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Hospitals

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LEARNING OBJECTIVES

- ☐ Identify how hospitals have developed in the U.S.
- ☐ Differentiate among some important different types of hospitals.
- ☐ Understand public and payer concerns with the cost and quality of hospital care.
- ☐ Describe the organizational structure of hospitals and how physicians relate to them.
- ☐ Analyze the challenges facing hospitals and hospital responses to these challenges.

TOPICAL OUTLINE

Historical development
Hospital statistics and characteristics
Payer and public concerns with costs and quality
Hospital organizational structure
New developments in hospital organization
Organizational challenges and response
Conclusions

KEY WORDS

acute care, alliances, average daily census, clinical quality improvement, community benefit programs, continuous quality improvement (CQI), full-time equivalents (FTEs), hospitals, investor-owned hospitals, joint

Commission on the Accreditation of Healthcare Organizations (JCAHO), medical staff organization, multiunit organizations, networks, organizational structure, ownership, patient-focused care, public hospitals, quality, rural hospitals, scope of services, systems, teaching hospitals, utilization

Smith and Kaluzny (1986) have characterized the health care system as a white labyrinth "so large, complex and subtle that it defies description." To many Americans, hospitals are just such white labyrinths. People often know little about how their local hospital or hospital system functions, and even those who work in hospitals often know little about the departments, occupations, or facilities in the system, other than their own. And hospitals, like other local organizations, open, grow, merge, and close.

In the 23 years that have spanned the seven editions of this book, the editors have struggled with ways to organize the materials by chapter. An example of a problem encountered would be whether mental hospitals be discussed in the "Mental Health" chapter or in this one. Hospitals provide "Ambulatory Care" (the title of another chapter). Also, many hospitals own a variety of long-term care facilities (the title of yet another chapter) ranging from nursing homes and subacute facilities to home care agencies and day care programs. Inpatient medical care doesn't warrant a chapter by itself. But the hospital and its culture remains a dominant one in health care delivery. Hospitals consume a smaller percentage of the health care dollar than they did in 1976, and inpatient utilization has decreased, but hospitals remain central to health care delivery and have grown into systems of many hospitals; and some systems are vertically integrated, to include facilities other than hospitals. These systems remained, for the most part, as of 2000, dominated by hospital culture, ownership, and control.

This chapter surveys the following topics concerning hospitals and hospital systems: (a) historical development; (b) statistics and characteristics; (c) concerns about hospital cost and quality; (d) organizational structure; and (e) challenges and responses. The primary focus remains on acute, short-term, general hospitals and hospital systems.

HISTORICAL DEVELOPMENT¹

The development of American hospitals and hospital systems can be divided into five periods:

1. The beginning, before 1870.
2. The first period of rapid growth, 1870-1910.

¹ The Historical Development section of this chapter, through 1980, remains in large part the same as in the first and second editions and was authored by M. Enright and S. Jonas.

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3. The first period of consolidation, 1910–1945.
4. The second period of rapid growth, 1945–1980.
5. The second period of consolidation, 1980–2000+.

The first hospitals were primarily of a religious and charitable nature, tending to provide care for the sick rather than providing for medical cure (Freyman, 1974; Rosenberg, 1987; Starr, 1982). In the American colonies, the earliest hospitals were actually infirmaries in poorhouses. Private voluntary hospitals (those provided or supported by community leaders) in the United States date back to the 18th century (Freyman, 1974). These institutions cared for the poor: Since hospitals could provide little effective medical treatment, there was no reason for doctors to use them for paying patients. By 1873, there were an estimated 178 such hospitals in the United States (Stevens, 1971).

From 1870 to 1910, as biomedical science and technology developed effective means of intervention, hospitals evolved into local physicians' workshops for all types and classes of patients. More effective hospital care was achieved primarily through advances in hygiene, including the development of trained nurses and techniques for asepsis and surgical anesthesia. Between 1870 and 1910 there was a period of spectacular growth, with the number of hospitals increasing from 178 in 1873, to more than 4,300 in 1909 (Stevens, 1971). Medical care became too complex for physicians to carry their entire armamentarium in their little black bags; special equipment and consultation with other medical specialists became essential.

According to Starr (1982), voluntary and public hospitals were established during the period of 1750 to 1850. From 1850 to 1890, many new hospitals were formed to meet the needs of specific religious or ethnic groups, or to specialize in the treatment of certain diseases or categories of patients, such as children and women. For-profit hospitals owned by physicians grew rapidly during the period of 1890 to 1920. Fewer new hospitals were built during 1910 through 1945 than during the periods before and after.

The types of patients in hospitals changed with medical discoveries. In 1923, the discovery of insulin drastically changed the character of diabetes treatment. Liver extract reduced the incidence of pernicious anemia in 1929. Sulfonamides began to affect treatment of pneumonia and some other infectious diseases in 1935, a trend that accelerated with the widespread use of antibiotics beginning in 1943, as well as the continuing development of immunization techniques. The development of rehabilitation services began to bring more disabled patients to the hospital. In the 1950s, hospitals increasingly treated chronic illness. As infectious diseases generally have been conquered (with the exception of HIV/AIDS), hospitals have increasingly focused on the pathology of trauma and degenerative and neoplastic disease.

The fourth period, 1945 to 1980, was a second major growth era for hospitals. It was marked by a tremendous increase in hospital services, costs,

and technology and by a more modest expansion in the number of hospitals. Many small rural hospitals were built during this period, financed by federal monies under the Hill-Burton Act. A major factor influencing the increased breadth and intensity of inpatient hospital services was the rapid growth of hospital insurance. The Blue Cross system was originally developed during the Great Depression in order to assure payment to hospitals. Hospital insurance developed rapidly during World War II as a result of collective bargaining agreement. During this period, the federal government limited wage increases to workers but not fringe benefits. Finally, in 1965, Medicare and Medicaid programs were created, the former providing health insurance for the elderly and the latter providing health care benefits for the poor.

Since 1980, hospital occupancy rates have decreased for a smaller number of hospitals with less total beds. There has been an emergence in the industry of hospital systems, networks, and alliances, some of which are quite large, most particularly in local markets. In some cities, 40 or more independent hospitals have been collapsed into three or four competing health systems. At the same time, hospital services other than inpatient care have expanded rapidly. Such services include chronic care and ambulatory care, often with satellite sites dispersed over a wide geographic area.

HOSPITAL STATISTICS AND CHARACTERISTICS

Hospitals can be differentiated by capacity, utilization and ownership, and by scope of services and types of patients served.

Capacity, Utilization, and Ownership

Table 6.1 provides summary statistics on general acute care hospitals, and some key facts on size, utilization, employment, and expenditures. Hospitals other than general acute care include governmental mental health and long-term hospitals, of which there were 1,218 in 1998 (American Hospital Association [AHA], 2000). Acute care² hospitals admitted more than 31.8 million patients in 1998, with an average length of stay of 6 days. On any day, there was an average of almost 525,000 patients hospitalized. These represent substantial decreases from 1983, as shown in Table 6.1 (AHA, 2000).

