

HIGHMARK.
FOUNDATION



Hospitals

Strengthening Systems & Supporting Communities



About the Highmark Foundation

The Highmark Foundation is a charitable organization, a private foundation and an affiliate of Highmark Inc. that supports initiatives and programs aimed at improving community health. The Foundation's mission is to improve the health, well-being and quality of life for individuals who reside in the Pennsylvania communities served by Highmark. The Foundation awards two types of grants: Highmark Healthy High 5 and general health. Highmark Healthy High 5 focuses on five critical areas of children's health – physical activity, nutrition, self-esteem, bullying prevention and grieving. General health grants support chronic disease, communicable disease, family health and service delivery systems. The Foundation strives to support evidence-based programs that impact multiple counties and work collaboratively to leverage additional funding to achieve replicable models. More information about the Highmark Foundation can be found at www.highmark.com.

Executive Summary

This brief is part of a series addressing issues of importance to the Highmark Foundation and its commitment to the health, well-being and quality of life of individuals and communities in the 49-county region of Pennsylvania served by Highmark Inc.

This publication highlights programs and services developed and offered by hospitals and health systems to assist communities in preventing or reducing illnesses and chronic diseases, and in providing greater access for the uninsured. According to hospital statistics by state, Pennsylvania ranks fifth in the number of hospitals, which offer a myriad of other related services to promote the health and well-being of the community. While other health care providers perform many of these roles, hospitals also represent an essential component of our nation's health and public safety infrastructure. Hospitals face increasing pressure to maintain sufficient financial resources to ensure their continued ability to meet growing health and public safety challenges.

The Highmark Foundation's mission is to help hospitals answer these challenges. Since 2003, the Foundation has awarded 31 multi-year grants totaling approximately \$8.2 million, including 28 grants to 21 hospitals in central and western Pennsylvania and three grants to two independent associations. Among these grants are one awarded to the Pennsylvania Health Care Cost Containment Council (PHC4) and two awarded to the Hospital Council of Western Pennsylvania (HCWP). PHC4 used its award to create a hospital-acquired infection (HAI) pilot program, partnering with Pennsylvania hospitals to collect real-time data using electronic surveillance. HCWP used its grants to develop a comprehensive approach for hospitals to address the threat of avian flu and to initiate a community stroke education and prevention program to improve stroke clinical care capacity in rural hospitals.

Many hospitals benefited from the grants awarded to HCWP and PHC4. These grants provided rural and urban hospitals with resources to increase access to care and build capacity to implement and deliver a wide range of programs and services that improve the health status of communities served. With the support of other funders and communities, these programs had a significant impact in Pennsylvania.

The Highmark Foundation partners with hospitals to develop innovative strategies through grant making. With these grants, hospitals expanded their traditional roles beyond providing sick and charity care and assumed an even greater medical and cultural role.

Background

The role of hospitals has evolved over the years from that of community institutions providing sick care to that of centers of excellence. This evolution is a unique phenomenon, reflecting societal attitudes toward illness and the welfare of the individual and group.¹ Once a facility for the care of the indigent, the diseased and the friendless, with a poor quality of treatment and nursing from which few emerged alive, the hospital as we know it flourished with the steady progress of medicine and surgery.²

The first hospitals were makeshift: military hospitals created during the Colonial Era and Revolutionary War, and quarantine and inoculation hospitals functioning during epidemics. By the early 19th Century, the sick poor were relegated to alms houses, with many becoming tax-supported municipal hospitals run by local governments. The first permanent institutions for the general care of the sick were organized in northeastern cities in the 18th and early 19th centuries, including Pennsylvania Hospital in 1751, New York Hospital in 1771, and Massachusetts General Hospital in 1821. These hospitals were not intended for the general public, since popular opinion regarded medical treatment in an institution by strangers as a last resort, appropriate only for those with no alternative.³

General hospitals ministered to all types of illness, while specialty hospitals focused on one disease or group of diseases. Hospitals cared mainly for the chronically ill, for whom the cultural aspects of daily hospital life were central. In addition, religious hospitals and other hospitals were organized to provide treatment and clinical training for groups excluded or discriminated against elsewhere, such as women, African Americans and Jews. In addition to bed care, many hospitals maintained outpatient facilities or dispensaries, which often provided the only professional medical care available to the poor.⁴

By the late 19th Century, three types of hospitals had evolved: municipal, proprietary, and voluntary. Municipal hospitals were typically larger and were supported by public funds and managed by public authorities, and many developed reputations for grim conditions and poor care. For-profit proprietary hospitals, often owned by physicians, relied on patient payments. Voluntary hospitals derived most of their financial support from private philanthropy, supplemented by public funding in some cases. As expanding hospital populations outpaced traditional funding sources, patients increasingly paid for their hospital stays, which ultimately helped remove the stigma of hospitalization as a last resort for the poor.⁵

Historical Overview of Hospitals

Toward the end of the 19th Century, the discovery of anesthesia, improvements in sanitation, establishment of hospital nursing schools, and other advances helped revolutionize hospital care. Since then, hospitals in large urban areas have become huge medical centers that not only treat the ill, but also advance medical staff education, train nursing staff, perform vital research into the cause and cure of disease, and help patients with convalescence and social problems. In many communities, the hospital is a major employer and source of economic stability.

