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REPORT TO THE SUBCOMMITTEE ON
EXECUTIVE REORGANIZATION AND
GOVERNMENT RESEARCH
COMMITTEE ON
GOVERNMENT OPERATIONS
UNITED STATES SENATE

79-00657



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Planning, Construction,
And Use Of Medical Facilities
In The Baltimore, Maryland, Area

5-167966

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

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031.14.1977



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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Dear Mr. Chairman:

This is the report on our review of the planning, construction, and use of medical facilities in the Baltimore, Maryland, area. The review was made in response to your request of September 18, 1969.

The responsible Federal, State, and local health organizations have not been given an opportunity to formally examine and comment on this report, although most of the matters were discussed with their representatives during the review.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained.

Sincerely yours,

Comptroller General
of the United States

11-2
The Honorable Abraham Ribicoff, Chairman
Subcommittee on Executive Reorganization
and Government Research
Committee on Government Operations
United States Senate

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
PHS	Public Health Service
VA	Veterans Administration

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WHY THE REVIEW WAS MADE

At the request of the Subcommittee's Chairman, the General Accounting Office (GAO) examined into the coordination among Federal and State agencies and local organizations in planning and constructing hospitals and skilled-nursing-care facilities in certain metropolitan areas.

GAO also reviewed the extent to which certain medical facilities and other services were shared among hospitals.

The reviews were made in Baltimore, Cincinnati, Denver, Jacksonville, San Francisco, and Seattle. These cities were selected on the basis of the levels of Federal financial participation in their construction of hospital and skilled-nursing-care facilities and their wide distribution throughout the United States. GAO did not review the quality of care being provided by hospitals and skilled-nursing-care facilities.

Federal, State, and local health-planning organizations have not been given an opportunity to formally examine and comment on the contents of this report.

FINDINGS AND CONCLUSIONS

Background

- 1 The Medical Facilities Development Division in the Maryland Department of Health and Mental Hygiene (State agency) administers Hill-Burton grants made by the Public Health Service (PHS) for construction and modernization of hospitals and other medical facilities. ^{DR435} 160

The State agency annually prepares a plan setting forth an estimate of the number of acute-care hospital beds and skilled-nursing-care beds needed for 5 years in the future. Although GAO verified the mathematical accuracy of the State agency's computation of future bed needs, an evaluation was not made of the appropriateness of the methodology prescribed by PHS for use by the State planners in determining future bed needs. (See pp. 4 and 22.)

Hospital bed need

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By 1975 the bed capacity in Baltimore area hospitals roughly will equal the need.

According to the 1971 State plan, the Baltimore area will need 7,361 hospital beds by 1975. As of December 31, 1970, facilities for 7,318 beds were in operation or under construction. By 1975 the capacity, estimated by GAO on the basis of plans for future construction, will have increased to 7,497 beds, or 136 beds in excess of the need projected in the State plan. (See p. 9.)

The 1971 State plan showed that 744 hospital bed spaces in the Baltimore area did not conform to Hill-Burton construction standards. These beds, however, are considered by the State agency to be safe for patient care and are available to meet the current and future patient-care needs. (See p. 9.)

Skilled-nursing-care bed need

The Baltimore area has more skilled-nursing-care beds at the present time than it will need by 1975.

According to the 1971 State plan, the Baltimore area will need 6,628 skilled-nursing-care beds by 1975. As of December 31, 1970, facilities for 7,502 beds were in operation or under construction. By 1975 the capacity, estimated by GAO on the basis of plans for future construction, will have increased to 8,104 beds, or 1,476 beds in excess of the need projected in the State plan. (See p. 15.)

The 1971 State plan showed that 2,436 skilled-nursing-care bed spaces did not conform to Hill-Burton construction standards. These beds, however, are considered safe by the State agency for patient care and are available to meet current and future patient-care needs. (See p. 15.)

Control over the development of medical facilities

If the sponsors of a hospital or skilled-nursing-care facility seek Federal financial assistance under the Hill-Burton program, or from the Federal Housing Administration or the Small Business Administration, assistance will not be provided unless the State agency determines that there is a need for the proposed medical facility.

On July 1, 1970, the Maryland Health Facilities Certification and Licensure Program took effect. This law requires the review and approval as to need for all hospitals and related nonprofit facilities (i.e., nonprofit skilled-nursing-care facilities), including those privately financed, by the appropriate areawide comprehensive health-planning agency before licenses to operate may be granted.

