

Health Care Indicators

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Contained in this regular feature of the journal is a section on each of the following four topics: community hospital statistics; employment, hours, and earnings in the private health sector; health care prices; and national economic indicators.

Community hospital statistics

Community hospital operating expenses during the year ending 1989 were \$195 billion (Table 1), 9.9 percent higher than in 1988 (Table 2). Labor costs were \$106 billion, up 10.0 percent from the previous year, and nonlabor costs increased 9.8 percent to \$89 billion. Growth in expenses for labor exceeded growth in nonlabor expenses for the first time since 1982, more because of a 3-year deceleration of nonlabor costs than to an acceleration of labor costs.

The American Hospital Association reported 33 million admissions in 1989, a 1.0-percent decrease from 1988 to 1989, and the number of inpatient days fell 0.9 percent during the same period (Figure 1). Simultaneous declines in both admissions and days left the average length of stay (the ratio of inpatient days and admissions) unchanged. On the other hand, 21 million surgical operations were performed during the year, 0.6 percent more than in 1988. Growth in surgical operations peaked in 1987, and have continued to grow, but at slower rates than experienced during the last 3 years. Outpatient visits also continued to increase, but the rate of increase had slowed from 8.3 in 1986, 5.8 in 1987, 6.2 percent in 1988, and to 4.0 percent in 1989, a rate more consistent with historical growth rates.

There were 930,000 beds available on average during 1989, 1.4 percent less than in 1988. The decrease in number of beds outpaced the decrease in inpatient days, leading to a small increase of 0.4 percent in occupancy rate (the ratio of inpatient days to beds times the days in 1989) as shown in Figure 2. The occupancy rate now stands at 64.9 percent up from 63.4 percent reported for 1986.

Average full-time equivalent (FTE) employment in community hospitals was 1.6 percent higher in the year 1989 than it had been the previous year. The ratio of adjusted patient days to FTE personnel continued to fall in 1989, therefore, FTE employment was growing more rapidly than were adjusted patient days.

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Private health sector: Employment, hours, and earnings

Levels of employment, hours, and earnings in private (nongovernment) health service establishments are shown in Table 3. These data were drawn from the Bureau of Labor Statistics "Establishment" survey of the private nonagricultural sector, which excludes—among other things—hospitals, clinics, and other health-related establishments run by all governments. An average of 7.7 million persons were employed on a full-time or part-time basis in private health service establishments during calendar year 1989; nonsupervisory employees worked a 32.5-hour week and earned \$9.82 an hour (Table 3).

In 1989, nonsupervisory employment in the private health sector grew more than twice as fast as in the general private economy (Figure 3), and growth in average hourly earnings for health sector workers also substantially exceeded that for the overall economy (Table 4). Health sector average hourly earnings were 6.4 percent higher in calendar year 1989 than in 1988, and nonsupervisory employment increased 6.8 percent during the same period. In contrast, average hourly earnings rose only 4.0 percent and employment grew only 3.0 percent in the private nonagricultural sector.

Within the private health industry in 1989, growth in employment and earnings varied by type of establishment. For example, the largest growth in work hours (nonsupervisory employment multiplied by average weekly hours) was experienced in physicians' offices, and the smallest was in the offices of dentists. Nonsupervisory payrolls (nonsupervisory work hours multiplied by average hourly earnings) increased the slowest, 11.7 percent, for offices of dentists and the fastest, 15.2 percent, for offices of physicians (Table 5 and Figure 4).

Health care prices

Medical care consumers

Prices paid by consumers for medical care, as measured by the Consumer Price Index (CPI) for all urban consumers, rose 7.7 percent between 1988 and 1989, 1.2 percentage points higher than the 6.5 percent rate experienced between 1987 and 1988 (Tables 6 and 7). Medical care CPI in the four quarters of 1989 indicates that price inflation is once again heating up, with hospital prices, prescription drug prices, and the net cost of private health insurance fueling this increase.

A similar pattern of accelerating growth is emerging for prices in general. The acceleration in the growth of nonmedical prices is attributable to energy prices which increased 5.7 percent since 1988. The general rate of inflation for all items has been accelerating since 1986, growing 4.8 percent for 1989.

Items in the medical care market basket exhibited different degrees of price inflation. Hospital prices (measured in terms of charges) stood 11.5 percent higher in 1989 than they had in 1988. The components of hospital prices, room charges, inpatient services, and outpatient services, all posted double-digit price inflation. Growth in professional services prices slowed slightly to 6.4 percent in 1989 with physicians' fees rising 7.3 percent. Prescription drug prices were up 8.7 percent during 1989, continuing to outpace overall medical commodities in price growth as it had done since 1981.

The percent change in measures of price inflation is shown in Figure 5.

Health care providers

Background on input price indexes

In 1979, the Health Care Financing Administration (HCFA) developed the hospital input price index. This input price index is designed to measure the pure price changes associated with expenditure changes for hospital services. The skilled nursing home facility (SNF) and home health agency (HHA) input price indexes were developed in the early 1980s. These indexes are often referred to as "market baskets" because they price a consistent set of goods and services over time. Since their creation, they have played an important role in helping to set payment percent increases and understanding the contribution of input price increases to growing health expenditures.

The input price indexes or market baskets, are Laspeyres or fixed-weight indexes that are constructed in two steps. First, a base period is selected. For example, for the prospective payment system (PPS) hospital input price index, the base period is 1982. Next, a set of cost categories such as food, fuel, and labor are identified and their 1982 expenditure levels determined. The proportion or share of total expenditures accounted for by specific spending categories is calculated. These proportions are called cost or expenditure weights. There are 28 expenditure categories in the 1982-based hospital regulation input price index. In the next step, a price proxy is selected to match each expenditure category. The purpose of the price proxy is to measure the rate of price increase of the goods or services in that expenditure category. The price proxy index for each spending category is multiplied by the expenditure weight for that category. The sum of these products (weights multiplied by the price index) over all cost categories yields the composite input price index for any given time period, usually a fiscal year or a calendar year. The percent change in the input price index is an estimate of price change over time for a fixed quantity of goods and services purchased by a provider.

The input price indexes are estimated on a historical basis and forecasted out several years. The HCFA-chosen price proxies are forecasted under contract with Data Resources, Inc. (DRI). Each quarter, 1 month after the end of a calendar quarter, DRI updates its macroeconomics forecasts of wages and prices. DRI bases its new forecasts on updated historical information

and revised forecast assumptions. New forecasts and estimates are done in February, May, August, and November. Most of the data in Tables 8 through 13 are forecasted and are expected to change as more recent historical data become available and subsequent quarterly forecasts are received.