In the 21st Century, the full-service, or standby, hospital plays a unique and critical role in the health care system. These hospitals are charged with providing care at all costs to all people, caring for all patients regardless of ability to pay, and with disaster readiness and response.^{6,7} Hospital emergency departments or emergency rooms provide an important access point for traditionally underserved populations, meeting a range of patient needs.⁸

The majority of hospitals in the United States provide primary or secondary care, since tertiary hospitals are extremely expensive to operate. Table 1 shows hospitals registered with the American Hospital Association by type and description:⁹

Table 1: Hospitals by Service Type and Description

Type	Description
General (Primary or Secondary)	Provide diagnostic and therapeutic services for patients with a variety of medical conditions.
Specialty (Tertiary)	Provide diagnostic and treatment services for patients who have specified medical conditions, both surgical and nonsurgical, including intensive care.
Rehabilitation and Chronic Diseases	Provide diagnostic and treatment services to disabled individuals requiring restorative and adjustive services.
Psychiatric	Provide diagnostic and therapeutic services for patients requiring psychiatric-related services.

According to the American Hospital Association, there are 5,815 registered hospitals in the United States. The total includes:¹⁰

- 5,010 (86 percent) community hospitals comprising:
 - 2,923 non-government, not-for-profit community hospitals
 - 982 for-profit (investor-owned) hospitals
 - 1,105 state and local government community hospitals
- 212 (3.6 percent) federal government hospitals (such as Veterans Affairs)
- 447 (7 percent) non-federal psychiatric hospitals
- 129 (2.2 percent) non-federal long-term care hospitals
- 16 (0.3 percent) hospital units of institutions (prison hospitals, college infirmaries, etc.)



Full-service hospitals are the main source of care for low-income and uninsured individuals. Most often, full-service community hospitals provide the majority of uncompensated care to 46 million (15 percent) uninsured Americans, including an increasing, aging Medicare population. As a result, the financial performance of these hospitals is typically poor.¹¹

Of hospitals, the Centers for Disease Control and Prevention report that according to the National Hospital Ambulatory Medical Care Survey of Emergency Departments conducted in 2006,¹²

- Number of visits: 119.2 million
- Number of injury related visits: 42.4 million
- Number of visits per 100 persons: 40.5
- Most commonly diagnosed conditions: injuries and poisoning
- Recent percent of visits with patients seen for less than 15 minutes: 22
- Median time spent in the emergency department: 2.6 hours
- Percent of visits resulting in hospital admission: 13
- Percent of visits resulting in transfer to a different hospital: 1.9

The data show the impact of hospitals on our communities. Hospital financing is also crucial for survival. Without sufficient funding, hospitals would be unable deliver high quality, cost-effective health care and services to meet the demands of those who depend on it.

Hospital Financing

Hospitals must spend money to function and provide patient care. Wages and salaries are the largest expenses for hospitals. The cost of providing quality care for medically indigent and uninsured patients without compromising services is a chronic challenge for hospitals.¹³ An annual survey of hospitals in the United States reports aggregate total expenses for all registered hospitals are more than \$690 billion, including \$626 billion for registered community hospitals.¹⁴ On average, one-third of hospitals lose money on operations, which are the primary source of revenue.^{15,16}

Typically hospital revenue is derived in a variety of ways:¹⁷

- By providing medical services
- By providing nonmedical services
- Through grants and donations from individuals, foundations, or government agencies
- By issuing long-term debt to finance large-scale projects

Additionally, hospitals group the ways they make money into three categories:

- Operating revenue from delivery of patient care
- Other operating revenue from non-patient-care activities
- Gains or losses from peripheral business activities



Financing Challenges

While patient care revenues are the primary revenue source, hospitals also must cope with rising levels of uncompensated care from bad debt and charity care. Uncompensated care excludes other underfunded costs of care such as underpayment from public funders like Medicare and Medicaid. In practice, however, hospitals often have difficulty distinguishing bad debt from charity care, which is financed through various sources. Hadley et al. documented these sources and estimated the cost of uncompensated care in the United States at \$57.4 billion in 2008 (Table 2).¹⁸ Of this amount, public funds financed as much as \$42.9 billion, or about 75 percent of total uncompensated care costs. Private payers, including self-pay patients, health maintenance organizations, preferred provider organizations and indemnity insurance policies, also are assuming an increasing role in supporting hospital costs.¹⁹