Although the organization and concept of comprehensive health planning is new, the State comprehensive health-planning agency and the Baltimore

Regional Planning Council, the areawide agency for the Baltimore area, have developed criteria for determining the need for medical facilities. Officials of both planning agencies said that they did not fully accept the planning concepts used by the State Department of Health and Mental Hygiene in preparing the 1971 State plan. Consequently the planning agencies did not use the estimates of future bed needs contained in the State plan for the purpose of evaluating the need for proposed facilities.

In the 1970 State plan, the State agency said that it and the State areawide comprehensive health-planning agencies should collaborate and should coordinate their information and planning. The State agency indicated that an initial step would be a study of the planning areas of the respective organizations with the objective of obtaining concurrence on regional boundaries. (See p. 19.)

Control over specialized services

In reviewing medical facility projects pursuant to the certification and licensure program, the Baltimore Regional Planning Council considers identification of the possible economies and improvements in service that may be derived from the operation of joint, cooperative, or shared health-care resources. In this way the council can control the establishment of specialized medical facilities and services and encourage the sharing of available specialized services.

Recently passed Public Law 91-296, which increases Federal financial participation in projects involving the sharing of health services, should provide hospitals which are seeking Federal grant funds with an incentive to share services.

GAO obtained information on the utilization of four specialized medical services--open-heart surgery, cardiac catheterization, radiation therapy, and artificial-kidney machines. Hospitals providing open-heart surgery, cardiac catheterization, and radiation therapy were sharing these services with other hospitals in the Baltimore area. Regarding artificial-kidney machines, information developed by the Maryland Regional Medical Program showed that there was a need for additional services in the Baltimore area. (See pp. 20 and 21.)

At the time of GAO's review, the Baltimore Regional Planning Council had initiated a study of specialized medical services in the Baltimore area. Officials of the council stated that data developed during the study would better enable them to control and coordinate the establishment and use of specialized medical services in the Baltimore area.

CHAPTER 1

INTRODUCTION

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HILL-BURTON PROGRAM

Title VI of the Public Health Service Act (42 U.S.C. 291), commonly known as the Hill-Burton program, authorizes the Public Health Service (PHS), Department of Health, Education, and Welfare (HEW), to make grants to States for the construction of medical facilities. PHS, under the Hill-Burton program, requires each State to designate a single agency to administer the program and to prepare a State plan annually, projecting for each designated service area of the State the need for medical facilities and comparing that projected need with the resources expected to exist.

Pursuant to Maryland Law, the Medical Facilities Development Division of the Maryland Department of Health and Mental Hygiene was designated as the State agency responsible for administering the Hill-Burton program. The State agency annually prepares an estimate of the number of acute-care hospital beds and skilled-nursing-care beds needed in Maryland for the ensuing 5 years. Estimates are made for each service area within the State.

The basic data used by the State agency to estimate the need for hospitals and skilled-nursing-care facilities in Maryland consists of current and projected population data furnished by the Bureau of the Census and hospital and skilled-nursing-care facility utilization data, expressed in terms of patient-days during the most recent year, furnished by the facilities. The PHS guidelines for preparing the State plan do not require that PHS, Veterans Administration, or military facilities--or the days of care that were rendered in these facilities--be considered in the planning process.

To arrive at an estimated average daily census of patients, the State agency multiplies the projected population by the current use rate (the number of days of inpatient care in the most recent year for each 1,000 population) and divides the result by 365. The resulting average

daily census is divided by 80 percent for hospitals and 90 percent for skilled-nursing-care facilities to arrive at an estimate of beds needed, assuming an 80-percent occupancy rate for hospitals and a 90-percent occupancy rate for skilled-nursing-care facilities. This provides an estimated 20- or 10-percent vacancy rate to meet emergencies. An extra 10 beds are added to the estimated number of hospital beds needed as an additional precaution to provide for treatment of emergency patients.

BALTIMORE AREA HEALTH COMPLEX

The Maryland State agency has divided the State into 19 service areas. According to PHS regulations, a service area is:

"The geographic territory from which patients come or are expected to come to existing or proposed hospitals, *** or medical facilities ***."

The Baltimore service area includes the city of Baltimore, Baltimore County, and Howard County. It is the largest urban area in the State and includes about 43 percent of Maryland's population.

