Chapter 8: Hospitals
First Half

Lecturer: Monika M. Wahi, MPH, CPH

Learning Objectives

At the end of this lecture, student should be able to:

- Name at least one reason for the expansion of U.S. hospitals, and at least one reason for downsizing them later
- Describe one hospital stakeholder group, and how that group exerts influence on how a hospital operates
- Be able to name and calculate at least one hospital utilization measure

Introduction to Hospitals

Introduction: Define "Hospital"

- "Inpatient" – overnight stay
- American Hospital Association – at least 6 beds, deliver patient services, dx or tx, for particular or general medical conditions
- Must be licensed, have physician staff, and continuous nursing services supervised by an RN
- Governing board, CEO
- Medical records, pharmacy, food services
- Building health regulations, Joint Commission
- Now "medical centers" that may also have "outpatient

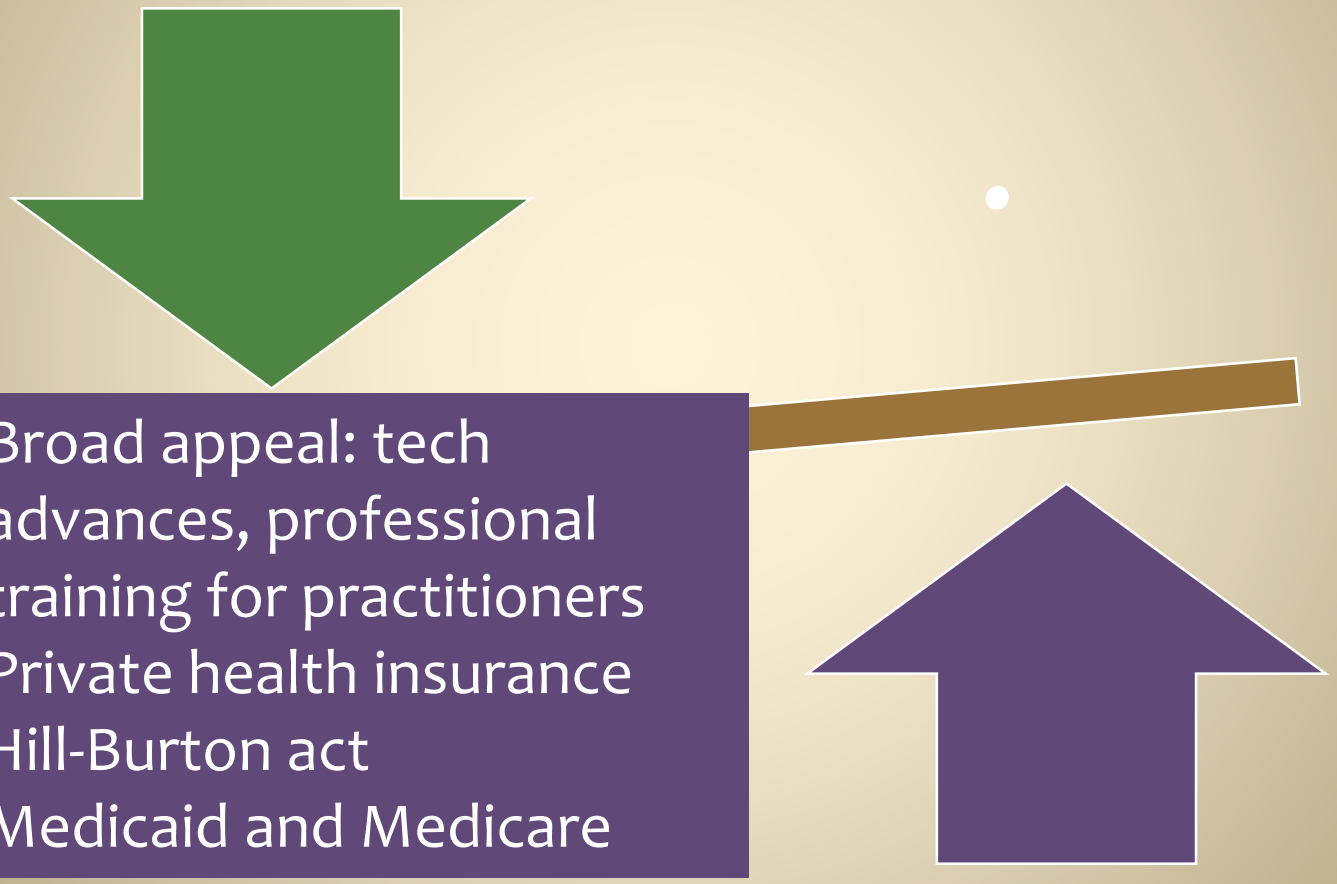
Major Stages of Hospital Evolution

1	<1850	Almshouses as primarily institutions of social welfare
2	Late 1800s	Community-owned private hospitals as charitable institutions supported by affluent donors
3	Late 1800s	Medical services/training serving all members of society, make profit
4	Early 1900s	Small number of physician-owned proprietary hospitals emerge
5	Mid 1900s	University-based centers of medical research
6	1990+	Emergence of medical systems providing a large array of health services

From Exhibit 8.1 (page 186)