Table 2: Sources of Funding of Uncompensated Care Spending (Billions, 2008 Dollars)

Funding Source (Pay Mix)	Amount Spent	Percent
Medicare	\$7.2	12.5%
Medicaid	\$10.9	19.0%
State and local	\$10.6	18.5%
Direct care programs	\$14.6	24.4%
Physicians	\$7.8	13.6%
Private	\$6.3	11.0%
Total	\$57.4	100.0%

These statistics strengthen the case for drawing financial support for hospitals from a wider variety of sources. With the increasing number of uninsured individuals, and decreasing hospital resources and endowment funding, charitable and philanthropic support from organizations like the Highmark Foundation is essential to the survival of hospital-based programs and services.

Preserving Economic and Community Benefit

As the foundation of health care in a community, hospitals play a critical role in reducing costs by:²⁰

- Focusing on wellness
- Better managing chronic diseases
- Speedy adaption of information technology
- Improving care delivery to each patient
- Increasing the transparency of hospital quality
- Improving understanding
- Reducing variation in care

Hospitals also make significant economic and social contributions in their communities. Consider just some of these benefits:²¹

- Hospitals in the United States employ 5 million people.
- Following restaurants, hospitals are the second-largest private-sector employer.
- When also accounting for hospital purchases of goods and services from other businesses, hospitals support one of every 10 jobs in the United States and \$1.9 billion in economic activity.
- Total impact of wages and salaries on the United States economy is \$718 billion.

Hospitals in Pennsylvania

Of 5,815 registered hospitals, Pennsylvania accounts for 181 (3 percent) general acute care hospitals that include all non-federal, short-term general and specialty acute care hospitals open to the public.²² According to hospital statistics by state, Pennsylvania ranks fifth among the number of hospitals in the nation, and in-state hospitals report gross patient revenues of \$117 million.²³

The dollar value of uncompensated care provided by Pennsylvania hospitals grew by 11.1 percent, or approximately \$75 million, increasing from \$677 million during Fiscal Year 2007 to \$753 million during Fiscal Year 2008. Since statewide uncompensated care grew faster than the 6 percent increase in statewide net patient revenue (NPR), uncompensated care as a percent of NPR rose from 2.27 percent in Fiscal Year 2007 to 2.38 percent in Fiscal Year 2008, the highest year-to-year percentage increase reported since Fiscal Year 2001. In addition, approximately 37 percent of uncompensated care was provided as charity care to patients that met the hospitals' charity care guidelines.²⁴ With 1.2 million uninsured Pennsylvanians, the number of dollars spent on charity care will continue to increase.²⁵ Moreover, as of December 2009, there were 353,301 uninsured Pennsylvanians awaiting adult Basic health insurance.²⁶ Health care reform should reduce or eliminate the numbers of uninsured Pennsylvanians thereby reducing hospitals' bad debt or charity care costs. Similar to hospitals across the nation, the amount of uncompensated care and bad debt assumed by Pennsylvania's hospitals exceeds the amount of operating revenue generated. As a result, many hospitals are losing money and must find additional resources to cover operating expenses, charity care, and community-based programs and services.

The impact of hospitals on Pennsylvania's economy is significant:²⁷

- Hospitals generate 280,451 full- and part-time jobs.
- Gross patient revenue accounted for \$117,016,155 from non-federal, short-term, acute care hospitals.
- Inpatient care remains constant. Of the \$31.6 billion in statewide net patient revenue, 60.7 percent or \$19.2 billion was derived from inpatient care.
- Community hospitals contributed \$76 million in their respective communities.
- In fiscal year 2008, net outpatient revenue and visits from all facility types, excluding state psychiatric hospitals, generated \$13 million from 44 million visits. The average outpatient per visit was \$318.

Hospital payroll and benefits contribute millions to the economy, which ripples down through local economies as hospital employees spend their paychecks in the communities where they live. Many communities, particularly those that are small, depend on hospitals as a major source of employment as well as its financial base. In some cases, a small community would not be able to survive without the hospital because it is the largest employer and the largest financial contributor to its economy.



Highmark Foundation's Approach to Funding Hospitals

In 2003, the Highmark Foundation board approved a \$1 million grant to improve the health status of people through support of the programmatic efforts of hospitals.