The number of acute care hospitals (see Table 6.1) decreased from 5,783 in 1983 to 5,015 in 1998 (AHA, 2000). Hospitals vary in size. In 1998, there

² Same as "community" hospitals; all nonfederal, short-term, general, and special hospitals whose facilities and services are available to the public. A short-term hospital is one in which the majority of its patients are admitted to units where the average length of stay is less than 30 days (AHA, 2000).

TABLE 6.1 Acute

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TABLE 6.1 Acute Care Hospital Facts

Parameters	1983	1998
Total number of hospitals	5,783	5,015
Beds (thousands)	1,018	840
Patient Admissions (thousands)	36,152	31,812
Births (thousands)	3,490	3,726
Outpatients (thousands)	210,044	474,193
Average Length of Stay (days)	7.6	6.0
Average Daily Census (thousands)	749	525
FTEs (per 100 adjusted census)	358	468
Expenses (adjusted per inpatient day)	\$369.49	\$1,066.96

Adapted from: American Hospital Association. (2000). Hospital Statistics. Chicago, IL: Author.

were 1,193 hospitals of less than 50 beds and 254 acute care hospitals of 500 beds or more (AHA, 2000). Acute care hospitals employed 3.8 million full-time equivalent (FTE) staff in 1998. Acute care hospital expenditures in 1998 totaled \$318.8 billion. Most acute hospitals are under nonprofit ownership, as shown in Table 6.2. (See also chapter 13 regarding governance and management.) Ownership patterns have not changed significantly during the last 15 years.

Scope of Services and Some Types of Acute Care Hospitals

Hospitals differ from one another with respect to size, mission, ownership, scope and complexity of services, competitive environment, population served, financial condition, participation in systems, networks and alliances, efficiency, and quality. For example, with regard to scope of services, according to the *AHA Guide* (AHA, 1999), Nor-Lea Hospital in Lovington, New Mexico had 28 beds and provided the following services: CT scanner, emergency department, health fair, home health services, hospice, outpatient care, nutrition programs, occupational health services, outpatient surgery, social work services, and ultrasound (AHA, 1999). Montefiore Medical Center in New York City had 1,032 beds and was listed as providing all the services that Nor-Lea provided. In addition, Montefiore provided alcoholism services, angioplasty, birthing room, breast cancer screening, cardiac catheterization, cardiac intensive care, case management, children wellness program, community health status assessment and service planning, community outreach, dental services, diagnostic radioisotope, drug abuse and outpatient services, lithotripter, freestanding outpatient center, geriatric, health information, health screenings, HIV/AIDS services, magnetic resonance imaging, medical surgical intensive care, neonatal intensive care, obstetrics, oncology, open heart surgery, patient education center, patient representative services, physical rehabilitation (inpatient and outpatient), positron emission tomography scanner, primary care department,

1998
3,026
1,218
771

1997, 94% of COTH members reported having a cardiac catheterization lab (vs. 33% for nonCOTH members); 85% reported a megavoltage radiation facility (only 47% for nonCOTH hospitals); and 65% of COTH institutions reported the capability to perform kidney transplants (only 5% of nonCOTH hospitals reported the capability to perform kidney transplants).

In 1997, COTH members comprised 6% of the nation's short-term nonfederal hospitals, but claimed 44% of the total deductions for charity care (approximately \$6.7 billion) and 26% of the deductions for bad debt (approximately \$4.5 billion) (AAMC, personal communication, 1999). For more information about COTH, see <http://www.aamc.org>.

Networks, Systems, and Alliances

The AHA defines networks, systems, and alliances as follows. A network is defined as a group of hospitals, physicians, other providers, insurers, and/or community agencies that work together to deliver health services. A system includes both multihospitals (two or more hospitals owned, leased, sponsored, or contract managed by a central organization) and diversified single hospitals. The latter are defined as bringing into membership three or more nonhospital organizations, and at least 25% of their owned and leased nonhospital pre-acute and post-acute health care organizations. An alliance is defined as a formal organization, usually owned by shareholders/members, that works on behalf of its individual members in the provision of services and products and in the promotion of activities and ventures (AHA, 1999). As of 1998, the AHA registered 2,176 acute care hospitals as being in health systems, 1,380 in networks, and 2,778 in group purchasing organizations (the dominant kind of alliance). The same hospitals can be registered in more than one category (AHA, 2000).

An example of a large nonprofit hospital that is part of a network, a system, and an alliance, is the Henry Ford Health System (HFHS) of Detroit, Michigan. By 1999, HFHS was a \$1.9 billion corporation, with 17,550 employees serving almost 20% of the Detroit metropolitan area population. It included 6 hospitals and 34 outpatient care sites. HFHS had affiliations with six medical schools and had 1,500 research projects with \$40 million in grant funding. HFHS was the sixth largest employer in Michigan (<http://www.henryfordhealth.org>).

Premier is an example of a hospital alliance formed for group purchasing and other activities, and represents, as of 1999, 215 owners and 950 other affiliated hospitals, and the 1,830 hospitals and health care facilities they operate. Premier's total purchasing volume reached \$8.5 billion in 1998 (<http://www.premierinc.com>).

Public Hospitals

Public hospitals are owned by agencies of federal, state, and local government. Federal hospitals historically have been designed for special beneficiaries:

American Indians, merchant seamen, military personnel, and veterans. State hospitals typically have provided long-term psychiatric and chronic care, especially for patients with tuberculosis in the past. There are also state university or teaching hospitals that provide short-term general acute care. An example of a public hospital system is the Veteran's Administration (VA), one of the nation's largest health care systems. As of 1999, the VA had 172 hospitals, 551 outpatient clinics, 131 nursing homes, 40 domiciliaries, 206 counseling centers, and 215,468 employees. These facilities serve more than 10% of the total veteran population each year (<http://www.va.gov>).

There are two main types of acute care public hospitals. The first type has similar characteristics to smaller nonprofit hospitals, is located in small towns or cities of moderate size, is used by private attending physicians, and serves paying and indigent patients.

The second type is located in major urban areas. Physician staff are mostly salaried resident physicians in training. Hospital deficits are paid by taxes. As of 1998, there were 1,218 state and local government general and other special hospitals with a total of 139,355 beds (AHA, 2000). These 1,218 hospitals (24% of all acute care hospitals) provided 16.6% of the acute care hospital beds, 14.3% of the inpatient admissions, and 16.9% of the outpatient visits (AHA, 2000).

Rural Hospitals

Rural areas are areas falling outside a metropolitan statistical area, which is defined as containing a city with a population of at least 50,000 or an urban area with a population of at least 50,000 and a total metropolitan population of 100,000 (AHA, 1992). In 1998, 2,199 (43.8%) of the nation's hospitals were rural; 72.7% of these hospitals had fewer than 100 beds (AHA, 2000).

Between 1982 and 1997, admissions to rural hospitals dropped from 8.3 million to 5.1 million, a 39% decline. Between 1980 and 1990, 280 rural community hospitals stopped providing inpatient acute health services (AHA, 1992). Key problems of rural hospitals include threat of closure, thereby depriving local residents of access to care; the questionable financial viability of hospitals with fewer than 50 beds; difficulties in assuring quality of care in such hospitals when operated as independent units; and difficulties in attracting skilled professionals to work in isolated rural localities. Rural American counties face different kinds of problems depending on economic structure. Although they are often thought to consist of farm areas, rural counties can be classified as economically dependent on farming; manufacturing; mining, oil, and energy; large, governmental installations; federal lands; and retirement settlement communities, or characterized by persistent poverty (AHA, 1988).