The Expansion and Downsizing of America's Hospitals

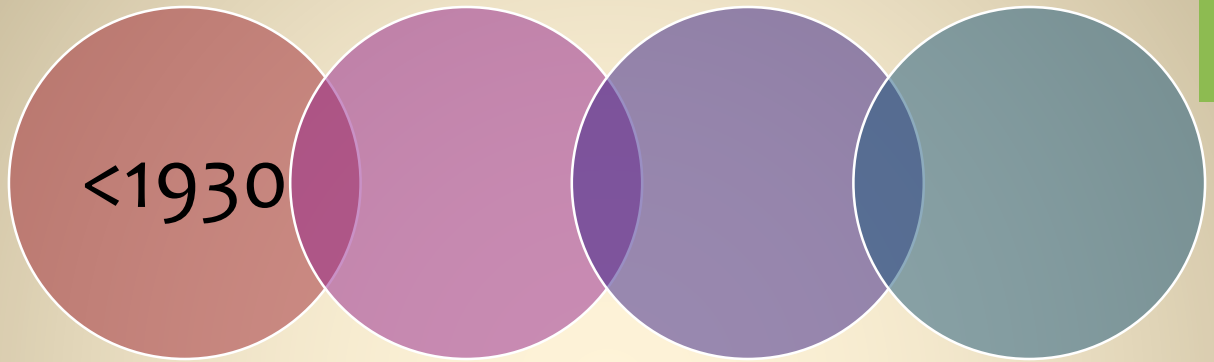
Expansion and Downsizing of Hospitals



- Broad appeal: tech advances, professional training for practitioners
- Private health insurance
- Hill-Burton act
- Medicaid and Medicare

From Exhibits 8.2 (page 189) and 8.3 (page 191)

First - Expansion



<1930

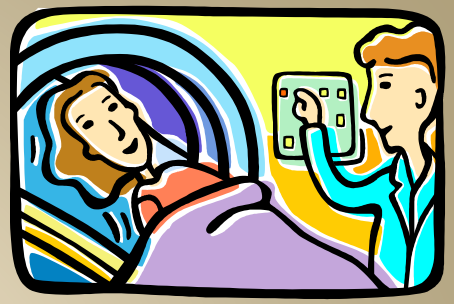
- Now accepting entire public
- Therefore, could make more money
- Had special technology only available at the hospital
- Colleges began training more doctors and nurses

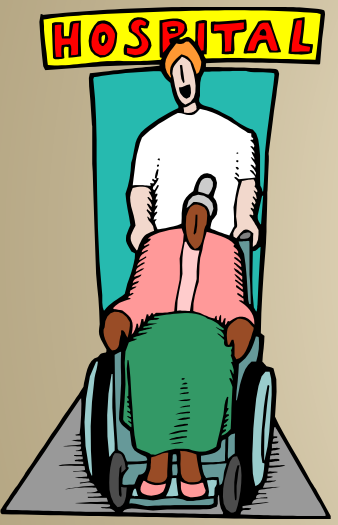
First - Expansion

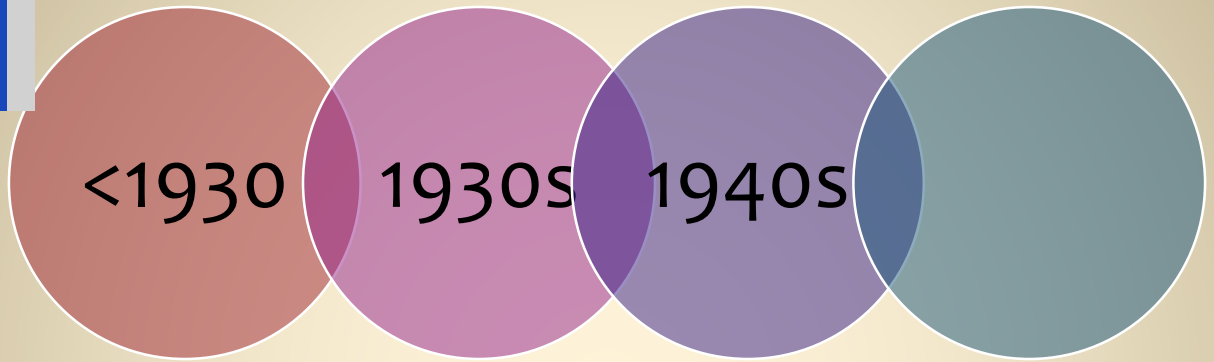
Moral hazard!
Provider-induced demand!

- Just having insurance generated new demand
- Covered mainly inpatient, few restrictions