The methodology and price proxy definitions used in the input price indexes are described in the *Federal Register* notices that accompany the annual revisions of the PPS, HHA, and SNF cost limits. A description of the current PPS input price index was published September 3, 1986 (*Federal Register*, 1986). The latest HHA regulatory input price index was published July 7, 1987 (*Federal Register*, 1987a) and the latest SNF input price index was published October 2, 1987 (*Federal Register*, 1987b).

Current data

Each input price index is presented in two tables: the first is a percent-change table, and the second provides the actual index numbers from which the percentages were computed. The hospital input price index for PPS is in Tables 8 and 9. The SNF input price index is in Tables 10 and 11. The HHA input price index is in Tables 12 and 13.

Since 1982, the PPS hospital input price index has risen at a faster rate each year than economywide prices (CPI all items) and economywide wage rates (average hourly earnings in the private nonagricultural sector) as shown in Figure 6. Two factors are particularly noteworthy in this faster rate of growth. The hospital input price index has a blend of hospital industry wage increases and economywide wage increases adjusted for the occupational mix of hospital employees (*Federal Register*, 1986). This blended wage variable tends to increase at a faster rate than economywide wage increases. In addition, hospital professional liability insurance costs have tended to rise substantially faster than economywide prices.

Overall, the hospital input price index, economywide prices, and economywide wages have moved in tandem during the period 1980-89. The major exception was 1980 when economywide prices, as measured by the CPI all items, increased 13.5 percent, economywide wages increased 8.1 percent, and the hospital input price index increased 11.7 percent.

Data highlight

The largest component of the hospital input price index is labor inputs of production at 55.8 percent (Table 8). For this category, inflation is measured by the rate of growth of wages and salaries. Recent literature suggests that one of the principal subcategories of labor inputs, registered nurses (RNs), are in short supply (Newschaffer and Schoenman, 1990; Wilensky, 1988). Efforts to understand the extent of this shortage have been hampered because of a lack of national data on the rate of growth in wages and salaries paid to RNs.

The University of Texas Medical Branch at Galveston (1989) collects data on a number of hospital occupations



including registered nurses, licensed practical nurses, physical therapists, occupational therapists and the like. The survey consists of hospitals and medical institutions that participate voluntarily. The institutions that are surveyed may vary from year to year. Nonetheless, to our knowledge this is the only continuing national survey that provides an indication of the growth in hospital wage rates by occupational group. Table 14 compares the rate of growth in RNs wages and salaries with average hourly earnings (AHE) of private hospital workers and average hourly earnings, for professional-technical workers economywide, measured by the Employment Cost Index (ECI) (Bureau of Labor Statistics, 1989). The starting rate for RNs rose 80 percent between 1980 and 1989. The maximum rate for RNs increased 91 percent during that period (Tables 14 and 15). Average hourly earnings for private hospital workers rose 85 percent during this same period, while economywide professional-technical average hourly earnings grew at a slower rate, 67 percent (Figure 7). The University of Texas data also indicate that in more recent years, the spread between the maximum and starting RNs wage rates has increased because of larger annual increases in maximum RN salaries. To better understand the differential rates of increase in wages for medical specialty occupations, the Office of National Cost Estimates will continue to monitor the data from the University of Texas study as well as any other data sources that may become available.

National economic indicators

To put health-related economic trends into perspective, this section shifts focus to discuss national indicators of output, employment, and inflation. Side-by-side comparison of various economic indicators highlights the interdependence of real growth, inflation, and unemployment. Acceleration and deceleration of price inflation tends to lag that of real growth by two to three years, although the lag in recent years is somewhat longer than in earlier years (Figure 8). There is an inverse relationship between real growth and the unemployment rate: To speed up the production of goods and services requires increased use of inputs, among which labor figures prominently.

Output and income

The gross national product (GNP), the most widely used measure of the Nation's output, grew 7.2 percent during the calendar year of 1989, reaching \$5.2 trillion (Table 16). The growth of "real" GNP (also called constant dollar or price-deflated GNP) slowed during 1989 to 2.9 percent (Table 17).

Personal income rose to \$4.4 trillion during the calendar year of 1989, up 9.0 percent from the calendar year of 1988. Growth in disposable personal income (personal income net of taxes) increased 8.7 percent during the same period reaching a level of \$3.8 trillion. The proportion of disposable income that was saved rather than spent (personal savings rate) was 5.5 percent, 1.3 percentage points higher than in the calendar year 1988.

Employment, unemployment, and earnings

During the calendar year of 1989, the unemployment rate for all workers was 5.3 percent, the lowest in quite some time. The U.S. workforce held 90.8 million jobs during 1989, up 3.0 percent from the same time 1 year ago. As the unemployment rate falls and the number of jobs to be filled continues to grow, pressure is exerted on wages to increase in order to attract additional persons into the workforce. For nonsupervisory workers, average hourly earnings increased by 4.0 percent during the prior year to a level of \$9.66 in 1989; average hours worked per week remained unchanged at 37.4.

Prices

The GNP fixed-weight price index, the most comprehensive measure of price inflation, grew 4.5 percent between 1988 and 1989. The GNP implicit price deflator (which reflects changes in the composition of output as well as price inflation), rose 4.2 percent between calendar year 1988 and 1989. During the same period, the CPI for all items and all urban consumers showed an increase of 4.8 percent.

The Producer Price Index for finished consumer goods grew 5.6 percent between calendar year 1988 and the calendar year 1989.

Grants and Contracts

Project reports

As grants and contracts are completed, the final project reports are placed with the National Technical Information Service for public access. The reports are available in paper as well as in microfiche, which is considerably lower in cost.

Following are the abstracts and ordering information for reports that describe research results of recently completed projects. They may be ordered or further information obtained from: National Technical Information Service Document Sales, 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650.

Nationwide Evaluation of Medicaid Competition Demonstrations: Medicaid Consumer Survey Results—Minnesota Prepaid Demonstration Project 1986-1988

Medicaid capitation/case management demonstrations in six States (California, Florida, Minnesota, Missouri, New York, and New Jersey) were implemented in 1982-83 to test alternative strategies for the delivery and financing of health care to Medicaid beneficiaries. The evaluation provided a comprehensive assessment of the demonstrations and examined and reported on:

- Implementation and operation issues.
- Health care utilization and cost impacts.
- Beneficiary access and satisfaction.
- Quality of care.
- Administrative costs.
- Ratesetting.
- Enrollment choice and biased selection.

The final report for the evaluation, which is contained in eight volumes and supporting appendixes, presented results from the 1986 and 1988 followup Medicaid Consumer Survey (MCS) conducted in Hennepin County, Minnesota.

The MCS was a 45-minute personal interview survey with Aid to Families with Dependent Children and Supplemental Security Income aged Medicaid beneficiaries to gather self-reported information on adult and child health care utilization, health status and activity/functional limitations, access to care, satisfaction with care, health habits, and physician advice. Similar surveys were done by the evaluation in 1986 with Medicaid beneficiaries in Missouri and California. Order by accession no. PB90-148198; cost is \$31.00 for paper copy, \$11.00 for microfiche. There is a \$3.00 handling charge.