The Highmark Foundation provided support to those hospitals which:

- Demonstrate the effectiveness of early interventions and preventive health programs
- Stimulate the efficient use of scarce health resources through cooperative planning and program initiatives among hospitals, and encourage cross-sector collaborations between and among health care institutions, schools and other organizations

Since that time, the Highmark Foundation has awarded 31 multi-year grants totaling approximately \$8.2 million. These awards include 28 grants to 21 hospitals in central and western Pennsylvania, and three grants to two independent, hospital-affiliated associations.²⁸ These programmatic grants provided recipients with resources to initiate or expand community-based, preventive-health programs and services for underinsured and uninsured communities. Grants were used to support chronic disease prevention and management, family health, and service delivery initiatives. One grant representing each of the Highmark Foundation's priority areas (with the exception of communicable disease) is highlighted in Table 3. The highlighted grants represent successful programs with the potential for larger-scale replication to reach more individuals.

Table 3: Highmark Foundation Grants by Priority Area

Grantee	Program Description	Priority Area	Award	Outcomes
Butler Memorial Hospital (2006)	Coordinated Services to low-income and uninsured women and their children from birth through age 5.	Family Health	\$200,000	The rate of return for postpartum care surpassed the projected goal. Prior to the program, the rate of return was 57 percent. The goal was to increase the rate of return by at least 10 percent. At the end of the grant period, the return rate of 78 percent exceeded the projected goal by 20 percent, demonstrating that education was effective in motivating mothers to return for follow-up care and ongoing education.
PinnacleHealth System (2006)	To improve ambulatory diabetes care among African-American and Hispanics.	Chronic	\$252,570	Overall hemoglobinA1c (HbA1c) improved significantly during the two-year period, by 2.5 percent in African-Americans and 1 percent in Hispanic populations. In addition, 20 percent of African American and 30 percent of Hispanic participants achieved HbA1c of <7 percent, as per American Diabetes Association goals, at follow-up, while none of the participants had a value under 7 percent prior to enrollment. It appears that a combination of comprehensive diabetes care and education resulted in increased self-monitoring and decreased HbA1c values. This program could serve as a best practice model because of its success and potential to be widely replicated.
Somerset Hospital (2006)	Young Athlete Training and Screening Program: Athletic training and concussion screening for students in grades 7-12.	Service Delivery	\$100,000	Significant decrease in body mass index (BMI) in a girl's volleyball team (20 girls) as a result of participation in strength training and conditioning. Education of athletes, parents, coaches, and trainers heightened concussion awareness and detection. Parents now work closely with coaches/trainers to make decisions about athletes playing sports after being evaluated for a potential concussion.

Three other grants totaling \$545,903 were awarded in the area of Service Delivery to two non-profit, 501(c)(3) non-hospitals – a regional trade association (Hospital Council of Western Pennsylvania) and an independent state agency (Pennsylvania Health Care Cost Containment Council). Recipients partnered with rural hospitals to assist them in increasing their capacities to effectively manage epidemics, improve stroke care in rural Pennsylvania, and reduce hospital-acquired infections through electronic surveillance. Although the organizations received the grants, the hospitals and communities involved benefitted directly.

Following are details of these three grants and the programs made possible:

Hospital Council of Western Pennsylvania (HCWP) – The HCWP provides western Pennsylvania member health care providers and affiliated organizations with expertise in hospital management, operations, emergency and disaster preparedness, and grant funding, among other services. Two grants were awarded to HCWP in 2004 (\$192,500) and 2006 (\$253,403) totaling \$445,903. The grants funded the following programs:

- *Improving Rural Stroke Care* – a community stroke prevention education program to improve clinical care capacity in rural hospitals through a two-part regional initiative delivered in 12 counties. The initiative was designed to reduce the incidence of stroke through community-based education and to provide physicians with the most current level of stroke care, including timely administration of tPA (tissue plasminogen activator) and services at the initial site of care. **Outcome:** A total of 728 rural health care professionals, including physicians, hospital staff, residents and emergency medical technicians, from 14 hospitals located in six rural counties, were trained to develop stroke care pathways, conduct community stroke screenings, and formulate strategies to improve stroke care deficiencies.
- *Facilitating the Preparation of Western Pennsylvania's Hospitals to Manage an Avian Influenza Outbreak* – Highmark Foundation challenged HCWP to translate state and federal plans into a template for use at 62 acute care general community hospitals in western Pennsylvania in the event of an avian influenza outbreak. The project's goal was to assess the region's hospitals' abilities to achieve a maximum level of readiness to address an outbreak of avian influenza or any other infectious disease. **Outcome:** Seven resource binders were prepared containing 15 strategies that could be adapted and then replicated at other types of health care facilities. Using the Centers for Disease Control and Prevention's FluSurge data to impact morbidity and mortality projections, a comprehensive primer also was developed for 28 of the 49 counties, representing a total population of 4.3 million.