First - Expansion



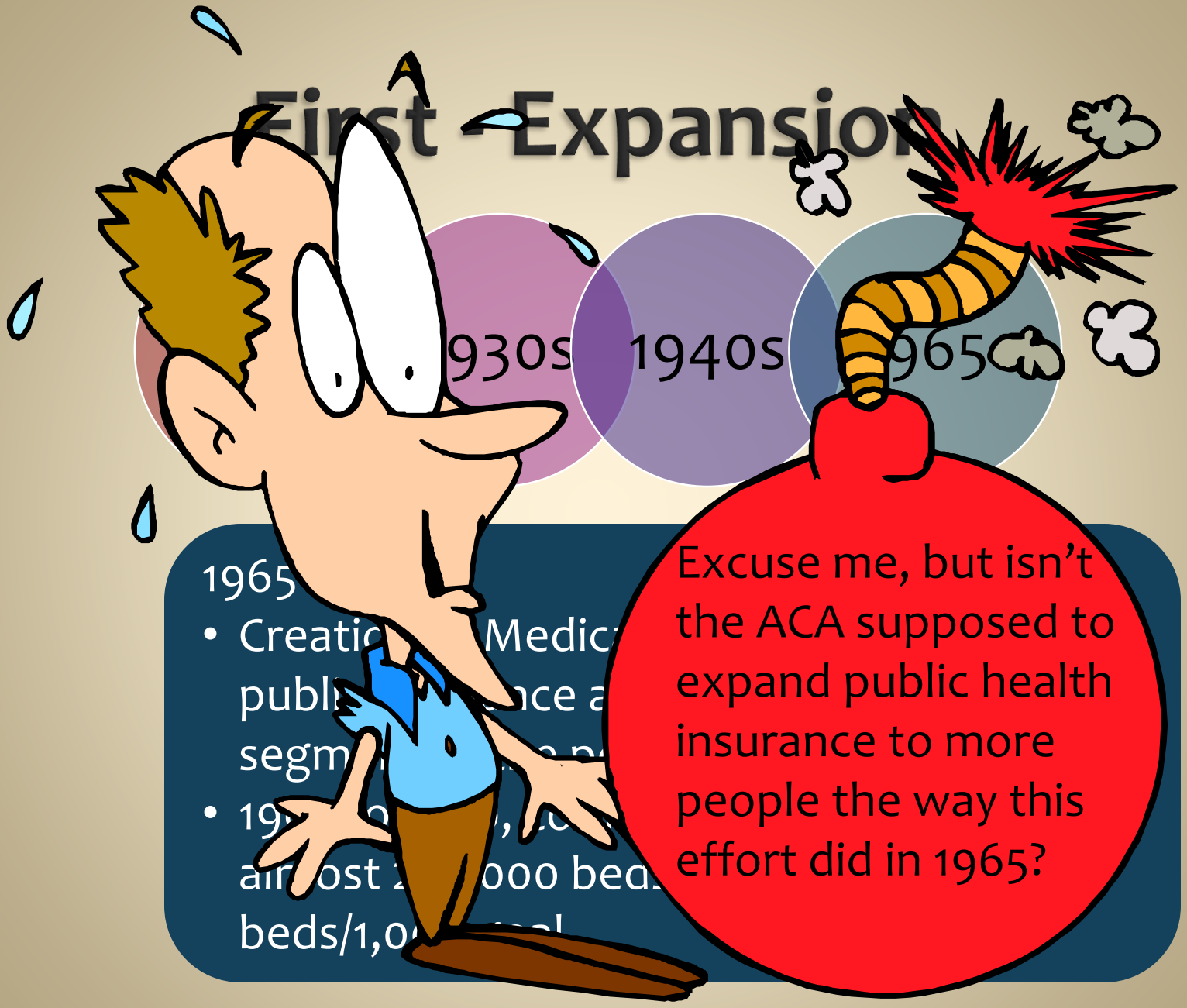




1940s

- Hill-Burton program has been regarded as the greatest single factor in increasing the nation's bed supply
- Brought hospitals to small and remote communities

First Expansion



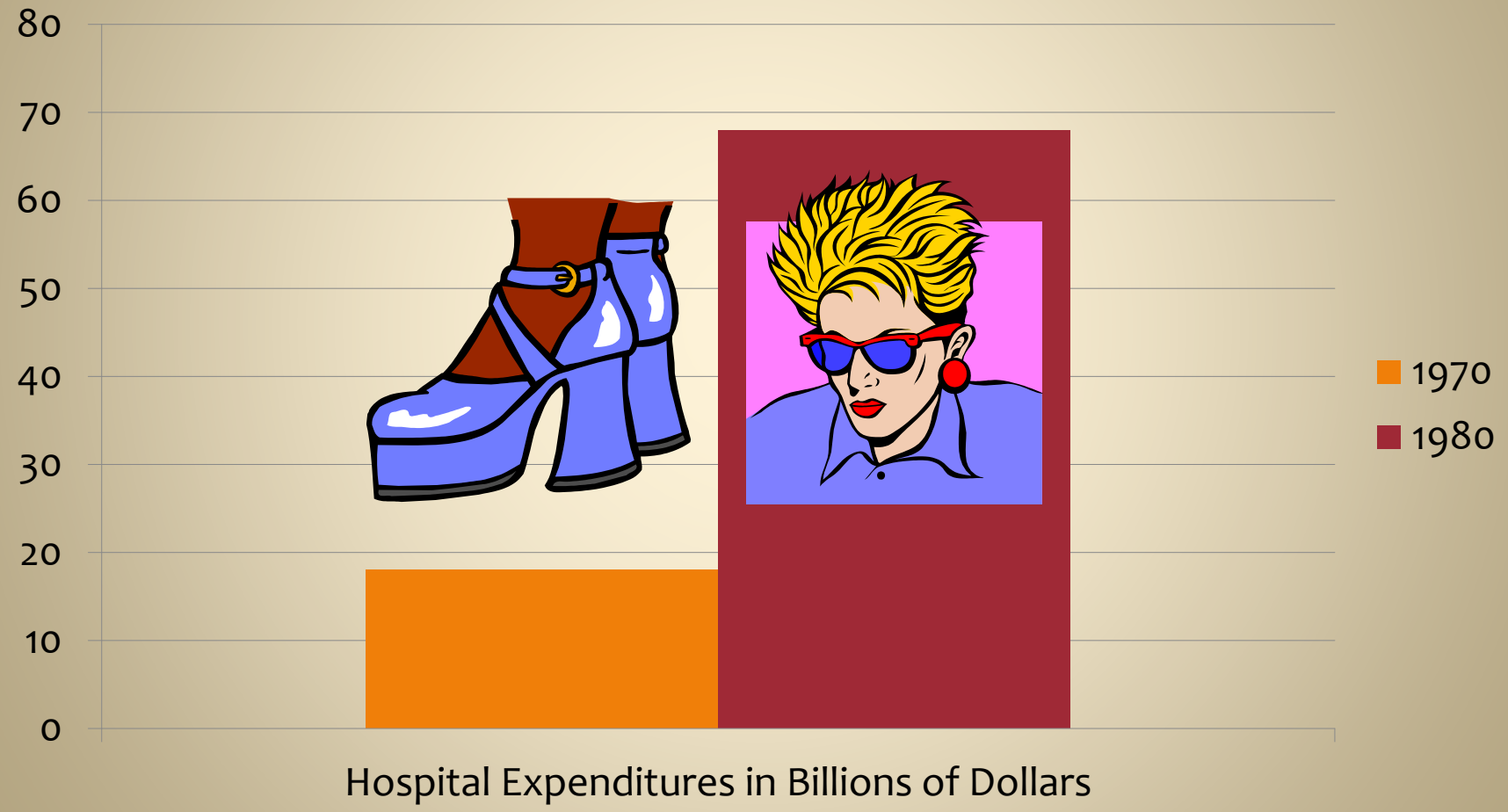
Proportion of Hospital Costs paid by Medica e w t up

Moral hazard!
Provider-induced demand!