As of December 31, 1970, there were 22 hospitals in the Baltimore area. Of these hospitals, two are operated by the Veterans Administration (VA) and one by PHS. In addition, construction of a non-Federal hospital was started in April 1971. The locations of hospitals in the Baltimore area are shown on the map on page 7.

Generally there are two types of nursing-care facilities--those which provide care for convalescent or chronic-disease patients requiring skilled nursing care and which are under the general direction of persons licensed to practice medicine or surgery in the State and those which provide domiciliary care. Only the facilities providing skilled nursing care qualify for Hill-Burton grants. Our review included only those facilities providing skilled nursing care. There are 79 skilled-nursing-care facilities (eight chronic-disease hospitals, two nursing units of hospitals, and 69 separate nursing homes) in the Baltimore area.

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HEALTH-PLANNING ORGANIZATIONS

Public Law 89-749, approved November 3, 1966, created the Partnership for Health Program which introduced the concept of comprehensive health planning. This new type of planning envisions that both providers and consumers of health services will participate in identifying health needs and resources, establishing priorities, and recommending courses of action.

The Maryland Comprehensive Health Planning Agency is responsible for administering and coordinating comprehensive health planning at the State level. The Baltimore Regional Planning Council is the areawide comprehensive health-planning agency. Its service area encompasses the city of Baltimore and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties.

In 1968 Maryland enacted legislation, commonly known as the Maryland Certification and Licensure Program, which required, effective July 1, 1970, that the need for all hospitals and related nonprofit health facilities (i.e., nonprofit skilled-nursing-care facilities) to be constructed, expanded, altered, or relocated must be reviewed, in accordance with prescribed guidelines, and must be approved by the areawide comprehensive health-planning agency before a license to operate may be granted by the State Department of Health and Mental Hygiene.

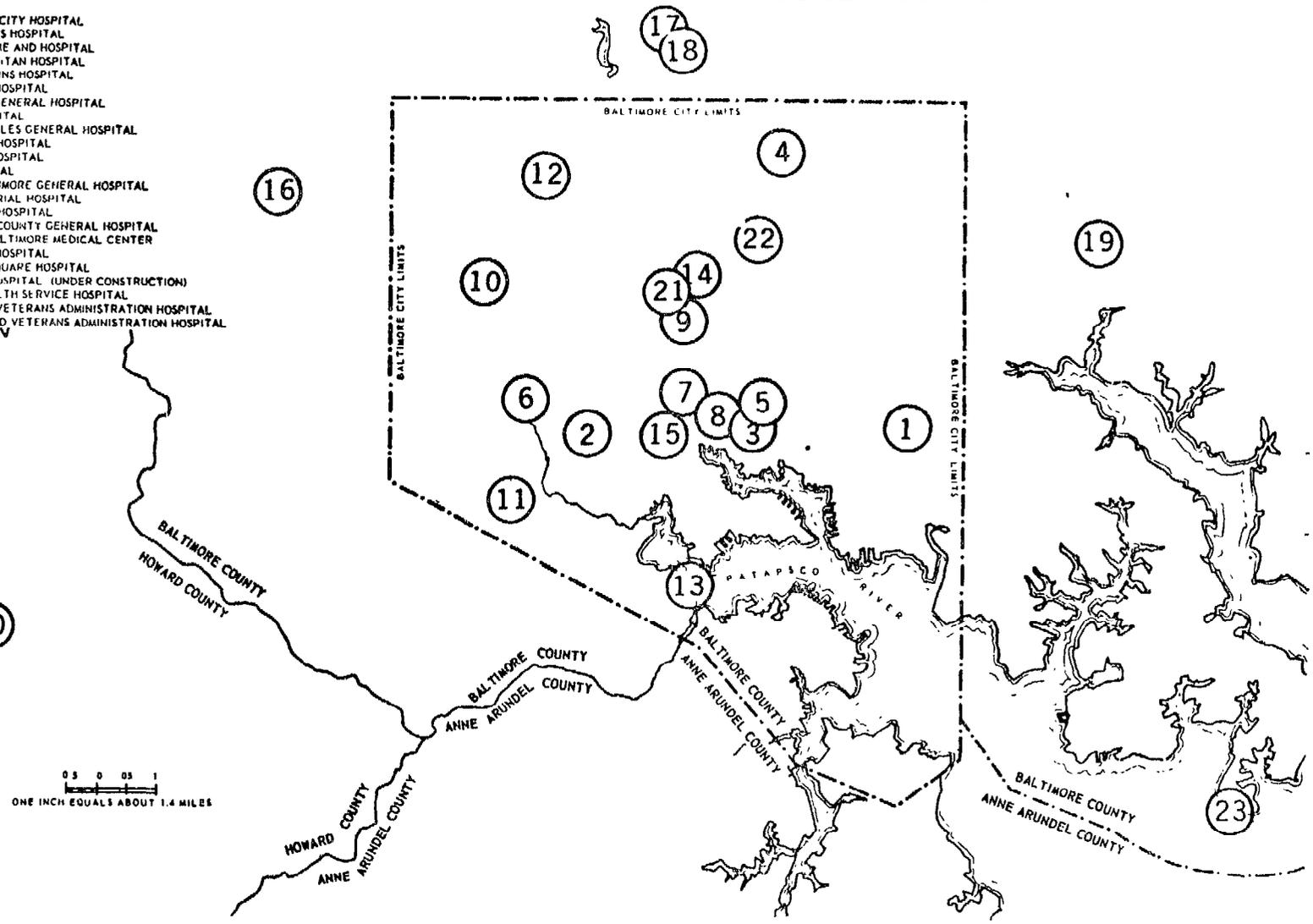
There are four areawide comprehensive health-planning agencies encompassing 13 of the 23 counties in Maryland. The remaining 10 counties do not have areawide comprehensive health-planning agencies. In the absence of an areawide agency, the Maryland Comprehensive Health Planning Agency must review and approve the proposed project. Health-related proprietary facilities, such as skilled-nursing-care facilities operated for profit, must be licensed to operate but are exempt from review as to need by the areawide comprehensive health-planning agency.