Pennsylvania Health Care Cost Containment Council (PHC4) – The PHC4 is an independent state agency established in 1986 and charged with collecting, analyzing and reporting health care cost and quality information. In 2006, PHC4 received a \$100,000 grant to implement a one-year pilot:

- *Reducing Hospital Acquired Infections (HAI) with Electronic Surveillance* – PHC4 partnered with MedMined Electronic Surveillance Services to collect data and provide “real-time” information to correct problems and costs of hospital-acquired infections. Through an RFP process, PHC4 awarded grants to 11 Pennsylvania hospitals to track and proactively prevent hospital-acquired infections by developing and implementing its own programs, which allowed each to execute processes and procedures that were relevant to its needs. Each of the 11 hospitals received grants in amounts ranging from \$6,000 to \$16,000 from the Highmark Foundation. Each hospital contributed 20 percent to the project based upon their admission rates, and MedMined provided 40 percent discounts on installation of the data system. **Outcome:** Hamot Hospital located in Erie, PA reported that prior to MedMined it missed approximately 60 percent to 70 percent of its HAIs by only focusing on a select cohort of patients. Surveillance of urinary tract infections (UTIs) was previously conducted. As a result, Hamot recognized UTIs as its number one hospital-acquired infection, representing 30 percent of its HAIs. This awareness prompted nursing leadership to set a goal to reduce UTIs across all units by 10 percent . Since implementation of MedMined, Hamot’s HAI rate for UTI of 40 percent has been reduced by 22 percent. In addition 9 of the 11 facilities continue to use MedMined in their prevention programs and daily workflow practices.



The Highmark Foundation has supported other hospitals in central and western Pennsylvania that have successfully integrated or will integrate chronic disease programs into their cadres of services upon conclusion of grant funding. The grants also contribute to these hospitals' local communities by supporting wages and salaries that trickle down into local economies, improving access to care for uninsured and low-income populations, and providing seed or start-up funding that turns projects into sustainable programs. These programs were designed to expand access to health education and health promotion for uninsured and or underinsured individuals. Outcomes for selected hospitals highlighted below demonstrate the significant impact that the Highmark Foundation has made on the health status of communities where these hospitals are located.

- **Uniontown Hospital:** Uniontown Hospital Diabetes Clinic (2005) – A grant of \$158,260 to support the creation of The Uniontown Hospital Diabetes Center to address the increasing incidence of diabetes in rural Fayette County. Approximately 14 percent of individuals in Fayette County have diabetes, compared to 6 percent in Pennsylvania and 8 percent in the United States. The Center surpassed its projected goal of treating 10 percent (790) of the diabetic population in Fayette County within the first two years of operation. A total of 1,043 low-income, diabetic patients received endocrinologist and/or clinic services (628) and/or diabetic education (415). Pre- and post-HbA1c levels were tracked at three months (pre-education) and six months (post-education). Significant improvements were achieved in individual results at or above the initial goals. A total of pre-education HbA1c results were reported greater than 9 percent, such as 10.7 percent, 11.5 percent, 12.7 percent, 15.9 percent, and 13 percent, which show HbA1c levels prior to program participation. These levels are dangerously high in diabetics. Post-participation HbA1c levels show a significant reduction. At post-education, 35 percent of participants achieved a result less than 8 percent (such as 6.1 percent and 5.9 percent). Seven percent is the desired range for diabetics.
- **Elk Regional Health System:** “New, Healthy You”: A Community-Based Breast Cancer Prevention and Awareness Education Program (2006) – A grant of \$99,000 to support the implementation of a breast cancer risk reduction program in rural Elk County. A total of 341 individuals, including community residents and breast cancer survivors, were educated on health and the effects of the environment. Program participants at five sites received a pre-test and a post-test to measure increases in knowledge. As shown in Table 4, post-test results demonstrated significant improvement in knowledge of environmental risks of breast cancer. Pre-test figures are actual scores, while post-test results represent percentage of improvement. In addition, mammograms were performed at no cost for uninsured individuals. From fiscal year 2005-2006 (4,409) through fiscal year 2006-2007 (4,757), the number of mammograms performed increased by 348.