Who is paying for that extra part of the Medicare pie? And why?

From Figure 8.1 (page 190).

Not only did Medicare's share go up….



From Figure 8.1 (page 190).

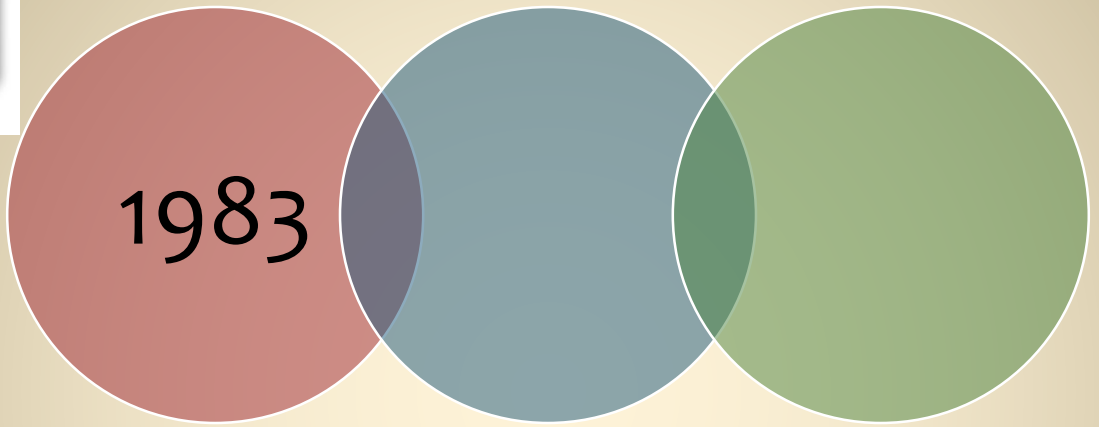
Expansion and Downsizing of Hospitals

- Broad appeal: tech advances, professional training for practitioners
- Private health insurance
- Hill-Burton act
- Medicaid and Medicare

- Medicare reimbursement changed to prospective method, shorter hospital stays
- Hospital closings
- Managed care's cost containment: more services outpatient, home health, skilled nursing care

From Exhibits 8.2 (page 189) and 8.3 (page 191)

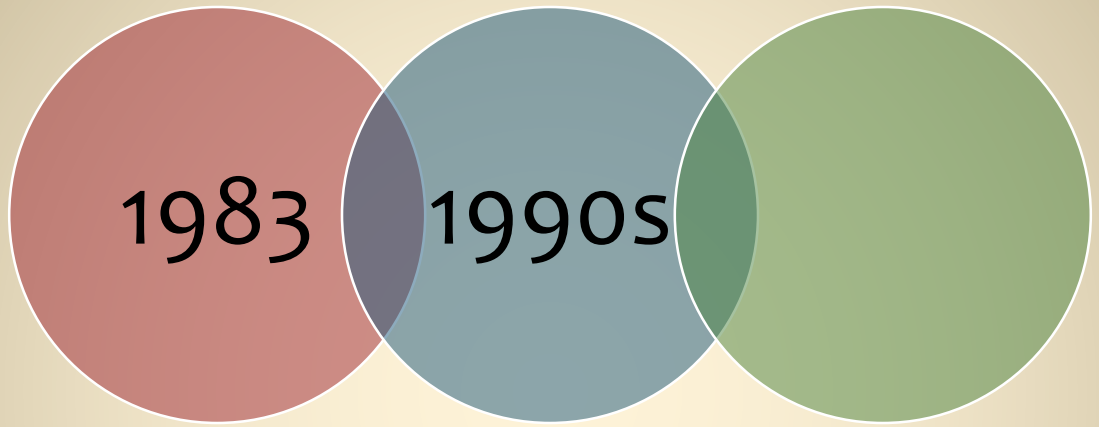
Now - Downsizing



1983

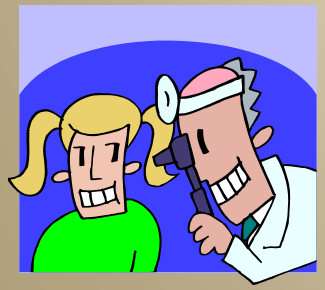
- Hospitals now forced to discharge patients more quickly
- Some forced to close
- Others continued to operate but take unused beds out of service
- PPS (prospective payment system) triggered the downsizing phase

Now - Downsizing

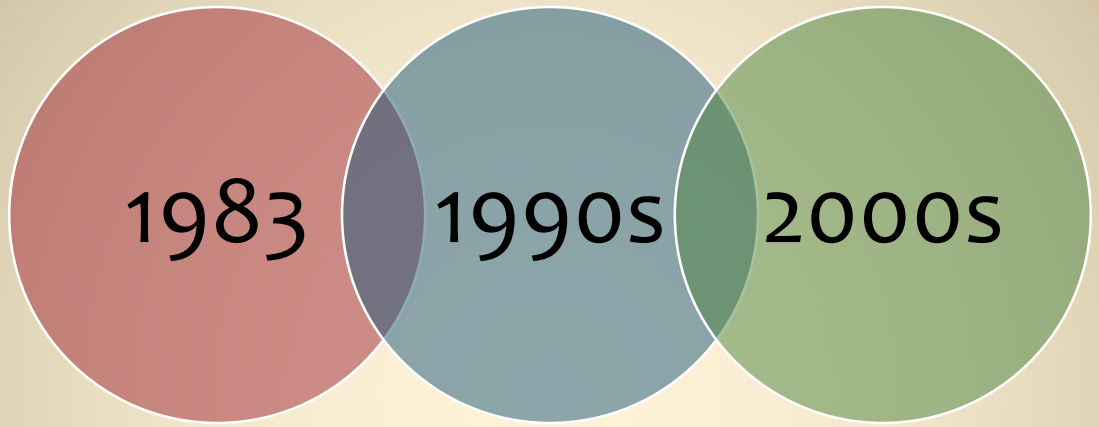


1990s

- Managed care curtailed inpatient use further
- Emphasized cost containment and efficient delivery of care
- Early discharges plus home health or skilled nursing homes
- Also, divert to outpatient all who qualify