Guidelines prescribed for administration of the Certification and Licensure Program have been promulgated by the Maryland Comprehensive Health Planning Agency for use by areawide agencies. These guidelines provide that the

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LOCATION OF HOSPITALS IN THE BALTIMORE SERVICE AREA

- 1. BALTIMORE CITY HOSPITAL
- 2. BON SECOURS HOSPITAL
- 3. CHURCH HOME AND HOSPITAL
- 4. GOOD SAMARITAN HOSPITAL
- 5. JOHNS HOPKINS HOSPITAL
- 6. LUTHERAN HOSPITAL
- 7. MARYLAND GENERAL HOSPITAL
- 8. MERCY HOSPITAL
- 9. NORTH CHARLES GENERAL HOSPITAL
- 10. PROVIDENT HOSPITAL
- 11. ST. AGNES HOSPITAL
- 12. SINAI HOSPITAL
- 13. SOUTH BALTIMORE GENERAL HOSPITAL
- 14. UNION MEMORIAL HOSPITAL
- 15. UNIVERSITY HOSPITAL
- 16. BALTIMORE COUNTY GENERAL HOSPITAL
- 17. GREATER BALTIMORE MEDICAL CENTER
- 18. ST. JOSEPH HOSPITAL
- 19. FRANKLIN SQUARE HOSPITAL
- 20. COLIMBIA HOSPITAL (UNDER CONSTRUCTION)
- 21. PUBLIC HEALTH SERVICE HOSPITAL
- 22. BALTIMORE VETERANS ADMINISTRATION HOSPITAL
- 23. FORT HOWARD VETERANS ADMINISTRATION HOSPITAL



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areawide agencies, in reviewing project applications, must consider

- the need for health-care services in the area and the requirements of the population to be served by the project;
- the availability and adequacy of health-care services in the area's existing health facilities which conform to Federal and State standards;
- the availability and adequacy of other health services in the area, such as preadmission, ambulatory, or home-care services, which may serve as alternatives or substitutes for the whole or any part of the services to be provided by a proposed facility;
- identification of the possible economies and improvements in service that may be derived from the operation of joint, cooperative, or shared health-care resources;
- the development of complete medical services, including inpatient, outpatient, and emergency-care facilities in the community to be served; and
- in the case of relocation, ensuring that adequate health services will continue to be available to the community served by the old facility.

CHAPTER 2

PLANNING AND CONSTRUCTION

OF HOSPITALS

According to the 1971 Maryland State plan prepared by the State agency using PHS guidelines, the Baltimore area will need 7,361 hospital beds by 1975. As of December 31, 1970, facilities for 7,318 hospital beds were in operation or under construction in the Baltimore area, and, if plans of hospital officials are carried out, we estimate that the total capacity of non-Federal hospitals by 1975 would be increased to 7,497 beds, or 136 beds in excess of the need projected in the State plan.