To survive in more competitive hospital markets, rural hospitals have undertaken a variety of innovative measures. According to the AHA rural hospital assessment (1988), rural hospitals have tried to increase patient volume by introducing or expanding ambulatory or long-term services;

Hospitals

and many have sought to reduce costs and consolidation ac

PAYER AND PUBLI

Hospital care is big business. Expenditures amounted to \$42 billion per American (Levinson, 1998). Spending has been rising slowly during the 1990s. Health care spending has increased, but hospital care are very expensive. In 1998, the average day, and over 40 million people pay these bills. Hospitals are trying to contain these costs.

What Does a Hospital Do?

In a response to a survey on financial management, hospitals ranging from \$42 million to \$1 billion, the least expensive of the hospitals for a female inpatient expired in the hospital was \$1,200.

This case is at a hospital in the city. Questions: How much did the patient receive? How much more cheaply, and how much more expensive, and how much more necessary and provided? How long of stay were justified? How much of these charges by the length of the stay?

Hospitals As Employers

The impact of hospital on communities, health care, and revenue means numerous employees. Union members, so it is important to have and others, lobby for better conditions.

and many have sought to expand technological capabilities, increase referrals, or reduce costs through shared service or networking arrangements and consolidation activities.

PAYER AND PUBLIC CONCERNS WITH COSTS AND QUALITY

Hospital care is big business. In 1998 hospital acute and long-term expenditures amounted to \$382.8 billion, representing 33% of the nation's health expenditures and 4.5% of the nation's gross national product, or \$1,362 per American (Levit et al., 2000). Hospital expenditures have been growing slowly during the past few years and the hospital share of national health spending has been growing only modestly. Costs for a day of hospital care are very expensive and increasingly so, typically over \$1,000 per day, and over 40 million Americans lack insurance or other coverage to pay these bills. Health plans, government, and commercial payers want to contain these costs.

What Does a Hospital Stay Cost Payers?

In a response to what are typical hospital charges for a long-stay inpatient, a financial manager of a large urban hospital abstracted four "typical bills," ranging from \$42,612 to \$76,574. A breakdown of hospital charges for the least expensive of these four, "Mrs. L" is shown in Table 6.3. This is a bill for a female inpatient, age 58, treated for simple pneumonia/pleurisy, who expired in the hospital after a stay of 25 days.

This case is at a large hospital, where charges are not among the highest in the city. Questions can be raised as to whether all of the services the patient received were necessary, and whether they could have been provided more cheaply, and whether Mrs. L's admission was necessary, although there is no reason to think other than that the services received were necessary and provided at reasonable cost, and that the admission and length of stay were justified. Private and governmental payers have responded to these charges by establishing fixed payments based on the type of case or the length of the patient's stay in the hospital.

Hospitals As Employers

The impact of hospitals on local economies can be very important. In small communities, hospital closure can remove a vital source of local employment and revenues to local hospital suppliers. Construction of a hospital means numerous jobs for construction workers and future hospital employees. Unions have a vital interest in continuing employment for their members, so it is no wonder that they, together with hospital associations and others, lobby vigorously not only against hospital closings, but also at

TABLE 6.3 Breakdown of Charges Rendered to "Mrs. L" During 25-day Hospitalization

	Charges for 1999
Room and Board	\$26,050
Laboratory	1,631
Therapy	425
Drugs	9,222
X-Ray	4,575
Blood Service	262
EKG, EEG, etc.	67
Miscellaneous	380
Total	\$42,612

Source: Valentine, R., personal communication (1999). Lutheran Medical Center.

the state level for governmental payment for the costs of charity care, bad debts, and graduate medical education, and push for increasing eligibility for Medicaid and Child Health coverage.

Concerns about the quality of hospital care have also become a national issue (see Kohn, Corrigan, and Donaldson, 1999). Quality is discussed at length in chapter 14. Because of the seriousness of the consequences of poor quality care in the hospital, this is of great concern to all Americans who may be admitted in any year or whose family or friends may be admitted. Hospital spokesmen may maintain that it is perhaps hard to believe that quality is as high as it is, given that hospitals are open 7 days a week, 365 days a year, while individual caregivers only work 40 hours a week, 48 weeks a year. Care is often very complex and requires teams of caregivers, including many physicians who are not salaried and spend most of their time away from the unit in which their patient is being treated. Chassin (1998) suggests that there are three main reasons for quality problems:

1. Overuse, providing a health service when its risk of harm exceeds its potential benefit.
2. Underuse, failing to provide an effective service when it would have produced favorable outcomes.
3. Misuse, avoidable complications of appropriate health care.

An example of overuse is unnecessary surgery. Underuse, for instance, is lack of access to needed care because of lack of health insurance. An example of misuse would be mistakes in medication distribution and use.

Leape (1994) argues there is much that physicians and nurses could learn from aviation, where designing for safety has led to an industry—which although highly complicated and risky—seems far safer. Leape suggests building in multiple safety checks, standardizing procedures, and institutionalizing safety. He suggests that hospital risk management activities

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should include all potentially injurious errors and seek out underlying system failures. Leape, like Berwick (1989), suggests focusing on system improvements rather than blaming individual providers.

Quality can be subdivided into two categories: technical medical quality and service quality. Technical quality would include proper diagnosis and treatment. Service quality would include patient convenience and control of medical treatment. Service quality considerations include patient understanding of treatment options and compliance regimens, patient choice of caregiver, relief from pain, and a quiet and clean hospital environment. (See Kenagy, Berwick, & Shore, 1999.)

HOSPITAL ORGANIZATIONAL STRUCTURE

The principal departments of the acute care hospital are medical and dental, nursing, other diagnostic and therapeutic support, financial, personnel, and hotel services. Most hospitals provide services to inpatients who are admitted and assigned a bed, and to outpatients who come to an emergency department, an outpatient clinic, or satellite center, for a diagnostic or therapeutic service for a procedure not requiring admission.

Medical and Dental Department Organization

Physicians and dentists relate to hospitals in different ways. Attending physicians on the hospital staff who are not salaried often conduct much of their business in private offices that they own or rent. These physicians may admit patients to more than one hospital and may compete with the hospital for patients or customers. Other physicians may be salaried or paid by the hospital, according to the amount of hospital work they do. These physicians often see patients or provide diagnostic services in offices that are provided for them by the hospital. Some hospitals employ physicians to provide primary care in competition with other physicians who are attending physicians or local nonhospital-affiliated practitioners. Other hospitals contract with physician groups to provide emergency care or subspecialist services on hospital premises or in satellite centers. There are some attending physicians who maintain their own practices distinct from the hospital but who also receive a part-time salary from the hospital for administrative work.