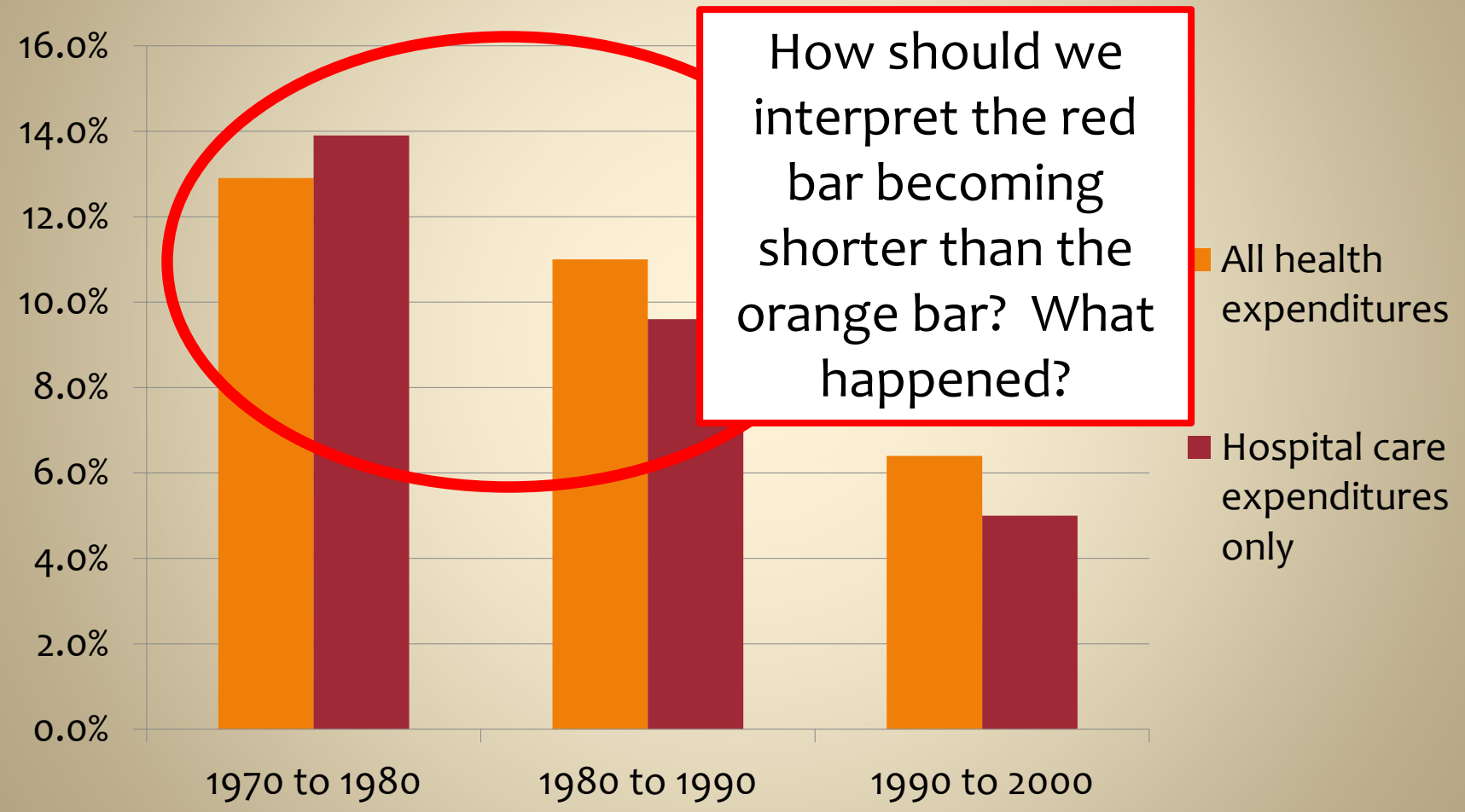
Now - Downsizing



2000s

- Rates of growth in spending declined after 1983 due to PPS
- Rates of growth in spending slowed even more in the 1990s due to managed care
- But rates of growth in spending are not the same as rates of spending!

Growth in Health and Specifically Hospital Expenditures



From Figure 8.2 (page 191)

Access and Utilization Measures

Measure of Access: Discharges

- How do you figure out how many people received hospital inpatients services? Discharges!
- Rates of discharge per 1,000 population
- Discharges do not include newborns
- "Total number of patients released from a hospital's acute care beds during a given period" including in-hospital deaths

Measures of Utilization: Days of Care

- Inpatient-day (or patient-day, or hospital-day) = night spent in hospital by patient
  - Same-day procedure? Not an inpatient-day – and no discharge
- Length-of-stay (LOS) = number of inpatient-days for a patient
- Average length-of-stay (ALOS) = average number of inpatient days (per place per time period)
- Days of care (per place per time period) = discharges x ALOS

Simple Example

Patient	Treatment	Date of Admission	Date of Discharge	LOS
Jane Doe	Hysterectomy	9/27/2007	9/29/2007	2 days
Juana Dos	Trauma tx	9/27/2007	10/3/2007	6 days
Jeanne Deux	Infection tx	9/27/2007	10/7/2007	10 days

- If these were the only 3 discharges between 9/27/2007 and 10/7/2007 for Hospital Q
  - For that Hospital Q for 9/27/2007-10/7/2007, the ALOS would be 2 + 6 + 10 divided by 3 (average) = 6 days
  - Discharges x ALOS = 3 x 6 = 18 days of care at Hospital Q for 9/27/2007 through 10/7/2007

Days of Care in the U.S.