Table 4: Aggregate Participant Outcomes by Site

Site	Pre-test	Post-test
St. Marys	42%	44%
Bennetts Valley	43%	38%
Ridgway	27%	61%
Johnsonburg	33%	53%
Emporium	25%	64%

- Jefferson Regional Medical Center:** Stroke Screening and Prevention Program (2007) – A grant of \$200,000 to support the creation of a Stroke Screening and Prevention Program. The program included two components – a hospital-based inpatient unit and community-based outpatient screenings. The program’s objective was to increase awareness and provide resources and follow-up for early detection and treatment of the signs and symptoms of stroke through inpatient, hospital-based education and community stroke screenings, educational sessions, and health fairs. A total of 16 comprehensive community stroke screenings were held with approximately 1,335 participants, 38 educational sessions were conducted for 3,056 participants, and counseling and follow-up calls were provided to 190 participants. If uninsured, participants were counseled and assisted with public health insurance forms. Jefferson Regional Medical Center also provided charity care for uninsured participants requiring additional follow-up.

Through the grant period (March 2007 – March 2009), a review of 438 Stroke Care Center inpatient charts showed discharge disposition. Of the 438 charts reviewed, approximately 263 (60 percent) indicated discharged to home, 99 (23 percent) indicated discharged to inpatient rehab, and 76 (17 percent) indicated discharged to long-term care, skilled nursing, hospice facility or expired. The results are significant because the number of patients discharged to home resulted from education of participants by this program about early recognition and awareness of stroke. The majority of patients were discharged into their communities rather than sent to skilled or assisted living facilities.

- Children’s Hospital of Pittsburgh Foundation:** Supportive Care Program (2009) – A grant of \$125,000 will support the salary of a Grief/Bereavement Coordinator position to enable the existing Supportive Care Program to serve more patients and families facing life-threatening illnesses or injuries, and support the clinical staff that cares for them. The Supportive Care Program is the only pediatric palliative care program in the western Pennsylvania region, and one of three in the state of Pennsylvania (Children’s Hospital of Philadelphia and Hershey Medical Center). In 2008, the Supportive Care Program at Children’s was identified by the Pennsylvania Department of Public Welfare as one of only three centers of excellence for pediatric palliative care in the state. In addition, as the only hospital in the 20-hospital UPMC Health System to create a Grief/Bereavement Coordinator position and expand program scope, Children’s has the opportunity to deliver comprehensive end-of-life care throughout the health system.

Hospital Trends

Many of the primary hospital and health system trends of the past decade, including cost control, utilization and spending to market forces, relate to reimbursement. The move toward bundled or episode-based reimbursement will have staying power. There is justifiable concern about the decline in paying patients, growing charity care and bad debt. In some areas, overcapacity remains a problem, yet there is a trend of building new hospitals in affluent areas that exacerbates the capacity issue. As a result of the recession and slow recovery, construction costs are relatively low and access to low-cost debt is available for many hospitals. For some hospitals, this is not the case. A number of hospitals have difficulty securing financing due to low bond ratings. At the same time, we see smaller hospitals being acquired or integrating with larger systems, but whether this consolidation results in a rationalization of capacity is unclear. Policymakers need to understand which regulations or controls may be necessary to ensure that, as hospitals amass more services and more bargaining leverage, their prices do not continue to contribute to the cost problem.²⁹

Spending is one trend where hospital administrators must develop effective strategies to more precisely identify the specific drivers and underlying factors. They also must implement targeted approaches that optimize resource utilization and service delivery. Policy proposals that fail to account for these complexities could create unintended consequences for providers, patients and communities.

Key hospital trends include:^{30,31}

- 1.) **Relaxed cost controls** – In the late 1990s, health maintenance organizations (HMOs) had successfully slowed healthcare spending growth. However, by the end of that decade, managed care's control began to loosen, negotiating power returned to providers, and health care costs again rose faster than the rate of general inflation. **Impact:** Health care providers should begin to contain costs.
- 2.) **Healthcare information technology (IT)** – Healthcare IT, though not fully developed in 2000, became a major force in hospital operations by the end of the decade. Innovations like computerized physician order entry and electronic medical records have improved safety as well as efficiency. **Impact:** As a result of billions of dollars in incentives since the HITECH legislation, healthcare IT shows promise of becoming universal.
- 3.) **Patient safety movement** – In 1999, the Institute of Medicine published one of the most influential reports in the history of United States health care. The report concluded that between 44,000 and 98,000 people die annually due to inpatient hospital treatment errors. **Impact:** Hospitals began to get much more serious about quality and safety. The industry embraced initiatives such as continuous quality improvement, which actually lowers costs because it reduces waste.

- 4.) **Physician entrepreneurship** – Due to lack of increases in reimbursements, physicians became entrepreneurs, investing in ambulatory surgical centers (ASCs), imaging centers and specialty hospitals as a way of supplementing declining income. The trend placed physicians in conflict with hospitals concerned about losing market share to leaner physician-run organizations. **Impact:** The ban on physician-owned hospitals in the health reform legislation means that physicians will still need to find ways to enhance their revenue.