Population-Based Study of Hospice, Parts I-IV

The purpose of this cooperative agreement was to study:

- Health service utilization among hospice and nonhospice terminal cancer patients.
- Effects of hospital prospective reimbursement on hospice case load and length of stay.
- Extent of hospice penetration of the market.

In order to provide both economy and power, seven data sets in the study were linked. The area under study, which was comprised of 13 counties in western Washington, compared health utilization patterns among hospice and nonhospice participants. This entailed using four types of hospices and two types of nonhospice groups: those with at least one home health visit and those that did not have home care.

During the last month of life, hospice patients in three of the four types of hospice (home health hospice patients, hospice-only hospice patients, and community-based hospice patients) used fewer hospital and skilled nursing facility days than patients in the home health conventional care group. No consistently lower inpatient utilization for hospice patients was found in the other months of the last year of life. Three multivariate models showed greater home health utilization among the home health agency-based and community-based hospice patients than among other hospice and nonhospice patients. No consistent effect of the prospective payment system was found.

The use of hospice is more likely among those who are more economically advantaged and are more likely to have social support. Patients diagnosed close to death were less likely to use hospice than those who were diagnosed earlier. Among patients diagnosed earlier, those with distant stage disease were more likely to use hospice than were those with a less severe stage cancer. Hospice participation was the major determinant of death at home. Order by accession no. PB90-162587; cost is \$23.00 for paper copy, \$8.00 for microfiche. There is a \$3.00 handling charge.

Effects of Alternative Family Support Strategies

This project was designed to study the respective costs and benefits of alternative programs of support to family members who care for their elderly relatives at home. The three types of support programs consist of:

- Paid respite care with up to a maximum dollar limit per family that is provided by a home health agency, three adult day care centers, and a skilled nursing facility.
- Education of family caregivers and case-managed services and training.
- Education and case-management combined with paid respite care.

In May 1983, the Health Care Financing Administration approved a first-year grant to the University of Washington for conducting the study. Service provision ended July 1987. A sample of 541 caregivers participated in the program.

The majority (79 percent) of the caregivers were female, 31 percent were spouses, and 59 percent were adult children of the elderly individual. The elderly care recipients were very old and frail, the median age was 82, and 25 percent were deceased within 1 year of entering the study. About one-third were reported to have a serious mental impairment. Order by accession no. PB90-162132; cost is \$31.00 for paper copy, \$11.00 for microfiche. There is a \$3.00 handling charge.

Non-Certified Hospice Cost Analysis: Final Report

The purpose of this contract was to determine:

- The costs associated with hospices that are not certified to receive reimbursement under the Medicare hospice benefit.
- The characteristics of noncertified hospices and their patient populations.
- How costs vary across different types of hospices and different patient populations.
- Why non-certified hospices elected not to participate in the Medicare hospice benefit.

A representative, stratified sample of noncertified hospices was drawn. Three types of hospice organizations were defined: community-based (located in home health agencies), hospital-based, and independent (sole mission is the provision of hospice care: this may be a freestanding inpatient facility or home-based care).

Data from fiscal years 1985 and 1986 were collected by certified public accountants in the 92 participating hospices. The two-volume final report shows all three models of hospice that were operating below the Medicare hospice benefit cap on average cost per patient of \$6,500. The patient capacity was 32.7, and 79 percent of the noncertified hospices could handle 30 or fewer patients.

Of the noncertified hospices patients, 94 percent were enrolled for less than 210 days (the original Medicare benefit limit). More than three-quarters of hospice patients had lengths of stay equal to or less than 90 days. The report notes that the three hospice types represent appreciably different cost environments. Order by accession no. PB90-163577; cost is \$45.00 for paper copy, \$15.00 for microfiche. There is a \$3.00 handling charge.

Case Management Costs: Conceptual Models and Program Descriptions

The report reviewed case management models and data collected by 51 case management programs. Four dimensions of case managements were identified: the nature of services provided, goals of the case management program, the reimbursement mechanism, and specific operational constraints. Using these dimensions, five empirical models of case management were identified: fee-for-service, private insurance, capitated/consolidated, public-funded with purchase authority, and broker. Data on case management costs and cost determinants were included. Also, a theoretical model relating program incentives and outcomes was developed, and the limitation of the data for estimating this model is discussed. Order by accession no. PB90-159369; cost is \$17.00 for paper copy, \$8.00 for microfiche. There is a \$3.00 handling charge.

Drug Utilization and Expenditures for Elderly Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) Program Beneficiaries: Longitudinal Cohort Analyses

The purpose of this contract was to conduct longitudinal analyses of prescription drug utilization and

expenditures for beneficiary cohorts based on date of enrollment in the Pharmaceutical Assistance Contract for the Elderly (PACE). This is a drug benefit program for the elderly managed in Pennsylvania by the Office of Aging.

The contract studied the changes in drug utilization for age groups within three cohorts: the initially enrolled 1984 cohort, the voluntarily enrolled 1985 cohort, and the voluntarily enrolled 1986 cohort. To ensure comparability of coverage, only those persons who enrolled in one year and then re-enrolled in the following year are included.

The descriptive analyses consisted of several measures of drug utilization, including number of prescriptions per year, total daily doses by type of drug, total expenditures, expenditures by types of drugs for the cohorts, and age groups within cohorts. Order by accession no. PB90-141326; cost is \$23.00 for paper copy, \$8.00 for microfiche. There is a \$3.00 handling charge.

Chrysler/United Auto Workers Medicare Insured Group Feasibility Study

This final report assessed the feasibility of Chrysler and the United Auto Workers (UAW) establishing a Medicare insured group (MIG). Under this arrangement, Chrysler would administer all Medicare benefits for Chrysler retirees and fully assume the financial risk both for expenses currently paid by Medicare and for providing existing Chrysler complementary benefits in return for receiving an experience-rated capitation payment.

The project was undertaken with the belief that a MIG could offer the opportunity to bring Medicare and employer retiree health costs under control and increase enrollee satisfaction, while maintaining quality of care.

To evaluate the likely impact of a Chrysler/UAW MIG, Health Data Institute (HDI) performed the following:

- Analyzed available information about current retiree health care costs and utilization.
- Estimated savings from feasible managed care initiatives.
- Developed a proposed ratesetting methodology with Milliman and Robertson, an actuarial consulting company in Pennsylvania.
- Investigated administrative issues with Blue Cross/Blue Shield of Michigan.