National days of care per
1,000 popul
older people
time in hos
younger

Women admitted to
hospitals more often
than men, bu
longer sta
adjustm
childbe

- Hospital use higher among blacks vs. whites
- Higher among poor vs. nonpoor
- Why?

Why these differences ALOS for different populations?

CAUSES MORE MORTALITY & MORBIDITY/DAYS OF CARE

- Low education
- Low income
- Smoking/tobacco use
- Substance abuse
- Poor diet, obesity, lack of exercise
- Poor access to primary care

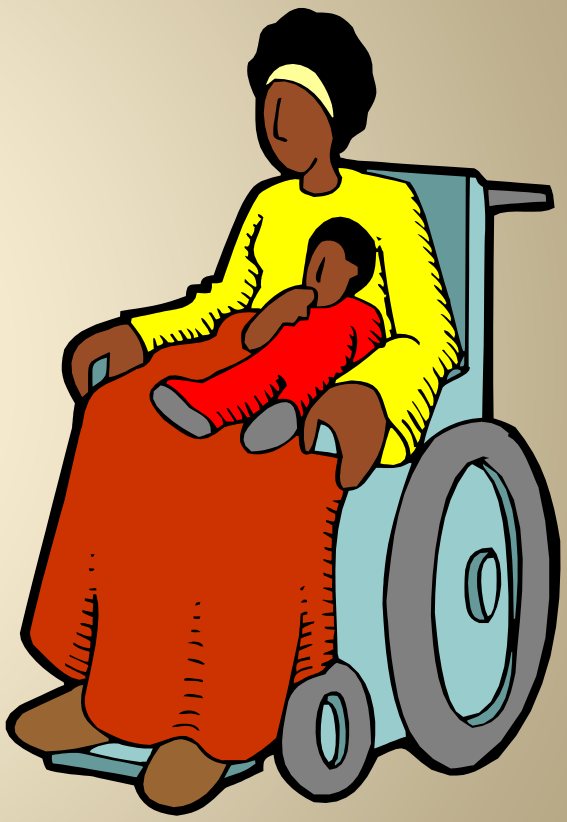
CAUSES LESS MO ALITY ID CA

Hey, aren't those the same people on Medicare and Medicaid?

- Good access to primary care

Efforts to Curb Hospital Costs Reduced ALOS

- Since 2003, ALOS for community hospitals has been 4.8 days, lowest ever recorded
- PPS (prospective reimbursement) had an impact
- Managed care in the 1990s
  - Growth of home health and subacute long-term care enabling earlier discharge
- Did this shift harm patients?
  - Since the development of facilities and advanced technology, quicker discharge did not cause medical harm to patients



Hospital Capacity and Utilization

- Capacity = number of beds set up, staffed, and made available in a hospital for inpatient use
  - 84% of all community hospitals have <300 beds
  - Average size in 2008 was 161 beds
  - Some rural hospitals (Critical Access Hospitals) have ≤25 beds
- Census = number of beds occupied on a given day

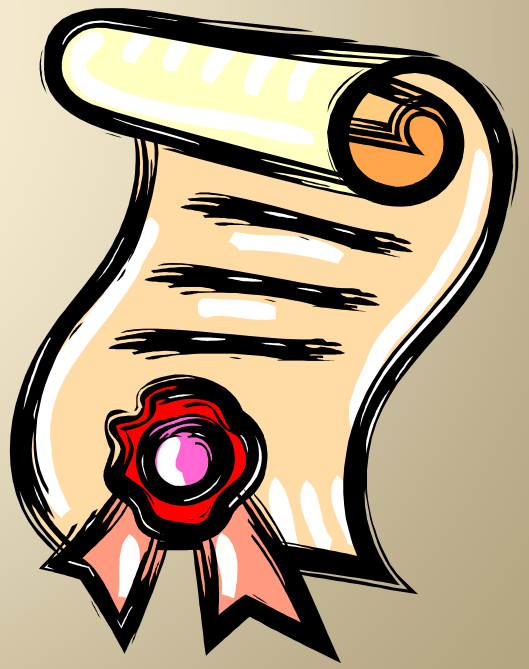
More on Capacity

- Cumulative census over a period of time = patient days or days of care
- Can also calculate an average census over a period of time
  - Select a time frame (e.g., a June 2012)
  - Count number of days of care over that month (e.g., number of days of care in June added up = 3,300)
  - Divide by number of days in period (e.g., 3,300/30 = 110)
- Occupancy rate = % of capacity used during a given time
  - For our hospital above, if total bed = 200, we would have an occupancy rate of 110/200=0.55 or 55%
  - In 2008, U.S. community hospital occupancy rate = 66.4%
  - Book gives another example
- Why so low?