When physicians admit patients to the hospital, in most instances they are free to order whatever tests or treatments they deem necessary. Thus the physician basically determines the amount of services used and the consequent costs of patient care. Physicians have every reason to want the best possible hospital setting in which to practice medicine, especially when it is provided at little personal cost to them.

Although the physician is technically a guest in the hospital, the hospital is responsible for the care its staff renders patients on a physician's

orders. Once, hospitals could not be held liable for the wrongful conduct of a physician, but this principle has changed as a result of a series of judicial decisions (Southwick, 1978). Changing legal doctrines regarding negligence and corporate liability of hospitals have established that hospitals are legally responsible, and to the extent that hospital negligence is involved, financially responsible for the care provided by their entire professional staff, including physicians (Showalter, 1999).

Physicians are primarily organized along the lines of the medical specialties. The larger the hospital and hospital network, and the more specialized the medical services, the greater the number of separate medical departments. There is no universal logic to the way in which medical departments are categorized. Some are separated from others by type of skill involved, some by the age or sex of their main patient group, and some by the organ or organ system that they primarily diagnose and treat. Departments found in most hospitals include

1. *Internal medicine*: general diagnosis and therapy of adults for problems involving one or more internal organs or the skin, in which the principal tools do not involve a physical alteration of the patient's body by the physician.
2. *Surgery*: diagnosis and therapy in which the principal tools involve a physical alteration of a part of the patient's body by the physician.
3. *Pediatrics*: general diagnosis and therapy for children, primarily but not entirely with nonsurgical techniques.
4. *Obstetrics/gynecology*: diagnosis and therapy relating to the sexual and reproductive system of women, using both surgical and nonsurgical techniques.
5. *Psychiatry/neurology*: diagnosis and therapy for people of all ages with mental, emotional, and nervous system problems, using primarily nonsurgical techniques.
6. *Radiology/diagnostic imaging*: diagnosis and therapy, primarily through the use of X-ray and other internal imaging techniques.
7. *Pathology*: diagnosis, both before and after treatment.
8. *Anesthesiology*: principally concerned with preparing patients so that they may be surgically operated on with no pain or discomfort during the procedure.

Other general medical departments include family and emergency medicine. More subspecialized medical departments tend to be organized around organs and organ systems, for example, ophthalmology (eye); otolaryngology (ear, nose, and throat); urology (male sexual/reproductive system and the renal system for both males and females); orthopedics (bones and joints); and so on.

There are 23 medical specializations for which professional certification may be attained by passing a medical specialty board examination. Specialties other than the ones previously mentioned include allergy and

immunology, physical medicine and physical medicine and thoracic surgery, and thoracic surgery may be granted and podiatrists.

Physicians and staff organizations approved by the procedures for execution are given authority. The officers deliver necessary, thorough, must oversee the activities to the

There are numerous which may include executive committee policies for the from the other if there is one, a board in deliberations. The to join the medicine, and into the executive committee appointment to executive committee

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immunology, proctology, dermatology, neurosurgery, nuclear medicine, physical medicine and rehabilitation, plastic surgery, preventive medicine, and thoracic surgery. There are clinicians other than physicians who also may be granted admitting privileges to a hospital; these include dentists and podiatrists.

Physicians and other clinicians practicing in hospitals have their own staff organization, with bylaws, rules, and regulations that must be approved by the hospital's governing board. Medical staff bylaws specify procedures for election of medical staff officers by membership. The officers are given authority under the bylaws to enforce rules and regulations. The officers delineate privileges and recommend disciplinary action when necessary, through the committee structure. They enforce the bylaws and must oversee the committee structure and submit reports of medical staff activities to the governing board.

There are numerous medical staff committees in the hospital, some of which may include nonphysicians, particularly nurses, as members. The executive committee, if there is one, coordinates all activity, sets general policies for the medical staff, and accepts and acts upon recommendations from the other medical staff committees. The joint conference committee, if there is one, acts as a liaison between the medical staff and the governing board in deliberations over matters involving medical and nonmedical considerations. The credentials committee reviews applications by physicians to join the medical staff and considers the qualifications of education, experience, and interests before making recommendations for appointment to the executive committee, which will then make recommendations for appointment to the governing board. In some hospitals the joint conference committee is also involved in the process.

Through the initiative of the Joint Commission on the Accreditation of Healthcare Organizations, the medical staff (and the board) are increasingly structured to place higher priority on clinical quality improvement and patient care outcomes. Medical staff committees can be structured in various ways to accomplish this purpose. Commonly, there is an overall medical staff committee concerned with clinical quality improvement, as well as various subcommittees such as infections control and quality improvement. In some cases what were formerly medical staff committees have become hospital-wide committees, as physicians and others have realized that improvement of clinical performance rests increasingly on teamwork of physicians and other clinicians and support staff and not on physicians alone.

The infections control committee is responsible for preventing infections in the hospital, through routine preventive surveillance, tracking down of outbreaks of infection, and education of hospital personnel. The pharmacy and therapeutics committee reviews pharmacological agents for inclusion in the list of drugs approved for use in the hospital. The tissue committee is responsible for ensuring quality control of surgery, principally by examining and evaluating bodily tissues removed during operations.

The medical records committee is responsible for certifying complete and clinically accurate documentation of the care given to patients. This committee also acts as a judge of clinical care, based on the written record. The utilization review committee evaluates the appropriateness of admissions and length of stay in the hospital and may review use of services and facilities for patients whose hospital care is paid by third parties.

The tissue, quality improvement, and utilization review committees provide for review of each physician's professional work by other physicians. As the hospital has become more complex, and medical practice more hospital-based and team-based, the practices of physicians have been subjected to more scrutiny. In many hospitals, the medical chain of authority exists side by side with an administrative chain. There are many areas of confused jurisdiction and overlapping or conflicting powers. Managers and physicians working together can attempt to integrate these hierarchies. Physicians are becoming more involved in hospital governing boards; boards of trustees are reviewing more closely the methods used to appoint physicians to hospital staff; and more full-time salaried physicians have been hired by hospitals, resulting in more direct physician-hospital reporting lines.

Because of the vested interests of various medical departments in a hospital, the addition of a full-time or part-time salaried chief of the medical staff and of medical departments can create latent or open conflict with trustees or management. To lessen controversy, in some hospitals appointments of chiefs are made for a specified time rather than for indefinite or lifetime tenure. As full-time chiefs of service become more common, many functions formerly handled by volunteer committees—such as quality improvement review, medical records, and continuing medical education—have been taken over by full-time paid employees.

Many hospitals have hired salaried medical directors and quality improvement review teams. As hospitals are made more accountable for alleged misconduct of attending physicians, much attention has been focused on the concept of due process. If a physician is to be deprived of his medical staff privileges, the process by which the decision is made must be able to stand up to the scrutiny of the courts (Southwick, 1978). Furthermore, many hospitals require physicians to have malpractice insurance as a condition of staff membership (Hollowell, 1978).