Key findings of the report were:

- Health care for Medicare beneficiaries represents a growing liability for Chrysler. Expenditures for complementary benefits increased 16 percent from 1984 to 1986. Of particular concern is the 22 percent growth in complementary payments for Part B (physician and nonfacility services) from 1984 to 1986.
- A MIG could cost Chrysler \$5 million per year more to administer than its complementary program costs. Operating costs are expected to be \$10 million per year, if everyone eligible enrolls. In addition, startup administrative costs for a MIG are estimated at nearly \$3 million.
- Chrysler's net payments could be substantially higher under a MIG compared to what it otherwise would pay, possibly by 60 percent of current payments or more.

- A MIG could break even financially only if it achieved Medicare levels of provider payment, neutral selection, and fully effective savings initiatives.

Order by accession no. PB90-146598; cost is \$39.00 for paper copy, \$11.00 for microfiche. There is a \$3.00 handling charge.

Chrysler/United Auto Workers Medicare Insured Group Feasibility Study Data Quality Report

This report described a demonstration in linking Medicare health insurance data to data from a private complementary benefits plan. Baxter's Health Data Institute (HDI) created a series of analytic files linking Medicare and complementary data for Medicare-enrolled employees and retirees of Chrysler Motors Corporation. Medicare data were provided by the Health Care Financing Administration (HCFA) and Chrysler complementary data were provided by Blue Cross/Blue Shield of Michigan. The files were developed as part of the Chrysler United Auto Workers (UAW)/Medicare Insured Group (MIG) Feasibility Study, under a cooperative agreement between HCFA, Chrysler, and the UAW.

The study evaluated the possible impact of Chrysler and the UAW establishing a MIG for Chrysler Medicare beneficiaries. Under a MIG, Chrysler would administer all Medicare benefits for Chrysler retirees in return for a capitation payment, fully assuming the financial risk both for expenses covered by Medicare and for providing existing Chrysler complementary benefits.

The report focused on the creation process and validity of the analytic files used in the feasibility study, rather than on the results of analyzing the files. Readers are then referred to the separate Chrysler/UAW MIG Feasibility Study Final Report for analytic findings, benefit plan summaries, and background information about the MIG concept. In general, the link between Medicare and complementary data was successful.

Although an emphasis was on the problems found in attempting to link files, the eventual outcome was a series of useable analytic files, which were not seriously compromised by the problems encountered. Order by accession no. PB90-146580; cost is \$23.00 for paper copy, \$8.00 for microfiche. There is a \$3.00 handling charge.

Physician Consultative Services Under Medicare

This study examined a 5-percent sample of Medicare Part A and Part B claims for 1986 and looked at the distribution of all physician consults by location, carrier, specialty, and procedure code. In order to examine the influence of patient, hospital, and diagnosis-related group (DRG)-specific characteristics on consult rates per discharge, a more detailed analysis of inpatient consults for patients in seven DRGs was also performed. Three-fourths of all consults were performed on inpatient services, while the remainder were performed in

physicians' offices. The distribution of location varied widely by carrier. Additionally, Medicare recognized almost 40 physician specialties and found that nearly one-half of all consults are performed by physicians in only three specialties: internists, cardiologists, and neurologists. Over 40 percent of consults, regardless of location, were billed at the initial comprehensive level.

In an analysis of inpatient consults within several DRGs, the following patient and DRG-specific factors appeared to be related to an increased rate of consults per discharge: the presence of chronic renal failure, and being placed in a DRG that was distinguished by greater age or the presence of complications. Hospital characteristics related to increased consult rates were: designation as a teaching hospital, location in an urban area, and increasing standard metropolitan area size.

The data did not show any clear evidence of substitution of physician consults for visits. Order by accession no. PB90-135708; cost is \$23.00 for paper copy, \$8.00 for microfiche. There is a \$3.00 handling charge.

The Illness Episode Approach: Informing Medicare Beneficiaries Insurance Decisions

This project developed a method of organizing and presenting data on the costs of 13 illnesses/conditions common among aged persons. The cost estimates were generated by developing typical scenarios of treatment and management of the specified illnesses/conditions. The net out-of-pocket costs for Medicare beneficiaries under different supplemental insurance or health maintenance organization (HMO) arrangements were computed.

The effectiveness of this information to induce more prudent health insurance decisions through reducing duplicative coverages and lower premium payments for the desired level of coverage was tested in the Los Angeles area. The effect of the cost of illness/net out-of-pocket approach was compared against a control group receiving the best generally available literature and information to explain benefits of alternative insurance options. Subjects were randomly assigned to the two groups. There were 324 experimental subjects and 302 control subjects. Data and subsequent decisions regarding the supplemented insurance coverages were obtained through mail surveys at 3 and 9 months after the presentations. About 60 percent of both groups made no change in their coverages following the presentation of the information.

There was an indication that the experimental group, though not reaching statistical significance at the 95 percent confidence level, had a greater increase in HMO enrollment. Overall, the experimental group had a greater reduction of premium expenditures and duplicative coverages. Order by accession no. PB90-133679; cost is \$45.00 for paper copy, \$15.00 for microfiche. There is a \$3.00 handling charge.

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News Briefs

Health care executives set conferences

The American College of Healthcare Executives has received a grant from Abbott Laboratories, Abbott Park, Illinois, to support the College's 1990 eastern and western conferences.

Both conferences, which are identical in content, focus on management issues of concern to health care executives. The eastern conference is set for October 4 and 5 in Washington, D.C., and the western conference will be held November 15 and 16 in Phoenix, Arizona. Keynote addresses will be presented by well-known individuals from within or outside of the health care industry. In addition, each conference will feature a "Town Hall Meeting," which will offer participants the opportunity to debate critical health care issues with one another and with a panel of industry leaders. This will complement a wide range of concurrent seminars on important topics ranging from access to care to physician relations to health care in a competitive marketplace. A number of other college-related activities, including management assessment programs and membership examinations, are offered in conjunction with the conferences.

For further information, contact the American College, Division of Education on (312) 943-0544.

Arizona long-term care system to be evaluated

The Health Care Financing Administration (HCFA) recently awarded a \$3.3-million, 5-year contract to Laguna Research Associates of San Francisco to evaluate Arizona's long-term care system (ALTCS) program. The evaluation will explore implementation issues such as the extent of provider participation, the success of the competitive bidding process, and the way case management operates in the ALTCS. In addition, outcome issues pertaining to the overall impact of the ALTCS on costs, utilization and access to care, patient satisfaction, and quality of care will be examined.

Specific questions within these evaluation issues include: whether or not long-term care (LTC) improves and if acute care services would be reduced by combining LTC and acute services payment to program contractors; what the effectiveness of Arizona's preadmission screening instrument might be in identifying individuals "at risk" for institutionalization; if home- and community-based services are a cost-effective substitute for institutional LTC; and, if the ALTCS is more cost-effective than a comparable State fee-for-service LTC program.

