

Hospital Acute Care Bed Need Methodology
Workshop # 2 Outline
November 13, 2009

Capacity / Supply / Bed Count:

Models Discussed:

○ **Model 1: Setup Beds**

- Count physical spaces that can be put back in place within 24 hours and without “reviewable – CRS” construction.
- Count CoN approved beds not yet licensed
- Count cannot exceed number of licensed beds
- Attestation by CEO or authorized executive that count is accurate
 - Hard Fences (requiring demand methodology)
 - ◆ Psychiatric
 - ◆ LTC/TCU/SNF/NF
 - ◆ LTAC
 - ◆ NICU (II & III)
 - ◆ Rehab level 1
 - Soft Fences
 - ◆ Med / Surg beds
 - ◆ Pediatric (hospital defined)
 - ◆ ICU
 - ◆ Adult Intermediate care
 - ◆ OB – mother bed
 - ◆ Chemical dependency
 - ◆ All others (using a default occupancy)
- Different types of beds having different occupancy standards
- Hospital specific weighted occupancy standards
- Flexibility for designated bed types – not all types are interchangeable

- Pros:
 - Doable
 - Repeatable
 - Doesn’t imply taking away licensed capacity
 - Realistic
 - Less DOH staff required

- Cons:
 - Spaces are physically but without staff or support services directly related to the patient room
 - Smaller critical access hospitals – how do we reconcile their actual capacity?
 - Self reporting is too subjective without third party validation
 - No base point to start from

- **Model 2: Average Daily Census (little support for using this as a primary model – possibly a secondary test)**
 - Capacity calculated annually as a multiple of average acute inpatient census.
 - Count all CoN approved beds?
 - What is the multiplier? Research needed?
 - Data source – CHARS
 - Take the past three year average, compare to last year and use the larger of the two.
 - If the multiplied ADC for each hospital exceeds the license at that hospital, then you would use the licensed hospital count.
 - This model could be used as a back up test against individual hospitals?
 - Hard Fences (requiring demand methodology)
 - ◆ Psychiatric
 - ◆ LTC/TCU/SNF/NF
 - ◆ LTAC
 - ◆ NICU (II & III)
 - ◆ Rehab level 1
 - Soft Fences
 - ◆ Med / Surg beds
 - ◆ Pediatric (hospital defined)
 - ◆ ICU
 - ◆ Adult Intermediate care
 - ◆ OB – mother bed
 - ◆ Chemical dependency
 - ◆ All others (using a default occupancy)
 - Pros:
 - Simple approach
 - Repeatable
 - Verifiable
 - Only counting space where care is being provided
 - Using the same data source as demand
 - Doesn't imply taking away licensed capacity
 - Cons:
 - CHARS data has 8-9 month lag time
 - Not a good primary test – relatively crude
 - Does not measure capacity rather it measures utilization
 - No obvious multiplier
 - Results could penalize efficiency over the 71% standard
 - Capacity that could come on-line at anytime
 - Doesn't address appropriateness of use
 - Only counting space where care is being provided

- **Model 3: Licensed Beds (currently no support for this model)**
 - Count licensed beds

 - Pros:
 - Simple
 - Repeatable
 - Verifiable
 - Transparent
 - Cons:
 - Doesn't reflect the reality about available beds in Washington State
 - Unfair to take such a simplistic approach

Additional considerations for all methods:

- Well-defined types of beds:
 - **Discrete service related bed types / Hard Fences:**
 - NICU II & III
 - Psychiatric
 - Rehab Level
 - LTC/TCU/SNF/NF
 - LTAC
 - **General service related bed types / Soft Fences:**
 - ICU
 - Pediatric
 - Gen Med / Surg
 - Adult intermediate care
 - OB – mother bed???
 - Chemical dependency
 - Ortho???
 - All others (using default occupancy standard)

- Timing of the capacity counts:
 - Midnight census
 - Late morning
 - Mid day

- Data collection
 - 2 year capacity survey
 - Lending stability for long term planning
 - CN adjustments
 - Adjust for facility closures
 - Adjust for CRS completed / approved projects

- Electronic survey tool needs to be well defined – reduce grey areas as much as possible
- Critical review / quality control check
- Identifying rooms that can be turned back into patient room within 24 hours
- Collected electronically
- Physical count of capacity?
- Attestation by CEO or authorized executive?
- Reliable source of data-Today

Other:

- Licensed bed count vs. sufficiency of ancillary and support services
- Flexibility for providers to use their beds for different uses?
- Surge capacity: When an extraordinary event occurs, hospitals utilize their emergency plan.