- 5.) **Healthcare consumerism** – The future of market-oriented health policy and practice lies in managed consumerism, a blend of the patient-centric focus of consumer-driven healthcare and the provider-centric focus of managed competition. With the decline of HMOs, consumer-driven healthcare becomes a new way to contain costs. High deductible plans with or without tax-free health savings accounts will make patients more cost-conscious consumers. Ratings of doctors and hospitals will aid patients in choosing the best providers. Retail clinics also serve these new consumers. **Impact:** Hospitals developed a new fascination with patient satisfaction surveys. Brand-new hospitals spent huge amounts on patient-friendly design features such as single rooms, sunlit atriums and concierge services. These features seemed to shift market share.

- 6.) **Healthcare personnel shortages** – The recession has temporarily erased the nursing shortage deficit as nurses are forced back into the workforce or into full-time work to offset family income decreases. In the meantime, physician shortages also emerged. The federal Council on Graduate Medical Education abandoned its long-held forecast of a physician surplus and predicted a shortage of 85,000 physicians by 2020. Since then, medical schools have been substantially increasing class sizes, but Congress has not removed a cap on the number of Medicare-funded graduate medical education positions for physicians that has been in place since 1997. **Impact:** The United States is headed toward an aggregate shortage of physicians. Given the extended time required to increase United States medical school capacity and to educate and train physicians, the nation must begin now to increase capacity to meet needs in 2015 and beyond.

- 7.) **Accountable health organizations** – While entrepreneurial physicians continued to spin off from hospitals throughout the last decade, an opposing trend also emerged. Many young physicians were eagerly becoming employees. Accountable health organizations such as the Mayo Clinic, Cleveland Clinic and Geisinger Health System thrived by closely aligning hospitals and doctors to make care more efficient and effective. **Impact:** Accountable health organizations are taking a lesson from the ambulatory surgical centers' playbook. Incenting physicians can make healthcare more efficient. However, the trend is not easy for hospitals, many of which have no expertise or experience in managing practices. Hospitals used to hire doctors merely to generate business. Now, hospitals want doctors to take financial responsibility for outcomes as well.



- 8.) Recession – The decade will be known for the financial turmoil that came at its end. In March 2009, Thomson Reuters, the world’s leading source of intelligent information for businesses and professionals, reported that the median profit margin of hospitals in the United States had fallen to 0.0 percent. **Impact:** Hospitals tightened their belts and many of them ended the decade solidly in the black. However, the number of non-paying patients remains high, and many health care leaders believe that hospitals are entering an era of having to do more with less.
- 9.) With health care reform, hospitals will benefit. **Impact:** The number of newly insured is expected to significantly decrease the amount hospitals lose each year when they provide uncompensated care.³²

Hospital Trends in Pennsylvania

Trends seen in Pennsylvania hospitals mirror many of those seen across the United States, including:³³

- A steady decline in total patient days for large, general, acute care hospitals. Among other hospital types, psychiatric hospitals experienced the sharpest decline in total patient days. Total patient days for children’s and specialty hospitals remained fairly constant.
- Total discharges for both large and small, general, acute care hospitals declined steadily.
- The combination of falling admissions and decreasing patient days produced declining occupancy rates for both large and small general, acute care hospitals, resulting in lower inpatient revenue.
- Total expenses increased significantly as patient revenues failed to keep pace with growth in expenses.

Conclusion

Modern hospitals are full-service institutions that have evolved beyond their traditional roles to provide a wide range of programs and services to improve the health of the communities they serve.

In a rapidly changing business environment, hospital administrators must be perceptive and proactive. If not, current trends will negatively impact their institutions and cause long-term problems such as fiscal difficulties, operating inefficiencies, and deficiencies. The economic recession, bad debt, charity care and spending have outpaced growth and, in some cases, eroded hospitals' financial base. While consolidation has occurred, there is no conclusive evidence that these mergers reduce expenses or save costs.

To help fill the resource void in today's health care marketplace, the Highmark Foundation has directly funded 21 hospitals in central and western Pennsylvania with grants to ensure that individuals have access to important programs and services. By supporting these hospitals, the Foundation also supports the community. This investment and results achieved demonstrate that, with additional resources, hospitals can assist communities with adoption of healthy lifestyle behaviors, deliver comprehensive approaches to improve HbA1c in diabetic outpatients, reduce the incidence of low-birth-weight babies, provide technical assistance for emergency or disaster preparedness, effectively address hospital-acquired infections, and better train health professionals in stroke care. Perhaps most important, many of the programs supported by the Highmark Foundation have been integrated into the hospitals' core group of services.

