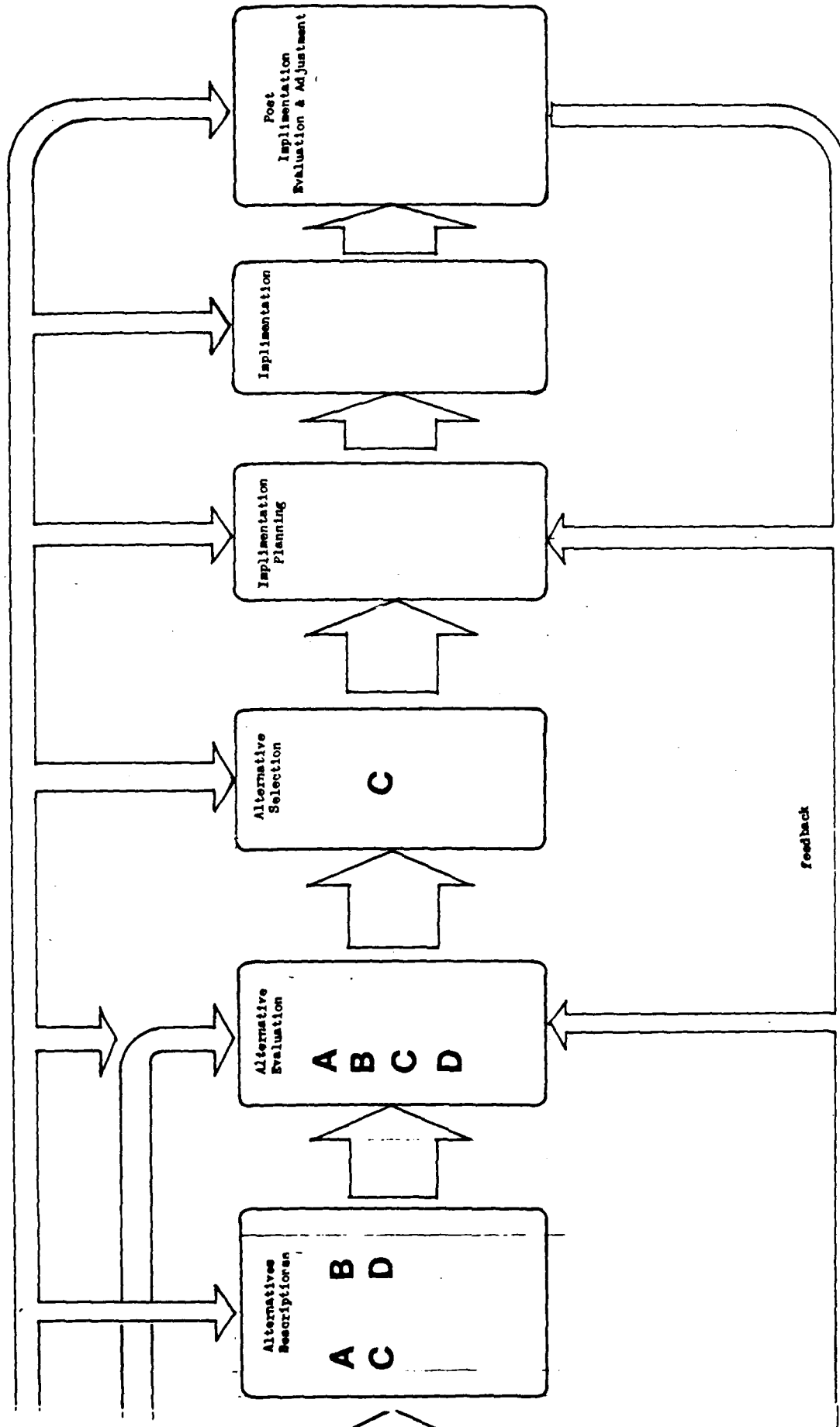
Conceptual Model for Decision Making Approach



FACTORS TO CONSIDER:

- a) the need to provide medical support to the active duty military
- b) the need to provide medical support to the dependents of active duty
- c) the need to provide medical support to the retired military
- d) the need to provide medical support to the dependents & survivors of retired
- e) ties to other activities on the military installation
- f) ties to the civilian community
- g) impact on civilian employees
- h) impact on the survivors graduate medical education program

10/2



- r } the need to provide additional space in the facility
 - s } the need to change the facilities to meet new standards
 - t } ability to provide support personnel
 - u } ability to provide support resources
 - v } geographic distance to other DoD medical facilities
 - w } the need for a mixed patient population
-
- 1 } desirability of location for assignments
 - 2 } economic impact on civilian community
 - 3 } the need to shift resources to other Army locations
 - 4 } ability of other DoD facilities to provide service to area
 - 5 } ability to contract for curtailed service
 - 6 } are services being provided in excess of appropriate civilian levels
 - 7 } excessive cost to provide service in question (unit cost)
 - 8 } the need for repair or maintain the facility
 - 9 } the need to functionally realign the facility