Of the 19 non-Federal hospitals in the Baltimore area, seven had 744 bed spaces in use, or available for use, which did not conform to Hill-Burton construction standards because the buildings were not constructed of fire-resistant materials or did not meet other safety requirements of the Hill-Burton construction standards. All seven hospitals complied with State and local licensing requirements. Further, the Maryland State fire marshal informed us that the hospitals containing the nonconforming bed spaces complied with the requirements of the Life Safety Code of the National Fire Protection Association and, in his opinion, were safe for patient use.

According to the State plan, the 744 nonconforming bed spaces would require modernization to conform to Hill-Burton standards.

The State plan, in accordance with PHS regulations, recognized the availability of these beds to meet current and future patient-care needs.

PLANNED CHANGES IN HOSPITAL BED CAPACITY

In accordance with PHS regulations for including facilities in the State plan to meet the need for beds 5 years hence, the State agency does not consider planned increases or decreases in bed capacity--only facilities under

construction. To obtain information on planned changes, we reviewed the records of the Baltimore Regional Planning Council which was responsible for reviewing all proposed projects involving construction, expansion, alteration, or relocation of hospital facilities in the Baltimore area under the Certification and Licensure Program.

Following is an analysis of the projected changes in bed capacity in the Baltimore area by 1975.

Community and hospital	Bed capacity at December 31, 1969, per State agency	Increase or decrease(-) in beds during 1970	Bed capacity at December 31, 1970	Estimated increase or decrease(-) in beds-- 1971-75	Projected bed capacity by 1975
Baltimore city:					
Baltimore City	537	-40 ^a	497	-	497
Bon Secours	270	-	270	-	270
Church Home and Hospital	297	-	297	28	325
Good Samaritan	67	-	67	-	67
Johns Hopkins	1,089	-	1,089	-	1,089
Lutheran	240	-	240	-	240
Maryland General	450	-	450	-	450
Mercy	414	-	414	-	414
North Charles	155	-	155	63 ^b	218
Provident	122	150 ^c	272	-	272
St. Agnes	425	-	425	-	425
Sinai	488	-	488	-	488
South Baltimore General	366	-	366	-	366
Union Memorial	414	-	414	-92 ^d	322
University	648	-	648	-	648
Total	5,982	110	6,092	-1	6,091
Baltimore County:					
Baltimore County General	94	-	94	-	94
Franklin Square	300	-	300	-	300
Greater Baltimore Medical Center	400	-	400	-	400
St. Joseph	432	-	432	-	432
Total	1,226		1,226		1,226
Howard County:					
Columbia General	-	-	-	180	180
Total	7,208	110	7,318	179	7,497

^aUnder construction. Remodeling of existing facility will reduce capacity by 40 beds.

^bPlanned addition will add 63 acute-care hospital beds and 32 skilled-nursing-care beds.

^cUnder construction. Project includes replacement of existing facility by construction of a new facility with a capacity of 272 beds.

^dPreliminary plans call for construction of a 322-bed facility to eventually replace the existing 414-bed facility. Obstetrical and pediatric beds initially will be retained in the old facility and then these services gradually will be phased out.

Following are the four major hospital construction projects which the Baltimore Regional Planning Council had approved or was studying at the time of our review.

<u>Facility</u>	<u>Estimated cost</u>
Union Memorial Hospital	\$25,926,500
Columbia Hospital and Clinics	3,750,000
North Charles General Hospital	6,370,000
Church Home and Hospital	3,968,000

Union Memorial Hospital plans to build a new facility with a capacity of 322 beds. Three hundred medical and surgical beds, the emergency room, the outpatient clinics, and medical and administrative service units of the existing 414-bed facility will be located in the new facility. Hospital officials plan to maintain pediatric and obstetrical beds in the existing facility for a period and then phase these beds out of service. It is planned that the new facility will not offer pediatric or obstetrical care. At the time of our review, the hospital had raised about \$5 million through a public fund-raising drive.

Both the State agency and the Baltimore Regional Planning Council approved the Union Memorial Hospital project, primarily because the majority of the existing hospital's beds did not conform to Hill-Burton construction standards.