There were 92,992 resident physicians in training in American hospitals in 1998 (American Medical Association [AMA], 2000). The number of hospital-salaried physicians other than resident physicians has more than quadrupled, from 10,000 in 1963 to 59,956 in 1998 (AMA, 2000). Salaried physicians are employed by hospitals as chiefs of services, to supervise medical care in intensive care units, as hospitalists who manage the care of inpatients with specific diseases such as heart failure, as emergency department physicians, and in primary care. Attending physicians are affected by such hiring, as hospital-employed physicians may compete with them for patients, deny them medical staff privileges (particularly to physicians new

to the community, strictly clinical and research.

Models of Medical Staff Organization

Shortell (1985) identified three models of medical staff organization: the traditional, the corporate, and the managed care model. The traditional model retains relationships with the community and requires services to be provided by the hospital organization. The corporate model is indirect, as the hospital chain of command is indirect. In the managed care model, hospitals this is a direct relationship between physicians and patients. Physicians are responsible for their own services as primary care physicians rather than as independent medical staff.

Shortell's second model, the corporate model, is characterized by a division of labor within medical staff. Each division, such as medical records and support services, has a division leader in management, of both medical and administrative staff. In Baltimore, Maryland, Kues, Jones, & Associates, Inc. (KJ&A) is an example of this model.

Under Shortell's third model, the managed care model, medical staff are organized into separate groups for their services. Each group of physicians is a separate legal entity. A version of this model is the medical groups, which plan to form the largest staff model in the country.

Shortell's fourth model, the managed care model, is a separate organization that handles well-defined medical services. Physicians are selected to participate in their time, to work within a defined structure. Some

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Models of Medical Services Organization

Shortell (1985) has conceptualized four different models of organization among physicians: traditional (departmental), divisional, independent-corporate, and parallel. Under the traditional model, while each department retains relevant medical specialists, it does not contain the support services required by the physician to provide care. These include nursing, housekeeping, dietary, and clerical staff. Figure 6.1 depicts a traditional hospital organizational chart, in which support services are organized separately from medical services. The medical staff's relationship to the hospital is indirect, as shown by the dotted line. Physicians are not a part of the hospital chain of command, as are nurses or assistant administrators. In hospitals this is referred to as a *dual authority structure* (Smith, 1955). Most physicians are not hospital employees. Many physicians do not see themselves as primarily responsible to hospital administration, but functioning rather as independent medical practitioners who must practice according to medical staff bylaws, rules, and regulations.

Shortell's second model of medical services organization, the divisional model, is characterized by the placement of functional support services within medical divisions, which are organized along departmental lines. Each division, such as medicine or physical medicine, includes many of the support services, like nursing and clerical (and sometimes dietary and medical records and other services), that it needs to do its tasks. Each medical division leader is responsible for management, including financial management, of both medical and support services. The Johns Hopkins Hospital in Baltimore, Maryland is organized along these lines (Heyssel, Gaintner, Kues, Jones, & Lipstein, 1984).

Under Shortell's third model, the independent-corporate model, the medical staff becomes a separate legal entity that negotiates with the hospital for its services in return for receiving support services. An independent group of physicians provides medical services to the hospital, under contract. A version of this type of organization is carried out by the Permanente medical groups, which have contractual relationships with the Kaiser Health Plan to form the Kaiser-Permanente medical care program, the nation's largest staff model health maintenance program.

Shortell's fourth model, the parallel model, involves the creation of a separate organization in order to conduct certain activities that are not handled well by the formal hospital organization. Certain physicians are selected to participate in a parallel organization for some percentage of their time, to work on important problems and report back to the formal structure. Some of these physicians would have positions in the formal

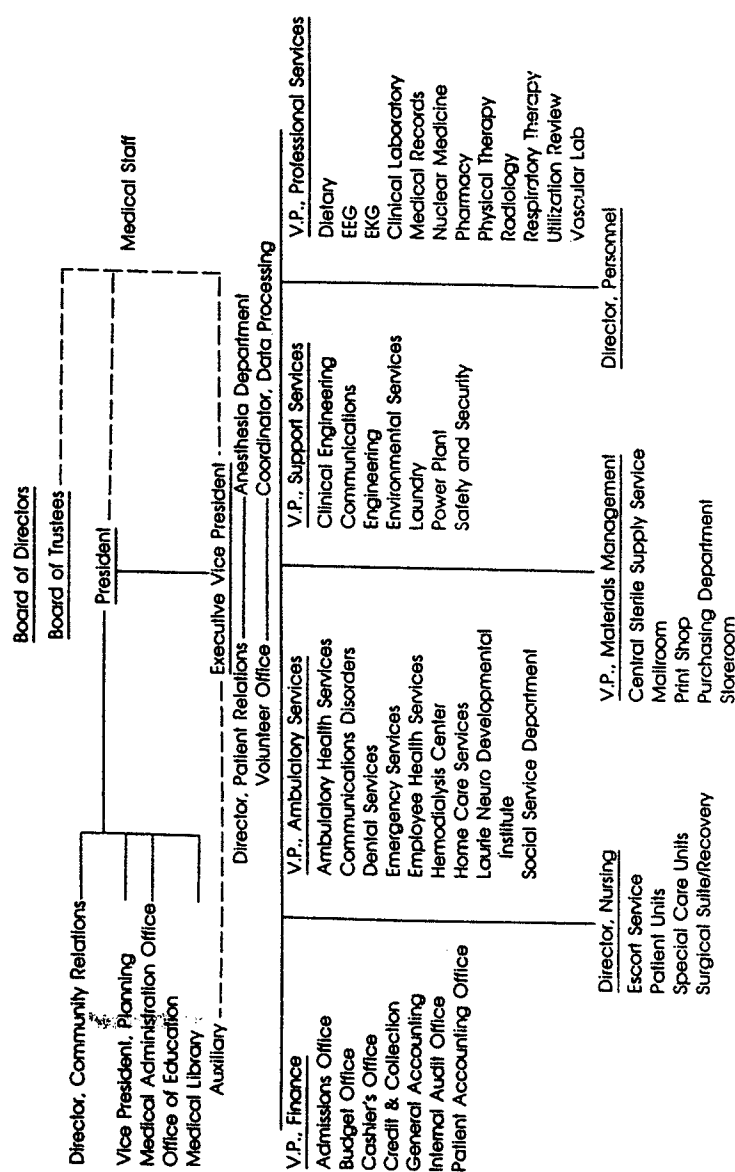


FIGURE 6.1 Traditional (departmental) organizational structure for hospital medical services.

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structure as well. Shortell reports that parallel structures have been implemented at Saint Johns Hospital in Santa Monica, California, and at Fairfax Hospital in Virginia.

Other Patient Care Services

The functional divisions of the nursing service follow the patterns discussed in chapter 4. Hospital diagnostic and therapeutic services, which may or may not be attached to one of the medical departments, include laboratory, usually under the direction of the department of pathology; electrocardiography, usually a part of internal medicine; electroencephalography, part of neurology; radiography, part of radiology; pharmacy; clinical psychology; social service; inhalation therapy, often part of anesthesiology or pulmonary medicine; nutrition as therapy; physical, occupational, and speech therapy, often part of the department of rehabilitation medicine, if there is one; home care; and medical records, among others.