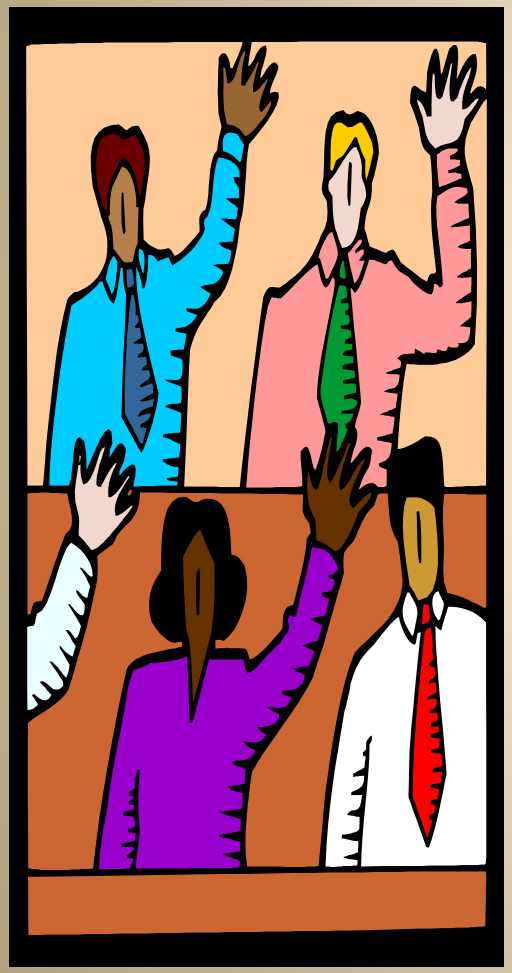
Licensure, Magnet Recognition Program, and Hospital Organization

Licensure, Certification and Accreditation

- Must have state license from the Department of Health
  - Building codes, fire safety, etc.
  - Minimum standards for personnel, equipment
- Must have certification from federal government to get Medicaid/Medicare patients
  - "Conditions of participation" are to meet certain standards
  - Joint Commission or the American Osteopathic Association accredited hospitals are "deemed " to meet these



Joint Commission



- Formed in 1951 as a private non-profit with the approval of various medical and hospital organizations
- Accredits different facilities (hospitals, substance abuse programs, etc.) if they meet standards
  - Different standards apply to different facilities
- More recently, greater emphasis on quality of care

What about before 1951?

Magnet Recognition Program

- 1994 – American Nurses Association conferred Magnet status on hospitals ("Magnet hospitals")
  - Strict standards on quality of patient care
  - Leadership in creating health work environments through nursing excellence and innovations
- Research shows Magnets attract and promote retention of well-qualified nurses, resulting in quality patient care
- Only 400 (7%) U.S. hospitals are Magnet
- Several are near: Boston Children's, MGH, South Shore Hospital, Dana-Farber Cancer Institute, others

Hospitals have to Answer to Many Stakeholders

Cast of Characters in Hospital Organization

- Board of trustees – group that hires/directs CEO
- CEO – Responsible for managing the hospital
  - Senior execs as staff (VP of Nursing, VP of HR, VP of Rehav Svcs, etc.)
  - Non-physician providers often report to these execs
- Chief of Staff/Medical Director – Actually the head of another organizational structure
  - Physicians report to Medical Director
- Non-physician providers administratively accountable to CEO, but professionally accountable to Medical Director

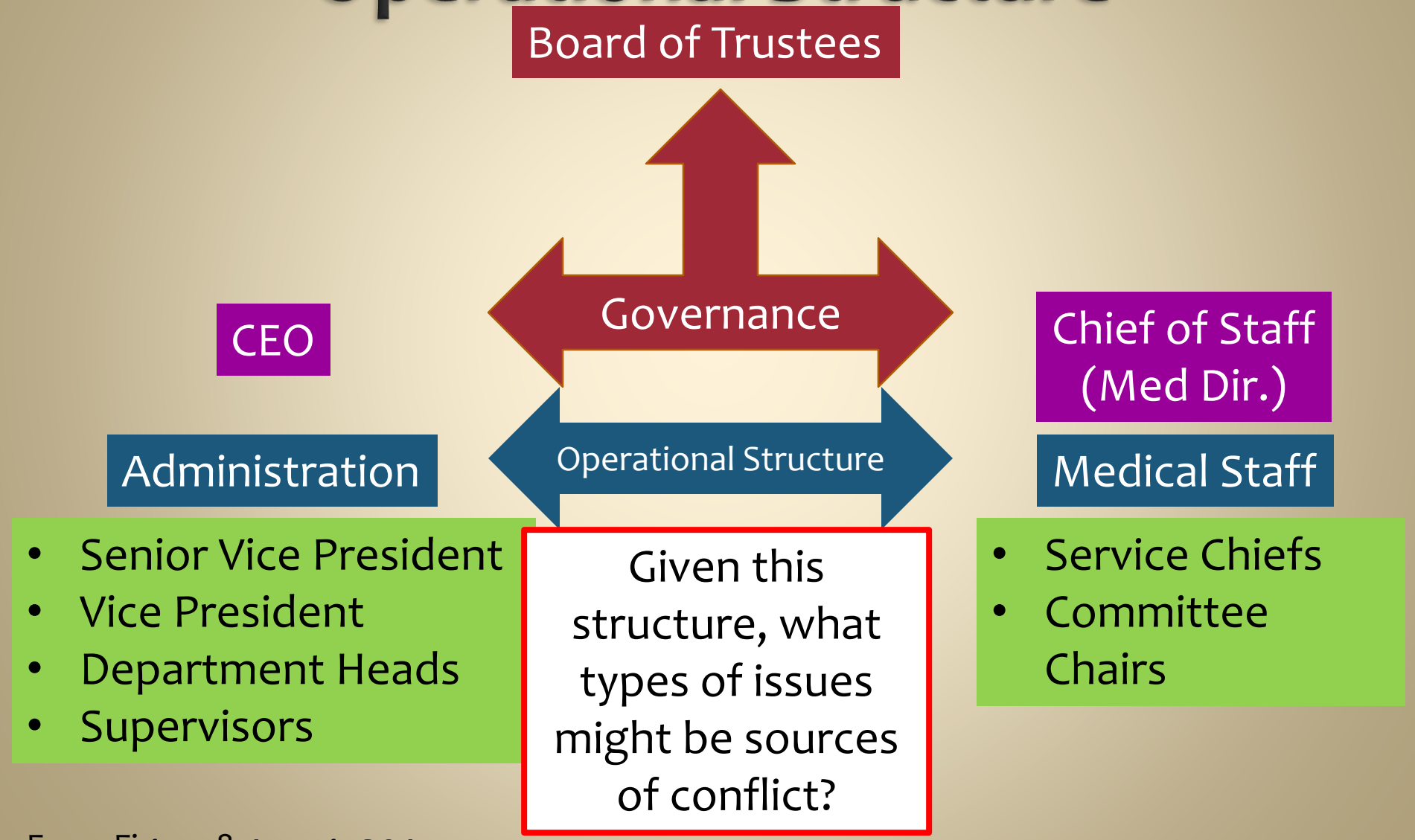
Hennepin County Medical Center Minneapolis, MN