The final report is expected by October 1994. A first year report on outcomes and a statistical summary will be available November 1990. Subsequent annual reports are scheduled for publications. For more information on this evaluation, contact William England at HCFA on (301) 966-6630.

Chronic ventilator dependent unit demonstration under way

Although Medicare pays roughly \$1 billion annually under the prospective payment system to hospitals for the care of chronic patients who depend on the support of mechanical respiratory ventilation, the hospital industry has argued that this is not sufficient to cover their costs. Furthermore, the industry believes that some patients can be "weaned" from the ventilator and returned to a more normal life through intensive rehabilitation.

As a result of this, Congress has mandated the Health Care Financing Administration's (HCFA) Office of Research and Demonstrations to fund a 5-year period demonstration project at five acute care hospitals. The sites will study the quality of care for their patients and address the appropriateness of classifying chronic ventilator units in acute care hospitals as rehabilitation units, and thus, qualify these services for exclusion from prospective payment. Related issues to be investigated include the effect of this change on quality, access, and effectiveness of care and appropriate sites for ventilator care.

The hospitals involved are the Mayo Foundation, Rochester, Minnesota; Rhode Island Hospital, Providence, Rhode Island; RMS Health Provider, Chicago, Illinois; Sinai Hospital of Detroit, Michigan; and Temple University Hospital, Philadelphia, Pennsylvania. HCFA has contracted with Lewin/ICF, Inc. to perform an evaluation of the demonstration and to provide a report on its outcomes. For further information, contact Thomas Talbott at HCFA on (301) 966-6685.

Alzheimer's disease demonstration focuses on community-based services

As the costs continue to escalate for the caring of dementia patients and their families, which places more demand on the country's formal and informal long-term care system, Congress has established the Medicare Alzheimer's disease demonstration.

This project, which was mandated by section 9342 of the Omnibus Budget Reconciliation Act of 1986 and implemented in December 1989, is an effort to identify the health care needs of such individuals and their families. Its purpose is to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to Medicare beneficiaries. It consists of two models that are studying case management, adult day care, homemaker and personal care services, and education and counseling for family caregivers. The models vary according to the intensity of the case management services and the monthly expenditure cap for demonstration services.

The sites participating in this project are: Amherst H. Wilder Foundation (St. Paul, Minnesota); Carle Clinic Association (Urbana, Illinois); Cincinnati

Area Senior Services, Inc. (Cincinnati, Ohio); Good Samaritan Hospital and Medical Center (Portland, Oregon); Miami Jewish Home and Hospital for the Aged (Miami, Florida); Monroe County Long-Term Care Program, Inc. (Rochester, New York); Northeast Community Mental Health Center (Memphis, Tennessee); and Wood County Senior Citizens Association, Inc. (Parkersburg, West Virginia).

The Institute for Health and Aging at the University of California, San Francisco, will conduct an evaluation of the project. For further information on this project, contact Dennis Nugent at the Health Care Financing Administration on (301) 966-6663.

Study on State nursing home payment systems available

The Center for Health Services Research at the University of Colorado recently completed a 5-year Health Care Financing Administration (HCFA) study that analyzed three major payment systems for Medicaid nursing home care: case-mix, facility-specific, and class-rate systems.

The study incorporated primary and secondary data collection and analysis activities, as well as site visits and case studies. The case-mix States included Maryland, Ohio, West Virginia, Illinois, Minnesota, and New York (with primary data collection from the first three). The facility-specific States were Colorado and Florida, and the class-rate States were Texas and Utah. Data on patient characteristics, case mix, quality, and related variables were collected in 1985-86 on approximately 4,900 nursing home patients in 160 nursing homes in 7 States. These data were supplemented by cost reports and other information obtained from the sample facilities and from Medicaid State agencies.

The major analyses of the study are reported in three volumes and will be available from the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650. They include: *A Multi-State Analysis of Medicaid Nursing Home Payment Systems (Volume 1)*; *Administering Nursing Home Case Mix Reimbursement Systems: Issues of Assessment, Quality, Access, Equity and Cost (Volume 2)*; and, *Analyzing Nursing Home Capital Reimbursement Systems (Volume 3)*.

For further information on this study, contact Judith Sangl at HCFA on (301) 966-6596.

Third party liability guide set for fall release

The Health Care Financing Administration's (HCFA) Bureau of Quality Control is in the process of updating the *Third Party Liability (TPL) Successful State Agency Practices Guide*.

This publication has been designed to disseminate general information about TPL activities in different States so that ideas on cost-effective procedures may be shared with each other. The Guide, which is expected to be available in fall 1990, will include names and addresses of key TPL people in each State, Federal and State reference data, State TPL forms, State TPL training, and successful practices and model legislation in the State. For additional information, contact Al Czerski at HCFA on (301) 966-3388.

Managed care service for elderly in three sites awarded

As directed and amended by section 9412 of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Health Care Financing Administration (HCFA) has made awards to the first 3 of as many as 10 sites to implement the Program for All-Inclusive Care for the Elderly (PACE) model as developed by the On Lok Senior Health Services in San Francisco.

On Lok has been operating since 1983 as a demonstration through waivers awarded to the organization and to the State of California by HCFA. These waivers enable On Lok to receive capitation payments from HCFA and the State for a voluntarily enrolled population.

The purpose of the program is to reproduce at test sites a managed care service model for 300 to 500 frail community dwelling elderly persons who, for the most part, are dually eligible for Medicare and Medicaid coverage and who are assessed as being eligible for nursing home placement, according to the standards established by participating States.

Approved for participation, the demonstration sites include: the Providence Medical Center, Portland, Oregon; the East Boston Geriatric Services Corporation, East Boston, Massachusetts; and, the Beth Abraham Hospital, Bronx, New York.

For further information on the demonstration, call Bill Clark of HCFA at (301) 966-6657.

Benefits and maternal and infant health guidelines announced

Two guides for State Medicaid agencies are available from the Health Care Financing Administration (HCFA).

Maternal and Infant Health: Medicaid Strategies to Save Lives and Money: A State's Opportunity provides State Medicaid agencies with strategies they can use to launch an effort to improve maternal and infant health through their Medicaid programs and to reduce the high rates of infant mortality and morbidity.

This guide is designed as an information tool to encourage States to take part in this initiative through their Medicaid programs. It explains why such an initiative is attractive in terms of saving both lives and money, and it shows how States can take advantage of Federal matching funds and technical assistance for enrolling eligible pregnant women in prenatal care, recruiting and retaining providers, and improving health care service delivery. Additionally, it explains what other programs can be linked to Medicaid to form the core of a comprehensive maternal and infant health program and where States can get technical assistance for HCFA.

For copies, write to Bill Hiscock, Bureau of Quality Control, HCFA P.O. Box 26678, Room 281 East High Rise Building, Baltimore, Maryland 21207-0278 or call (301) 966-3275.