Hospital Administrative Structure

The nonclinical services that the hospital provides can be categorized into four subsystems: finance, facilities and equipment, human resources, and management. The financial subsystem includes capital, operating costs, and cash budgeting; pricing and cost allocation; long-range financial planning; and collection policies. In addition, some hospitals also have endowments to invest and grants to prepare and manage.

The facilities and equipment subsystem includes dietary, engineering, and environmental services; clinical engineering; power plant; grounds; housekeeping, communications and purchasing services; and storeroom, among others. The human resources system includes job analysis and description, job evaluation, wage and salary administration, recruitment, screening and selection, communication to employees, training and development, organizational development, collective bargaining, and labor contract administration. Finally, the management subsystem includes planning and marketing; community, patient, and public relations; data processing and management information systems; legal services; and compliance with regulations, among others.

Many of the services above, such as legal, or dietary, housekeeping or even information systems may be contracted out to large corporations such as national law firms, ServiceMaster, Aramark, and 3M Health Information Systems. The organizational structure for a multihospital system is more complex and comprises a central headquarters, sometimes an intermediate divisional organization, as well as the hospitals and other health care organizations, as shown in Figure 6.2.

FIGURE 6.1 Traditional (departmental) organizational structure for hospital medical services.

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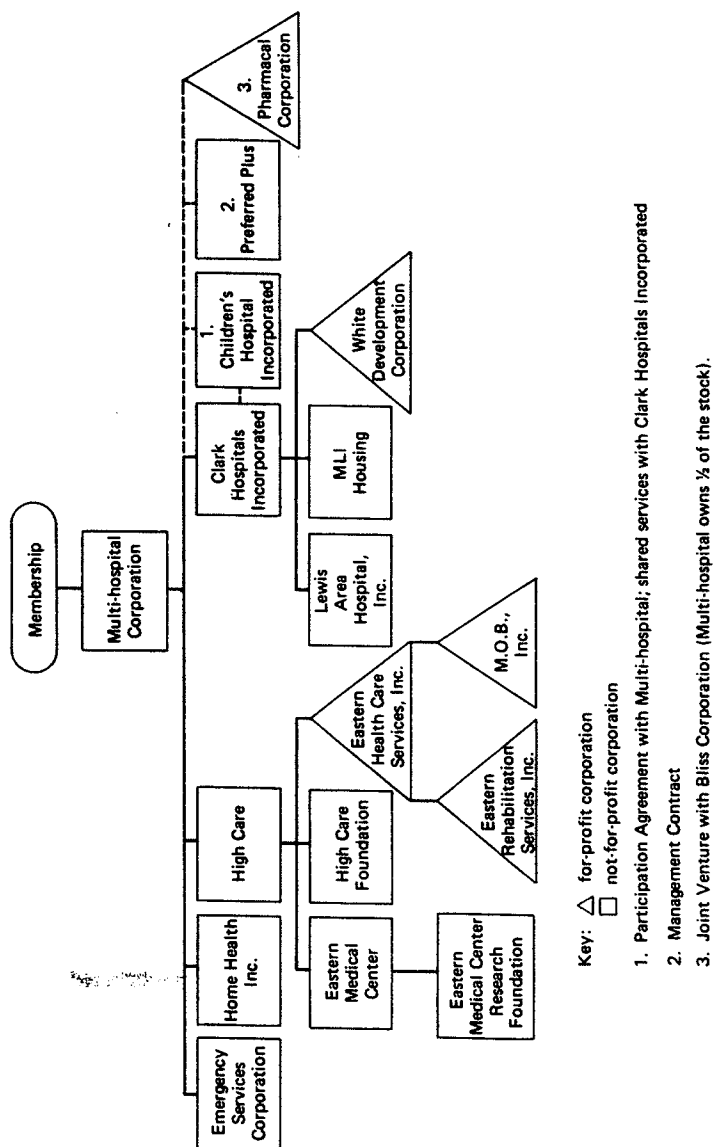


FIGURE 6.2 Multihospital system organizational chart.

NEW DEVELOPMENTS IN HOSPITAL ORGANIZATION

Over the last 5 years, there has been continued pressure on hospitals to contain costs, improve quality, and to justify resources used relative to contribution to community health. Hospitals have adapted to these pressures in many ways. In the 1990s, this includes multiunit organizations, clinical quality improvement, patient-focused care reorganization, and community health benefit programs.

Multiunit Organizations

There were 142 hospital mergers and acquisitions in 1999, involving 142 hospitals. There has been a steady decline in mergers and acquisitions since 1996, when there were 235 deals involving 768 hospitals (Bellandi, 2000). One of the most noteworthy mergers in 1999 was that of St. Louis-based Daughters of Charity National Health System and Sisters of St. Joseph Health System of Ann Arbor, Michigan, to create St. Louis-based Ascension Health. It is the nation's largest not-for-profit healthcare system, with more than \$6 billion in revenues and 73 owned or affiliated hospitals (Bellandi, 2000). In 1999, 19 not-for-profit hospitals were purchased by for-profit hospitals. Columbia/HCA Healthcare Corporation, the largest for-profit, spun off 56 hospitals to two new companies, leaving Columbia with 207 hospitals (Bellandi, 2000).

According to Griffith (1999) there are two major forms of multiunit organization. His definition of "alliance" differs from that of the AHA. He defines alliances as separately owned organizations entering into inter-organizational relations primarily for strategic purposes, such as referring patients to each other for services the respective parties do not provide themselves. The participants remain under separate ownership. Multi-corporate organizations are merged organizations with unified ownership. Griffith distinguishes three types of multi-corporate organizations: *parent-subsidiary*, such as an owned foundation dedicated to a specific activity; *holding company*, which retains certain central control but encourages flexibility to companies owned such as hospitals with protected assets and tax advantages; and *joint venture*, which is two or more parent corporations invest in a subsidiary, such as a physician-hospital organization.

Mount Sinai NYU Health is an example of a vertically integrated not-for-profit holding company serving the greater New York City area. It includes ambulatory care, hospitals, and employed and affiliated physician groups. It is centralized, as mission, plans, and CEO financial and acquisition powers are reserved as the parent company's. Local units have separate boards but their strategic authority is limited.

There is a lot of controversy concerning the advantages and disadvantages of large multi-corporate organizations. The advantages behind their formation—to increase volume, cost savings, and greater leverage in bargaining

FIGURE 6.2 Multihospital system organizational chart.

with managed care organizations—have as yet not been proven. Another advantage is said to be improved quality of care resulting from standardization and specialized expertise. Those hospitals remaining independent can argue with some justification that when the advocates of merged multi-corporate organizations have not achieved the success that they had argued would occur, the advocates have changed the criteria for success. When mergers occur among for-profit corporations they are usually accompanied by considerable downsizing, on the order of thousands of employees. This has largely not occurred, for whatever reasons, in health care.

Continuous Quality Improvement

Continuous quality improvement (CQI), also called total quality management (TQM), is a concept which has been applied for many years in American business, particularly in response to widespread Japanese implementation of CQI ideas developed by such Americans as Deming (1986), Juran (1964), and Crosby (1979). The basic approach is to measure variation in a work process in relation to a standard, and then to implement programs to decrease process variation and improve performance results.

