

Hospital Acute Care Bed Need Methodology
Capacity Sub-Workgroup
November 6, 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
 - OB, Psych, Med / Surg, Rehab level 1 (possibly level 2), NICU, Intermediate Care, LTC

 - 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
 - Self reporting is too subjective without third party validation
 - No base point to start from

- **Model 2: Average Daily Census**
 - 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.
 - OB, Psych, Med / Surg, Rehab level 1 (possibly level 2), NICU, Intermediate Care, LTC

- 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
 - 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**
 - 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:**
 - NICU III
 - Psychiatric
 - Level 1 Rehab
 - Intermediate Care Level II
 - LTC
 - **General service related bed types:**
 - ICU
 - Pediatric
 - Gen Med / Surg
 - Ortho
- Timing of the capacity counts:
 - Midnight census
 - Late morning
 - Mid day

- Data collection
 - Collected and published annually?
 - 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.