Surveillance and Utilization Review in the Medicaid Program, A Guide to Successful State Agency Practices provides information to State Medicaid agencies on exemplary practices to assist them in managing utilization of benefits in the Medicaid program. This also will assist each agency, with the exception of a few States with

waivers, in implementing their own automated Medicaid Management Information Systems (MMIS).

The objective of MMIS is to provide a system for processing Medicaid claims and to retrieve and produce utilization data and management information about medical care and services furnished to recipients. An integral part of MMIS is the Utilization Review Subsystem (SURS), which identifies the providers and recipients most likely to be making unnecessary, abusive, or fraudulent use of the Medicaid program. Additionally, it processes information on medical and health care services utilization for guiding the actions of managers for the Medicaid program.

This guide presents methods for improving identification and correction of aberrant behavior of Medicaid recipients and providers. It also serves as a technical reference to enable States to identify and assess those practices that have proven to be successful elsewhere and can be transferred to their States.

For copies, write to Jeannette Keenan, Bureau of Quality Control, HCFA, Room 273 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207 or call (301) 966-3392.

Nurse practitioners and physician assistants improve nursing home care

In the Nursing Home Connection, a Massachusetts demonstration project, nurse practitioners and physician assistants provided care at least comparable to that provided by physicians and showed real potential as part of the primary care team approach for nursing home patients. Additionally, the program evaluation found modest improvements in both the quantity and quality of care provided at no increase in overall costs. High levels of satisfaction with the program on the part of nursing home directors and administrators were also noted. Some of the most impressive differences in quality of care were seen in the scores achieved for seven tracer conditions. Demonstration patients had higher scores on six of the seven tracers; differences were statistically significant for congestive heart failure, hypertension, and new cases of urinary incontinence.

The findings are the joint product of a study by three leading institutions: the RAND Corporation, the University of Minnesota, and Boston University. The study was supported by the Health Care Financing Administration, the Pew Charitable Trusts, the Boston Foundation, and the Cox Memorial Trust.

The evaluation, a 3-year effort, included 2,600 patients from 200 nursing homes in eastern Massachusetts. The Urban Medical Group, one of the demonstration provider groups, developed the demonstration's medical paradigm. Fifteen new provider groups participated in the evaluation. Within the demonstration, nurse practitioners and physician assistants worked under the supervision of physicians, but Medicare and Medicaid waivers lifted requirements for onsite physician supervision, allowing them to assume a more independent caregiving role. Their duties included conducting physical exams and medical evaluations, ordering tests, special diets and rehabilitation therapy, and adjusting medications upon oral orders from the attending physician. In addition, restrictions on the number of reimbursed visits were eased for demonstration providers.

As a direct result of the evaluation, new legislation was incorporated into the Omnibus Budget Reconciliation Act of 1989 along the lines established in the demonstration. The final report, *Results from the Evaluation of the Massachusetts Nursing Home Connection Program*, is available for \$10.00 from the RAND Corporation, 1700 Main Street, Box 2138, Santa Monica, California 90406.

Results of infant mortality survey available

The "Infant Mortality Data Survey," conducted by the Health Care Financing Administration's (HCFA) Infant Health Task Force and the Centers for Disease Control's Division of Reproductive Health, was distributed in the spring of 1989 to all State Medicaid Agencies, the District of Columbia, Puerto Rico, and the Virgin Islands. These results from 47 States and the District of Columbia will be valuable to researchers desiring to survey the State Medicaid agencies for data on infants and mothers.

The survey concerns are the availability of newborn infant data from State Medicaid data files including linking infant services with those of the mother, linking the infant with other Federal programs, and linking the medical records with vital statistics records. The survey also covers the availability of data about the care for the mother during pregnancy including prenatal visits, drug and laboratory usage, and demographic data such as income, race, age, marital status, and treatment facilities.

A copy of the brief abstract containing the survey results can be obtained by calling Harvey Tzucker of HCFA at (301) 597-3912.

Affordable insurance model for elderly to be tested

With the help of a \$1.7-million grant, New York is one of two States preparing a statewide long-term care insurance plan for its elderly residents.

Initial enrollment may begin as early as 1991, pending the approval of Federal Medicaid waivers, said State officials. Within 6 years, New York expects to enroll approximately 100,000 of its elderly residents in the new insurance plan.

The project is being funded with a 3-year grant from the Princeton, New Jersey-based Robert Wood Johnson Foundation, and is considered a possible model for other States because it will combine public and private financing to make coverage more affordable.

Study focuses on restructuring the nursing profession for survival

Recent efforts to lessen the impact of the Nation's growing nursing shortage will not provide long-term solutions to the current health care crisis, according to a new study, *The Nursing Shortage: New Approaches to an Old Problem*, from the United Hospital Fund of New York.

The study states that one important step would be for policymakers to differentiate among levels of nursing activity, creating a "career track" that offers wider opportunity for professional growth in terms of title,

salary, and responsibility, fully commensurate with nurses' experience and ability. Allowing job candidates to start out on this track with responsibilities matching more educational backgrounds could attract individuals who might ultimately rise to the upper levels of responsibility. It could also provide opportunities for many who might not advance so far, but who might nonetheless contribute significantly to the hospital personnel pool.

Copies of this publication are available for \$5.00 per copy, plus \$2.50 per order for postage and handling. Orders must be prepaid and should be sent to the Publications Program, United Hospital Fund, 55 Fifth Avenue, New York, New York 10003. Information about special rates for bulk orders can be obtained by calling (212) 645-2500, extension 314.

Game of aging concerns released

The American Association of Homes for the Aging (AAHA) has released a new simulation board game to teach people who work, or who are planning to work in retirement housing, about the difficult dilemmas they may face in serving the elderly. Called "The Game of Aging Concerns," examples are used from over 1,000 real-life predicaments submitted by AAHA members and cover a wide range of critical issues including death and grief, finances, physical and mental health, relationships and living arrangements. Players discuss different solutions to situations and join each other in role playing. This promotes teamwork and can be used as part of a training program as players are challenged to examine their own values and attitudes, to look at issues from the perspectives of residents, families, staff, and management, and to consider the impact of their decisions.

Those interested in ordering the Game may send \$30.00 plus \$3.00 shipping and handling per game to AAHA Publications, 1129 20th Street, NW., Suite 400, Washington, D.C. 20036 or call (202) 296-5960.

Health care catalog available

The American Hospital Association (AHA) is currently offering *The Complete AHA Catalog 1990*, which lists materials directed to health care management professionals that include books, periodicals, reports, guidelines, audiovideo programs, and data produced by the Association. This issue will debut a new section on AHA services that include list awards programs, consulting, education programs, information and data, insurance programs, investment programs, and memberships.

Copies of the Catalog may be obtained by calling 1-800-AHA-2626 or by writing to AHA, Marketing Communications Department, 840 North Lake Shore Drive, Chicago, Illinois 60611.