CQI begins with a definition of what the quality standard is for a particular process, such as a hospital infection rate. Focus is on the consumer of the product or service, where this is a doctor who wishes quick turnaround in X-ray reports, or a patient or a potential patient seeking a diagnosis or a cure. Everyone who provides the product or service becomes involved in understanding how quality is measured and in discussing how to improve quality. Rather than focusing on poor quality outcomes and how to avoid them, the work team becomes involved in setting continuously improving standards for better performance and in finding ways to meet those standards. (See chapter 14 for a further discussion of what is done in hospitals to improve quality.)

The benefits of CQI can perhaps best be understood by comparing CQI with traditional organizations, in which managers are in charge, focus is on production and slogans, and emphasis is placed on getting the work done in the cheapest way, assuming given levels of quality, rather than on meeting or exceeding consumer or user expectations. The steps of the CQI process are as follows:

1. Find a process to improve;
2. Organize a team that knows the process;
3. Clarify current knowledge of the process;
4. Understand the causes of variation in the process;
5. Select the process improvement and continue data collection;
6. Do the improvement, data collection, and analysis;
7. Check the results and lessons learned from the team effort; and
8. Act to hold the gains and to continue to improve the process.

Hospitals

Examples of preadmission rooming, operating room scheduling, and having fewer agency staff nurses; and

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Examples of hospital processes that can be improved are increasing the preadmission rate for diagnostic tests to reduce turnaround time in the operating room; making maximum use of registered nurse skills, employing fewer agency nurses, and improving the recruitment and retention of staff nurses; and, lowering the hospital cesarean rate.

Highlights for this last process, implemented at the West Paces Ferry Hospital, a Hospital Corporation of America hospital in Florida (McEachern & Neuhauser, 1987) are described in the following example. Twelve physicians were taught how CQI works on two evenings and a Saturday from 8:00 a.m. to 2:00 p.m. The C-section rate nationally was 25%, at West Paces Ferry Hospital the rate was 21%; at competitor hospitals the rate was 17%. An 11-person cross-functional team was organized. They saw an opportunity to improve clinical outcomes and patient satisfaction by having fewer cesarean deliveries. A variation among physicians was noted of C-section rates from 15%–26% of all births, and among physicians with over 44 patients per year, from 16%–44%. Forty percent of the C-sections were caused by the baby's failure to progress in the birth canal. A mother's previous C-section accounted for 13% of the cases (27% of these were at the patient's request). The cross-functional group then changed their CQI opportunity statement, focusing on the education of physicians and mothers that a prior C-section was not a necessary reason for another C-section. Lowering the rate of the repeat C-sections was subsequently accomplished.

According to Deming (1986), there are 14 points that must be followed to successfully implement CQI. These are as follows:

1. Create constancy of purpose for improvement of product and service;
2. Adopt the new philosophy;
3. Cease dependence on inspection to achieve quality;
4. Don't award business on the basis of price tag alone;
5. Improve constantly every process for planning, production, and service;
6. Institute training on the job;
7. Institute leadership;
8. Drive out fear;
9. Break down the barriers between staff areas;
10. Eliminate slogans, exhortation, and targets for the workforce;
11. Eliminate numerical quotas for the workforce and numerical goals for management;
12. Remove barriers that rob people of pride in workmanship;
13. Institute a vigorous program of education and self-improvement for everyone; and
14. Put everyone in the organization to work to accomplish the transformation.

The Patient-Focused Hospital

Patient-focused care is an attempt to improve quality and contain hospital inpatient costs by restructuring services so that more of them take place on nursing units rather than in specialized units. Another method of implementing patient-focused care is to cross-train staff so that they can perform several jobs for the same small number of patients in a nursing unit, rather than focusing on performing particular functions in a unit for a much larger number of patients. Thus, for example, X-ray, pharmacy, and admitting services can all be done in the nursing unit by staff who can do more than one function. The same staff can, for example, serve the patient food, clean the patient's room, and assist in the patient's nursing care.

As services have been customarily organized in hospitals, to get a routine X-ray for an inpatient can require 40 separate steps and consume 140 minutes of personnel time. Up to 24 hours of time may elapse from the doctor's initial request to receipt of the report, and it can involve 15-20 employees. Moreover, most of the steps are not medical nor clinical activities. According to Smith (1990) hospital staff spend most of their time on nine activity categories: medical, technical, and clinical; hotel and patient services; medical documentation; institutional documentation; scheduling and coordination; patient and staff transportation; management and supervision; and being "ready for action" (i.e., standing by in the emergency department whether or not patients are there requiring services). In a study in Lakeland Regional Medical Center, a 750-bed hospital in central Florida, Smith and his colleagues found that only one sixth of personnel-related costs were consumed by medical, technical, and clinical activity, and that almost twice that amount of time was spent on writing things down. Scheduling and coordination took as much time as medical activity, and being ready-for-action (in case patients should arrive) consumed more time than those.

Smith (1990) suggests that restructuring services at Lakeland can result in reducing the number of staff required for patient care activities from 2,200 to between 1,200 and 1,300, and that this can actually improve the quality of care and service levels. The hospital would be divided into five 125-bed operating units. The area allotted to each unit would be sufficient to contain: a mini-lab, diagnostic radiology rooms, linen and general supply, stock rooms, and so on. Medical documentation could be reduced by almost two thirds, scheduling and coordination by more than two thirds, and ready-for-action time by two thirds.

If the patient-focused hospital is such a good idea, why haven't more hospitals already implemented it? We can only speculate on the reasons: (a) because hospitals have, traditionally, never had to improve productivity in order to receive adequate reimbursement; (b) because hospital interest groups such as doctors and nurses may oppose changing the status quo

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and there are no effective champions who see benefit from implementing what are costly and expensive processes; (c) because in many hospitals such changes will require extensive renovations in the physical plant.

Hospital Community Benefit Programs

Rising public concern about the high cost and inaccessibility of quality health services has focused on the acute care hospital as one of the major causes of the problem, rather than as a catalyst for reform. Increasingly, the hospital is viewed as being more concerned with generating income for survival than with improving the health of the community; as competing to offer the latest application of high technology rather than meeting community need and avoiding unnecessary duplication of facilities; as meeting the needs of professionals rather than serving the poor and disadvantaged; and, as filling beds with inpatients rather than responding to community problems affecting the health status of population groups.

The Hospital Community Benefit Standards Program (Hudson, 1992) was funded by the W. K. Kellogg Foundation to demonstrate that new credible standards could assist and encourage leading hospitals to manage highly effective community benefit standard programs. It also demonstrates that community benefit programs based on these standards could put hospitals in the forefront of efforts to reform the health care system and help to provide better access to care for those without health insurance.

This Program adopted four standards (Kovner & Hattis, 1990a): (a) there is evidence of the hospital's formal commitment to a community benefit program for a designated community; (b) the scope of the program includes hospital-sponsored projects for the designated community to improve health status, access to care, and contain the growth of community health care costs; (c) the hospital's program includes activities designed to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community; and, (d) the hospital fosters an internal environment that encourages hospital-wide involvement in the program.