NURSES, TECHS, HR, ETC. HOSPITAL EMPLOYEES

PHYSICIANS MEMBERS OF HENNEPIN FACULTY ASSOCIATES

HENNEPIN FACULTY ASSOCIATES

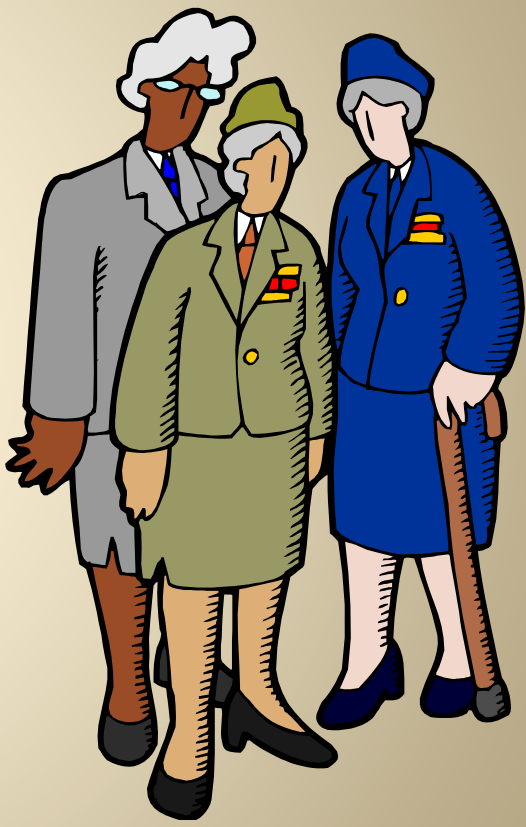
Hospital Governance and Operational Structure



From Figure 8.4, page 204.

Some Exceptions

- VA hospitals employ all their own staff
- Some hospitals employ a number of salaried hospitalists (they do not work for the physician group)
- Physician group may employ a handful of non-physicians (nurses, administrative support)



Ethics and Public Trust in Hospitals

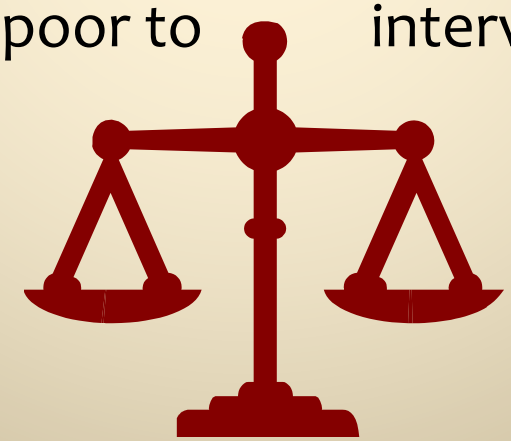
Moral Responsibilities of Beneficence and Non-Maleficence

BENEFICENCE

- Obligation to do all it can to alleviate ill health caused by illness or injury
- Includes essential services (such as ER services) to those who are too poor to pay

NON-MALEFICENCE

- Do not harm patients
- Physicians must use best possible judgment to maximize health benefits and minimize risk of all interventions



In what situations in the hospital might these two responsibilities compete?

Ethical Issues Hospitals Face

- End-of-life/withdrawing life support
- Patient consent before treatment
- Patient participation in selecting treatment
- Providers are to keep information confidential
- Fairness, equality, non-discrimination in HC delivery

How Hospitals Address Ethical Issues

Hospital Ethics Committee

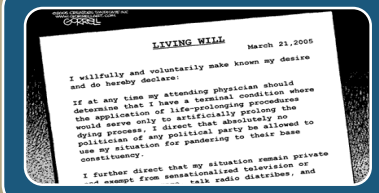
- Develops guidelines/standards, makes decisions
- Interdisciplinary: phys., nurses, clergy, SW, legal/ethics

Patient Self-Determination Act of 1990

- Applies to all facilities participating in Medicare/Medicaid
- All patients must be given patients' rights information

Informed Consent

- Every patient has a right to make an informed choice
- Physicians must provide information to mentally capable


LIVING WILL

March 21,2005

I willfully and voluntarily make known my desire and do hereby declare:

If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that absolutely no politician of any political party be allowed to use my situation for pandering to their base constituency.

I further direct that my situation remain private talk radio diatribes, and

Advance Directives

- Patients expressing wishes before becoming incompetent
- Much preferred to alternative, but rarely done in practice

Hospitals and Public Trust

- Hospital's mission is to benefit the community, whether public or private
  - Hospital administrators are charged with acting prudently with fiduciary responsibility
- Hospital to be viewed as a community asset
- When such a viewpoint is lost, and hospitals put other priorities (especially financial concerns) above serving the community, a breach of public trust can occur.
- Hospitals must be integrated in the HC system
- Growing emphasis on holding hospitals accountable for the health of their communities

Conclusion

- Hospitals have undergone a major evolution in the U.S. health care system
  - First, a period of expansion
  - Next, a period of downsizing
- Several utilization metrics have been developed to compare hospitals fairly
- Many hospitals face unique challenges of governance, licensure, and ethical issues
- Hospitals will continue to evolve and will play an important role in the future of the U.S. HC system

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At the end of this lecture, student should be able to:

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- Be able to name and calculate at least one hospital utilization measure