The Columbia Hospital and Clinics Foundation plans to build a 180-bed hospital and an outpatient clinic in Howard County. The hospital and clinic are intended for use by subscribers to the Columbia Medical Plan, a prepaid group practice medical program that has been offered to area residents. The Baltimore Regional Planning Council approved the project in June 1970. Construction of the first phase of the hospital, containing 60 beds and the outpatient clinic, began in April 1971. Approval of the Columbia Hospital is discussed further on pages 18 and 19.

North Charles General Hospital plans to build an addition to its existing facility which would increase its capacity from 155 beds to 218 beds. The Church Home and Hospital facility is planning to increase its capacity from 297 beds to 325 beds. At the time of our review, both projects were in early stages of planning and were under review by the Baltimore Regional Planning Council.

UTILIZATION OF EXISTING HOSPITAL BEDS

To measure the utilization of existing hospital facilities in the Baltimore area, we computed the occupancy rate for each of the 19 non-Federal hospitals by dividing the average daily patient load (patient-days divided by 365) during calendar year 1969 by the bed capacity. The average occupancy rate for the non-Federal facilities had been about 80 percent during that year. These were the most recent statistics available at the time of our review.

The following table shows the bed capacity and the occupancy rates of the 19 non-Federal hospitals in the Baltimore area.

<u>Community and hospital</u>	<u>Bed capacity at December 31, 1969</u>		<u>Average occupancy rate (note a)</u>	
	<u>Licensed (note b)</u>	<u>Survey (note c)</u>	<u>Licensed capacity</u>	<u>Survey capacity</u>
Baltimore city:				
Baltimore City	484	537	66.4%	59.8%
Bon Secours	254	270	80.9	76.1
Church Home and Hospital	297	297	86.2	86.2
Good Samaritan	67	67	70.1	70.1
Johns Hopkins	1,034	1,089	98.9	93.9
Lutheran	240	240	98.7	98.7
Maryland General	440	450	75.4	73.8
Mercy	334	414	81.6	65.8
North Charles	151	155	87.1	84.9
Provident	118	122	77.3	74.7
St. Agnes	425	425	89.8	89.8
Sinai	488	488	88.1	88.1
South Baltimore General	366	366	62.6	62.6
Union Memorial	414	414	85.7	85.7
University	<u>648</u>	<u>648</u>	<u>61.7</u>	<u>61.7</u>
Total	<u>5,760</u>	<u>5,982</u>	<u>81.8</u>	<u>78.9</u>
Baltimore County:				
Baltimore County General	93	94	96.4	95.4
Franklin Square	156	300	(d)	(d)
Greater Baltimore Medical	400	400	87.9	87.9
St. Joseph	<u>346</u>	<u>432</u>	<u>87.2</u>	<u>69.8</u>
Total	<u>995</u>	<u>1,226</u>	<u>88.6</u>	<u>74.6</u>
Total	<u>6,755</u>	<u>7,208</u>	<u>82.7</u>	<u>78.9</u>

^aBased on occupancy statistics for the period January 1 to December 31, 1969.

^bLicensed beds represent the maximum number of beds that the State authorized the facility to operate.

^cSurvey beds represent the available bed capacity as determined by the State agency applying PHS criteria. This determination is based primarily on a minimum requirement of square footage of usable floor space per bed. Minimum required square footage is defined as 100 square feet per bed in a single room and 80 square feet per bed in a multi-bed room.

^dReplacement facility of 300 beds completed in December 1969. The replaced hospital had a capacity of 170 beds with an occupancy rate of 58 percent. The occupancy rate was adversely affected by the gradual phaseout of the facility.

Most of the non-Federal hospitals in the Baltimore area offer pediatric and obstetrical care in addition to general medical and surgical care. Our analysis of occupancy statistics for non-Federal hospitals in the Baltimore area for calendar year 1969, compiled by the Maryland Hospital Association, showed that the occupancy rates for the total pediatric and obstetrical beds were lower than the occupancy rates for the total medical and surgical beds.