Evaluation of patient outcomes examined in periodical

As health costs increase, a growing concern is whether the money paid for health care is well spent and if one medical treatment is preferable to another. The January issue of *The Internist: Health Policy in Practice*,

published by the American Society of Internal Medicine (ASIM), looks at the forces emerging behind medical outcomes assessment and what changes are anticipated in the near future. The issue also provides practical information on the recent Medicare physician payment reform legislation passed by Congress.

For a copy, send \$3.00 to ASIM, 1101 Vermont Avenue, NW., Suite 500, Washington, D.C. 20005-3457. One-year subscriptions are available for \$24.00. Media copies are available upon request.

Also offered by ASIM in its 10th edition to its "Your Doctor Is ..." series, is "Your Internist is an Infectious Disease Specialist." This information provides helpful insights into infectious diseases training, roles and services, how to prepare for the first visit, what to expect, and why these specialists are different from other physicians. To order this brochure or for more information on the series, contact the ASIM Literature Order Department NR, 1101 Vermont Avenue, NW., Suite 500, Washington, D.C. 20005. Cost for the brochure is \$16.00 for 100 copies, \$75.00 for 500 copies, and \$128.00 for 1,000 copies. Orders totaling \$10.00 or more may be charged to VISA or MasterCard by calling (202) 289-1700.

Acquired immunodeficiency syndrome information guide published

How to Find Information about AIDS is specifically directed to helping anyone who needs to locate both general and specialized information on acquired immunodeficiency syndrome (AIDS). Both the health professional and general public using this resource are provided with key access points such as government agencies, community hotlines, organized resources, funding sources, major publications, and information databases.

The book also contains up-to-date information on AIDS hotlines, educational programs, institutions devoted to the funding of research treatment, prevention, and the locations and services of various research facilities and government and private agencies working with issues related to the AIDS epidemic.

The hardbound book (SBN:0-86656-752-6) is \$24.95 and may be ordered from Haworth Press, Inc. by calling 1-800-3-HAWORTH weekdays 9:00 a.m. to 5:00 p.m. Eastern Time. Individual orders must be prepaid by personal check or credit card. Their mailing address is 10 Alice Street, Binghamton, New York 13904-1580.

Canadian health care expenditures examined

Trends of health care expenditures in Canada in relation to the experience in other developed countries are presented in *Health Care Expenditures in Canada: Myth and Reality; Past and Future*, which includes past health care spending in Canada, the current level of expenditure, and the likely future in this area.

Discussed are popular misconceptions about what determines expenditure on health care and the dramatic transition that occurred in the early 1970s in the pattern of health care expenditure growth in Canada. Before that time, Canada's per capita expenditure on health care was above the average of industrialized western countries, but

since then, has been regularly less. Possible causes of this phenomenon are reviewed—changing demography, disease patterns and technology, rising expectations and wages, and the methods of finance—and a conclusion is reached that the exercise of government discretion in controlling the cost of health care provides a plausible explanation.

As for the future, according to the book, such factors as ethics, technology, demography, and economic growth are leading to a revolution in the health care system. Services are going to be far more efficiently managed, monitored, and assessed than they are now, with a view to achieving true cost effectiveness.

Copies of this book are available for \$12.50 per copy; address inquiries and orders to Canadian Tax Foundation, Publications Department, 130 Adelaide Street West, Suite 1900, Toronto, Ontario M5H 3P5 Canada.

History of medicine explored

In the comprehensive volume, *History of Medicine*, historians trace transformations in medical and allied professions and their effect on medicine and society by exploring medicine's development during the Greek and Roman eras, the Middle Ages, and the early days of the United States. From this vantage, answers are proposed to issues such as why treatment of men and women has differed over the ages and why the medical profession controlled birth control information in order to preserve their own status and power.

The hardbound book (SBN:0-86656-309-1) is \$24.95 and may be ordered from Haworth Press, Inc. by calling 1-800-3-HAWORTH weekdays 9:00 a.m. to 5:00 p.m. Eastern Time. Individual orders must be prepaid by personal check or credit card. Their mailing address is 10 Alice Street, Binghamton, New York 13904-1580.

Publication offered on medicine's socioeconomic aspect

Socioeconomic Characteristics of Medical Practice 1988 by the American Hospital Association is designed to provide current, accurate, and relevant information on the socioeconomic aspects of medicine. The information presented is derived in large part from the Socioeconomic Monitoring System (SMS) of the American Medical Association (AMA).

The book includes articles on trends in medical practice in the 1980s, medical malpractice, Medicare participation rates, and physician earnings. The articles are followed by detailed tabulations of statistics and trend information on a broad range of physicians' practice characteristics, including income, expenses, fees, and a number of specific practice activities.

Also included are definitions for statistical terms used in the book and examples of how best to utilize the information presented in the tables. The design and methodology of the SMS are also discussed.

The book is available from AMA, Book and Pamphlet Fulfillment, P.O. Box 10946, Chicago, Illinois 60610-0946 for \$75.00, AMA members \$40.00, or by calling 1-800-621-8335. Order by catalog number OP192688. VISA and MasterCard accepted.

Contacts for funding health grants listed in new directory

Health Grants Telephone Directory: A Complete Guide to Funding Contracts at the U.S. Department of Health and Human Services is a guide to grantseekers for processing their applications for health and social services grant programs offered by the Department of Health and Human Services.

This directory lists 54 offices that handle more than 200 grant programs with the phone numbers of qualified individuals with whom grantseekers may call for consultations.

Copies of the directory (ISBN 0-937925-44-6) are available for \$1.50 each and may be ordered through Capitol Publishers, Inc., by calling 1-800-327-7203 weekdays 9:00 a.m. to 5:00 p.m. Eastern Time. In Virginia, call collect (703) 739-6444. Orders must be prepaid by check or credit card. The mailing address is 1101 King Street, Box 1454, Alexandria, Virginia 22313-2054.

Guide for managing hospitals' internal controls released

Internal Control of Hospital Finances: A Guide for Management by the American Hospital Association has been designed for auditors and accounting personnel in hospitals' internal control structures (control environment, accounting systems, and control procedures) to ensure that adequate and cost-effective controls are in place, and outlining what factors and conditions should be considered when documenting and evaluating them. The content reflects the recent dramatic changes in information systems technology, Medicare regulations, and managed care.

Areas treated include: assessing the control environment, analyzing the accounting system, evaluating the control procedures to determine if objectives of the procedures are being achieved, focusing on the internal control structure in a computerized accounting system and on the particular needs of small hospitals and other health care entities, addressing the role of the board and senior management in controlling a hospital's operations, and suggesting an action plan for assessing controls.