Refer to this side
Enter on this side



SERVICES	HOSPITALS													
	ARMY HOSPITALS				CIVILIAN HOSPITALS		MILITARY SERVICES							
Allergy & Immunology	A	B	C	D	E	F	G	H	A	B	C	A	B	C
Anesthesiology														
Dermatology														
Family Practice														
General Practice														
General Surgery														
ETC.														

or Facility
Closure Enter
this side



Capability Levels:
Active Duty and Their Dependents
Existing Situation
With Additional Personnel Only
With unlimited Resources but Dependent upon Demand & Effective Use of Resources

Capability to Provide Services to Support:

4,000 20 beds	10,000 25 beds	15,000 30 beds	22,000 60 beds	workload, beds/visits
2 MCs	3 MCs	4 MCs	6 MCs	physicians
\$15,000	\$17,000	\$20,000	\$30,000	dollars
10	15	17	23	support personnel
0	0	2 Inter	3 Inter 1 Res.	other training needs of Service's system

Capabilities & Resource Indicators:

Explanation:

Curtailment or closure actions (proposals) can be identified by service and facilities. Alternative methods (locations) for meeting demand needs or training needs can be identified by moving along the vertical axis to alternative locations with the capabilities to meet the identified needs. capabilities of civilian hospitals is stated only in terms of estimated excess capabilities.

Symbol Key:

- Curtailment Action Proposed
- Movement of care mission or training mission to another Army facility (can be more than one facility)
- ◇ Movement of care provision to civilian hospital(s).
- △ Movement of care provision to the facility of another DoD Service.

Scope of Analysis

WPDR CRITERIAS SCOPES OF ANALYSIS	A			B			C			D			E			F			G			H													
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	T	
Hollistic to DoD	5	5	5	15	5	5	15	2	1	④	5	4	2	11	5	5	5	15	5	4	4	13	4	5	5	14	5	5	5	5	15				
Hollistic to a Service	1	2	4	7	1	1	3	⑤	1	5	5	11	1	1	1	③	1	3	4	8	1	1	1	③	1	5	5	11	1	3	4	8			
Isolated to Geographic Area of the Hospital	1	1	2	④	1	3	2	6	1	5	5	11	1	5	5	11	1	1	③	5	5	5	15	2	1	1	④	1	1	1	③				
Isolated to the Hospital	1	5	1	7	1	5	1	7	1	5	5	11	1	5	5	11	1	4	4	9	5	5	5	15	1	5	5	11	1	4	4	9			

Numerical evaluation of criteria varies between 1, indicating a good performance, and 5, indicating a poor performance.

NOTES: /^a May involve more than one service.

CRITERIA: 1. Avoids unnecessary service rivalry.

2. Insures appropriate scope of analysis.

3. Minimizes unnecessary data collection.

WPDR Worst Potential Decision Result See Appendix I at Tab I for listing of WPDRs and explanation.

Decision Levels

WPDR (See Appendix I at Tab I)	A			B			C			D			E			F			G			H																		
	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3									
CRITERIA DECISION LEVELS	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	
DoD Steering Group	5	2	5	12	5	2	5	12	2	2	1	⑦	5	5	5	15	5	5	15	5	1	5	11	1	2	2	1	⑥	5	5	5	15								
Tri-service Panel	5	3	5	13	5	3	5	13	3	1	2	3	9	5	5	5	15	5	5	15	5	3	5	13	2	1	2	2	7	5	5	5	15							
Committee of three Surgeons General	5	3	5	13	5	4	5	14	2	1	1	4	8	4	5	5	14	4	4	12	5	3	4	12	2	1	1	3	7	5	4	5	14							
Chief of Staff of single Service	2	1	3	6	3	1	3	7	4	5	4	5	18	2	1	2	5	1	1	3	5	5	1	3	9	5	4	5	19	4	1	4	9							
The Surgeon General of Single Svc.	1	1	1	③	1	1	2	④	4	5	4	5	18	1	1	1	③	1	1	1	③	2	1	1	4	5	4	5	19	3	1	4	8							
Major Command	2	3	1	6	2	2	1	5	5	5	5	20	2	1	1	4	1	1	1	③	1	1	1	③	5	5	5	20	1	1	3	5								
Medical Treat- ment Facility	5	5	4	14	5	4	5	14	5	5	5	20	5	5	5	15	2	4	2	8	4	3	5	12	5	5	5	20	1	1	1	③								

Numerical evaluation of criteria varies between 1, best alternative to 5, worst alternative.

- CRITERIA: 1. Appropriateness of decision level.
 2. Acceptance of potential decision.
 3. Lowest level(s) at which decision could reasonably be made.
 4. Need to avoid biased decision.
 T. Accumulated scoring of alternative decision level. Lowest accumulated score indicates optimum level(s) for decision.
- NOTES: WPDR Worst Potential Decision Result
 Criteria number 4 is applied only to those situations where there is impact to more than one service.
 Tri-service panel is predominantly of nonmedical members.

END

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DTIC