Forty-nine hospitals participated in a national demonstration, many of which made substantial movement toward local reform of health services. Community benefit can be viewed as an extension of continuous quality improvement and of patient-focused care beyond the hospital walls and into the community. Focus is on problems of health status, access to care, and containment of community health care costs, about which the hospital, other health care providers, and community leaders can do something meaningful. Initiatives are based on national standards that can be adapted locally, that will alter local resource distribution patterns. Examples of such demonstration site programs include the following: providing more prenatal care, especially to at-risk mothers, thereby improving the health status of mother and child; improving access to care and reducing the number of

low-weight babies; closing duplicative facilities and services; and establishing special programs to reach groups lacking access to health care for economic, social, linguistic, and cultural reasons.

Why would hospitals want to spend time or money on community benefit programs for which they are neither reimbursed nor required by government to implement? Obviously, there is no "mission without margin" (provision of services without payment for services) over the long run, particularly given that opportunities for cross-subsidization have been curtailed by managed care and government payers. But there are often opportunities for hospitals to reallocate current expenditures, or raise charitable funds, in ways that lead to improved community health outcomes.

Other possible reasons for a lack of involvement by many hospitals in more active community benefit programs include the following: (a) other priorities such as acquiring new technology are seen as more important; (b) a lack of support for community health priorities by specialist physicians and others who see their vital interests threatened by such initiatives; and, (c) because hospital leadership lacks the skills and experience in working with community leaders to obtain needed data to justify programs, and to integrate and coordinate resources locally to improve health outcomes at current levels of expenditures.

ORGANIZATIONAL CHALLENGES AND RESPONSE

Thirty-five years after the passage of Medicare and Medicaid, hospitals are going through another period of consolidation. Despite acknowledged overcapacity, there is an unwillingness in communities served to let the free market drive failing hospitals into bankruptcy. Hospitals are valued locally, especially by the people who work in them. Pressures for change in hospitals include the following: purchaser pressure on operating margins, regulatory pressure for quality improvement, competition for the premium dollar with health plans and physician groups and for market share with other delivery systems, the cost of rapidly changing new technology, the aging of the population, and changing customer expectations for service. Hospitals have responded and continue to respond by becoming part of larger systems, changing the scope of the services they provide, and by specializing in what services they provide to whom.

There is a vast variance in hospital operating margins depending in large part on where they are located and whom they serve. But because of purchaser pressure hospital margins are decreasing at the same time that cross-subsidization opportunities are being restricted. For example, HMOs do not want to subsidize nonpaying patients nor the cost of medical education; this will force some hospitals to close or become part of larger systems.

There is increasing standardization of clinical protocols in hospitals and of medical processes in delivering care. This followed the publication of the Institute of Medicine's *Report on Errors in Medicine*, and was also a

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Hospitals are competing with insurance companies and physician groups to maintain their share of the health plan dollar, and with other delivery systems for market share in their main lines of businesses such as heart, cancer, rehabilitation medicine, women's health, emergency care, and general and orthopedic surgery. Although most hospitals are members of most health plan networks, this may change as health plans work out arrangements with some hospitals and not others to steer volume to network hospitals in exchange for lower prices and assured quality.

Hospital care is the site of rapidly changing new technology ranging from improvements in the care of patients such as laser surgery, organ transplants, intensive care, and burn units, to improvements in medical care support such as optical scanning, information systems, and telemedicine. Only certain hospitals, particularly those in multiunit organizations, are expected to be able to make the necessary investments and risk the higher short-run costs in return for better information, quicker response time, and fewer recording errors.

Partly as a result of improved medical care, life expectancy of Americans continues to increase. Those over 65 and those over 75 are making up an increasing proportion of the total population. The aged use more hospital services per capita. They also use more of other types of health services, which hospitals can also provide and increasingly are providing, such as home care, hospice care, and adult day care. This will increase the demand for hospital care, although there may not be an exact fit between where current facilities that are underutilized are and where the demand actually occurs. If health insurance is extended to nursing home care, this may increase pressure to limit payments to hospitals.

In response to purchaser pressure, certain hospitals will compete primarily on price, while other hospitals will seek a niche in the marketplace by responding to the needs of those who are willing to pay more for customized services. For example, certain obstetrical hospitals can be marketed directly to women, as a combination luxury hotel with beauty treatment and health education, rather than as a workshop for physicians delivering babies. Entire hospitals or important divisions within them will increasingly focus principally on provision of cancer or heart services. Certain general hospitals may be preferred, even though their costs are higher, because their food and nursing services are preferred.

CONCLUSIONS

In this chapter we have reviewed the historical development of hospitals, key hospital statistics and characteristics, concerns about costs and quality,

organizational structure, and challenges and responses. I foresee continuation of the following trends for hospitals in the first decade of the 21st century:

- Growth and integration of large multiunit organizations.
- Continuing high costs of hospital care.
- Increasingly differentiated hospitals or larger units within hospitals for patients requiring similar treatments.
- Increasing standardization of treatment for patients with similar medical conditions and demographic characteristics.

The reasons for these changes have to do with the formation of larger hospital systems in response to the competitive demands of large purchasers for adequate quality and contained costs. New technology, information systems, and professional workforce are increasingly expensive, increases in reimbursement are capped, and all hospitals cannot generate sufficient volume to provide a full range of services. So hospitals will increasingly specialize in the types of patients they can best care for. This is less true in sparsely populated, large, rural areas, but even in rural America hospitals will increasingly share services with out-of-area hospitals and partition services between periphery and central hospitals.

CASE STUDY

St. George Hospital has an inpatient capacity of 60% and lost \$6 million last year on annual revenues of \$200 million. St. George is located in a large eastern city and competes with four other hospitals, two of which are having merger discussions. Most of St. George's medical staff is in private practice, and many physicians admit to other hospitals as well. Managed care companies have 20% of the market in town; St. George's has contracts with most of these companies.

You are Charlie Sweat, Board Chair. You've been approached by Glenn Morris, Board Chair of Victory Hospital (which made \$100,000 last year). He has asked you to persuade your board to merge your hospital with his. Victory Hospital is 20% smaller than St. George and is not religiously sponsored. Morris is suggesting a full merger, with 50% of the board from each hospital. He believes that the resulting entity will be better able to compete and have greater bargaining power with managed care plans and government regulators.

What are some of the factors that St. George's should consider before continuing discussions with Victory?

DISCUSSION QUESTIONS

1. Explain how hospitals have developed in the United States.
2. Why are costs so high and quality so uneven in American hospitals?

Hospitals

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3. In what ways can hospitals be influenced to play a more appropriate role in the American health care delivery system?
4. How should physicians relate to hospitals and why?
5. To what extent should hospitals be regulated and by whom?

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7

Ambula

Andrew P.

LEARNING OBJEC

- ☐ Explain what i:
- ☐ Explain what i:
- ☐ Describe wher
- ☐ Describe how care.
- ☐ Describe the r care.

TOPICAL OUTLIN

Ambulatory care
 Primary care
 Emergency care
 Subspecialty care
 Home health care
 Complementary &
 Patient networks
 Summary and cui

KEY WORDS

ambulatory care,
 cialty ambulatory
 care, patient netv