The Guide (catalog number 061151) can be ordered from AHA Services, Inc., P.O. Box 99376, Chicago, Illinois 60693, for \$54.95 (includes the publication *Internal Control Supplement*). The price for AHA members is \$43.95 (includes the Supplement). Additional copies of the Supplement can be ordered from the same address for \$21.95. Price is \$17.95 for AHA members.

Health personnel status report available

The Sixth Report to the President and Congress on the Status of Health Personnel in the United States from the Department of Health and Human Services is a comprehensive reference document describing what is currently known about personnel in the major health fields, their numbers, and characteristics.

All information is based on analyses of available data as of the mid-to-late 1980s and assessments by the

Bureau of Health Professions on the development, current status, and anticipated changes in the disciplines that affect physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, nursing personnel, public health personnel, and students preparing to enter these fields.

The cost of the publication is \$53.00 for paper copy, \$8.00 for microfiche, and it may be purchased from the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161. The sales ordering desk phone number is (703) 487-4650. Order by publication number HRP-0907200. Payments must be prepaid by personal check or credit card.

Study on electronic dissemination of Federal information released

Informing the Nation: Federal Information Dissemination in an Electronic Age highlights the challenges and opportunities facing the major institutions that primarily are responsible for disseminating Federal information electronically. Examined are the issues of existing conflicts over maintaining and strengthening public access to government information and balancing the roles of individual Federal agencies, government dissemination, mechanisms, and the private sector.

The study also addresses issues such as: key technology trends, alternative futures for the U.S. Government Printing Office (GPO), the Depository Library System (governed by the GPO), and the National Technical Information Service (NTIS). It also examines electronic dissemination of congressional information, electronic dissemination of Government information to the press, and the Freedom of Information Act in an electronic environment.

The price for an issue is \$16.00, and it may be purchased from NTIS, 5285 Port Royal Road, Springfield, Virginia 22161. The sales ordering desk phone number is (703) 487-4650. Order by accession no. PB89-114243. There is a \$3.00 handling charge. Orders must be prepaid by personal check or credit card.

Source for health care institutions transactions available

In the light of pressure facing health care industry professionals to consolidate, both vertical and horizontal, among health care institutions, *Merging Health Care Institutions, A Guide for Buyers and Sellers* offers strategies for understanding and conducting acquisitions and other forms of combinations—mergers, dispositions, changes in sponsorship, consolidations, sales of assets, or institution-to-institution joint ventures. This material also reflects the adjustments and changes from the Tax Reform Act of 1986 (Public Law 99-514), which governs mergers and acquisitions.

It also addresses, in some detail, the peculiar form of business combination that arises sometimes in the not-for-profit context: change of control through a change of sponsorship or membership of a not-for-profit health care corporation.

Chief financial officers will find indepth strategies on the validation, accounting, and tax ramifications for the various type of joint ventures, and an analysis of the regulatory and antitrust aspects of such transactions. This

is followed by a detailed review of the labor and employment ramifications of these transactions.

The Guide can be ordered from the American Hospital Association Services, Inc., P.O. Box 99376, Chicago, Illinois 60693 for \$55.00 or by calling the Ordering Processing Department at (312) 280-6000. The price for AHA members is \$42.50. Additional copies of the Supplement can be ordered from the same address for \$21.95. Price is \$17.95 for AHA members.

Publisher offers health-related periodicals

Four health care periodicals are being offered by Aspen Publishers, Inc. In *Health Care Management Review*, leading health care authorities share their knowledge on key aspects of health care finance, marketing, management policy, operations, regulation, and other topics. The price of a four-issue annual subscription is \$82.00 plus \$4.00 for handling.

The Journal of Ambulatory Care Management, devoted exclusively to the management information needs of professionals in ambulatory care. The price of a four-issue annual subscription is \$79.00 plus \$4.00 for handling.

Hospital Cost Management and Accounting provides budgeting and costing procedures, guidelines for cost allocation, and systems for tracking patient costs. Written and edited by experts in hospital cost accounting, this monthly publication is available for \$156.00 a year, plus \$5.00 for handling.

Hospital Strategy Report offers guidance on how to compete in the health care environment, focusing on alternative delivery systems, aftercare diversification strategies, new revenue sources, creative financing, and new business ventures. The price for an annual subscription for this monthly periodical is \$148 plus \$5.00 for handling.

These publications can be ordered from Aspen Publishers, Inc., P.O. Box 990, Frederick, Maryland 21701-9782. Maryland residents must add a 5-percent sales tax.

Hospital dynamics explored in collection of essays

The American General Hospital, Communities, and Social Contexts is a collection of 10 essays by leading scholars in the social history of medicine that explore the increasing complexity of both the internal and external dynamics in the world of the hospital as well as the relationships between the two. Part one places American general hospitals in the larger context of their regional, ethnic, religious, and racial communities; part two focuses on the professional communities within the hospital.

To order, write to Cornell University Press, 124 Roberts Place, P.O. Box 250, Ithaca, New York 14851-0250. The cost is \$31.50 for cloth (order number ISBN 2349-X) and \$9.95 for paper (ISBN 9604-7). A check, money order, or charge directly to MasterCard, VISA, or American Express is accepted. New York State residents add 7 percent sales. For postage handling, add \$2.00 for first copy and \$.50 for each additional copy.

Book offers physicians better understanding of statistics

Measuring Medical Practice, a publication from the American Medical Association (AMA), is designed to provide physicians with a basic understanding of statistics. Concepts in statistics are developed as well as a glossary. Mathematics is kept to a minimum to increase readability. Other areas treated include: area-to-area variations in statistics pertaining to the delivery of health care, the release of hospital mortality data, utilization review, quality assurance, and the activities of peer review organizations.

Copies of the book are available from AMA, Book and Pamphlet Fulfillment, P.O. Box 10946, Chicago, Illinois 60610-0946 for \$15.00, AMA members \$10.00, or by calling 1-800-621-8335. Order by catalog number OPO50087. VISA and MasterCard accepted.

Statistical components handle inquiries

Inquiries regarding the availability of statistical information other than those pertaining to the specific contents of articles in the *Health Care Financing Review* should be directed to the following components:

For Medicare Statistics

Statistical Information Services Branch
Division of Information Analysis
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Room 3-A-12, Security Office Park Building
6325 Security Boulevard
Baltimore, Maryland 21207
Telephone: (301) 597-3934 (inquiries from government offices); (301) 597-3933 (inquiries from the public)

For Medicaid Statistics

Division of Medicaid Statistics
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Room 2-A-1, Security Office Park Building
6325 Security Boulevard
Baltimore, Maryland 21207
Telephone: (301) 597-3792

For Data Documentation and Public Use Files Requests

Division of Data Documentation and Release
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Room 3-A-10, Security Office Park Building
6325 Security Boulevard
Baltimore, Maryland 21207
Hot-line telephone: (301) 597-5151