The financial issues facing hospitals in Highmark's coverage area are complex. While these grants cannot solve every problem faced by hospitals, they can and do provide greater access for individuals, empower them to leverage additional resources, and enable hospitals to redesign and strengthen systems in ways that can yield tangible, lasting benefits.

Source Information:

- ¹ Overview: Center for Hospital and Healthcare Administration History. [cited April 5, 2010]; Available from <http://www.aha.org/aha/resource-center/Center-for-Hospital-and-Health-Administration-History/index.html>.
- ² Hospitals. [cited April 5, 2010]; Available from <http://www.encyclopedia.com/doc/10119-Hospitals.html>.
- ³ Ibid.
- ⁴ Ibid.
- ⁵ Ibid.
- ⁶ Prepared to Care: The 24/7 Role of America's Full-service Hospitals, 2006. [cited April 6, 2010]; The Chartis Group.
- ⁷ Emergency Department Visits. [cited April 6, 2010]; Available from <http://www.cdc.gov/nchs/faststats/eservice/html>.
- ⁸ Ibid.
- ⁹ The Access Project. 2001. A Community Leader's Guide to Hospital Finance: Evaluating how a hospital gets and spends its money. 45 pp.
- ¹⁰ Fast Facts on US Hospitals. [cited April 6, 2010]; Available from <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts-html>
Registered hospitals are those hospitals that meet AHA's criteria for registration as a hospital facility. Registered hospitals include AHA member hospitals as well as nonmember hospitals.
- ¹¹ Ibid.
- ¹² Centers for Disease Control and Prevention: Emergency Department Visits. [cited April 7, 2010]; Available from <http://www.cdc.gov/nchs/faststats/ervisits.htm>.
- ¹³ The Access Project, 2001.
- ¹⁴ Fast Facts on US Hospitals. [cited April 6, 2010]; Available from <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts-html>.
- ¹⁵ Ibid.
- ¹⁶ The Access Project, 2001.
- ¹⁷ The Access Project, 2001.
- ¹⁸ Source: Hadley, Jack, John Holahan, Teresa Coughlin, and Dawn Miller. 2008. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." Health Affairs Web Exclusive w399-415.
- ¹⁹ The Access Project, 2001.
- ²⁰ Keeping Health Care Affordable. [cited April 8, 2010]; Available from http://www.aha.org/aha_app/issues/Affordability/index.jsp.
- ²¹ Source: Chart 6. 12: Impact of community hospitals on U.S. economy; all states, DC and Total U.S., 2007. Avalere Health, using BEA RIMSII (1997/2006) multipliers for hospital NAICS code 622 released 2008, applied to American Hospital Association Annual Survey data for 2007.
- ²² Fast Facts on US Hospitals. [cited April 6, 2010]; Available from <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts-html>
- ²³ American Hospital Directory Hospital Statistics by State. [cited April 9, 2010]; Available from http://www.ahd.com/state_statistics.html.
- ²⁴ Pennsylvania Health Care Cost Containment Council (PHC4) Financial Analysis, Volume One, June 2008. 29 pp.
- ²⁵ Fast Facts on US Hospitals. [cited April 6, 2010]; Available from <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts-html>.
- ²⁶ Pennsylvania's adultBasic Program: 2009 Annual Report to the Legislature. 2009. 25 pp.
- ²⁷ Pennsylvania Health Care Cost Containment Council (PHC4) Financial Analysis, Volume One, June 2008. 29 pp.
- ²⁸ Several hospitals received more than one grant.
- ²⁹ Roche, K. Hospital trends.(March 25, 2010), [cited April 14, 2010]; Available from <http://vitaadvisors.com/2010/03/25/hospital-trends/html>.
- ³⁰ Trendwatch: Geographic Variation in health care spending: A closer look. American Hospital Association, November 2009.
- ³¹ 8 Top Hospital and Health System Trends of the Past Decade. [cited April 14, 2010]. Available from <http://www.hospitalreviewmagazine.com/news-and-analysis/business-and-financial/8-top-hospital-and-health-trends>.
- ³² In Health Reform, Boons for Hospitals and Drug Makers. www.nytimes.com/2010/03/22/business/22b12health.html
- ³³ Pennsylvania Hospital Trends 1990-1996. [cited April 14, 2010]; Available from <http://www.phc4.org/reports/fin/96/trends/default.htm>.



Highmark is a registered mark of Highmark Inc.

Highmark Foundation
120 Fifth Avenue, Suite 2112
Pittsburgh, PA 15222
Toll free: 1-866-594-1730

Information about the Highmark Foundation's grantmaking can be found at
www.highmark.com

June 2010