<u>Period</u>	<u>Occupancy rate</u>		
	<u>Medical and surgical beds</u>	<u>Pediatric beds</u>	<u>Obstetrical beds</u>
Jan. to Mar. 1969	87.4%	63.3%	74.3%
Apr. to June 1969	86.8	63.4	72.3
July to Sept. 1969	87.8	62.6	76.9
Oct. to Dec. 1969	87.9	60.9	74.9
Calendar year 1969	86.6	62.5	74.7

FEDERAL HOSPITALS

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Two VA hospitals and one PHS hospital are in the Baltimore area. One VA hospital, located in Baltimore city, is a general medical and surgical hospital with a 291-bed capacity. The other VA hospital is located in the Fort Howard area of Baltimore County. This facility is a general medical and surgical hospital with a capacity of 338 beds. During fiscal year 1970, the Baltimore and Fort Howard VA Hospitals had occupancy rates of 74 percent and 80 percent, respectively.

In its fiscal year 1971 appropriation request, VA requested \$21 million to construct a 450-bed hospital to replace the Fort Howard facility. The other VA hospital in Baltimore would continue in service. The proposed facility would be located in Baltimore city contiguous to the University of Maryland Medical School, with which it would be affiliated. In requesting replacement of the Fort Howard Hospital, VA stated that the Fort Howard facility was physically obsolete, isolated from the Veteran population, difficult to staff, and a great distance from the affiliated University of Maryland Medical School. At the time of our review, the proposed replacement facility had not been approved by the President of the United States.

PHS operates a 261-bed hospital in Baltimore. PHS hospitals provide care principally to American seamen, U.S. Coast Guard personnel, PHS commissioned officers, and Environmental Science Services Administration personnel. Active and retired military personnel, and their dependents, are admitted to PHS hospitals on a space-available basis. During the year ended September 30, 1969, the occupancy rate of the Baltimore PHS hospital was about 76 percent.

PLANNING AND CONSTRUCTION OFSKILLED-NURSING-CARE FACILITIES

According to the 1971 State plan, the Baltimore area will need 6,628 skilled-nursing-care beds by 1975. The capacity of skilled-nursing-care facilities in the Baltimore area as of December 31, 1969, was 6,885 beds. As of December 31, 1970, facilities for 7,502 beds were in operation or under construction, and, if plans of local nursing home and hospital officials are carried out, we estimate that the total capacity by 1975 would be increased to 8,104 beds, or 1,476 beds in excess of the need projected in the State plan.

According to PHS guidelines, skilled nursing care is the provision of 24-hour service which is sufficient to meet the total nursing needs of all patients. This includes the employment of at least one registered professional nurse responsible for the total nursing service and of a registered nurse or licensed practical nurse in charge of each tour of duty.

Of the 79 skilled-nursing-care facilities in the Baltimore area as of December 31, 1969, 43 had a total of 2,436 bed spaces in use, or available for use, which complied with State licensing and safety requirements but which did not fully conform to Hill-Burton construction standards, mainly because the facilities were not constructed of fire-resistant materials. All skilled-nursing-care facilities complied with State and local licensing requirements. The Maryland State fire marshal informed us that the facilities containing the nonconforming bed spaces complied with the requirements of the Life Safety Code of the National Fire Protection Association and, in his opinion, were safe for patient care.

The 1971 State plan showed that these bed spaces would require modernization or complete replacement to conform to Hill-Burton standards. The plan recognized, in accordance with PHS regulations, that these beds were available to meet current and future patient-care needs.

On the basis of patient-day statistics for calendar year 1969, we estimated that the average occupancy rate for skilled-nursing-care facilities was about 77 percent. An occupancy factor of 90 percent is prescribed in PHS regulations for use in computing the number of beds needed in a service area.

PLANNED CHANGES IN BED CAPACITY
IN SKILLED-NURSING-CARE FACILITIES

Our analysis of data maintained by the State agency showed that officials of skilled-nursing-care facilities expected to add 1,219 beds by 1975. As of December 31, 1970, three nursing homes with a capacity of 617 beds were under construction and four nursing homes with a capacity of 530 beds were planned for construction. Further, one nursing home planned to add 27 beds, a chronic-disease hospital planned to add 13 beds as part of a modernization project, and one acute-care hospital planned to add a 32-bed skilled-nursing-care unit. We estimate that, if these plans are carried out, the total capacity of skilled-nursing-care facilities in the Baltimore area by 1975 would be increased to 8,104 beds, or 1,476 beds in excess of the need for 6,628 beds projected in the State plan.

Following is an analysis of projected changes in bed capacity by 1975.

<u>Type of facility</u>	<u>Bed capacity</u> <u>at December 31,</u> <u>1969</u> <u>(note a)</u>	<u>Increase</u> <u>in beds</u> <u>during</u> <u>1970</u>	<u>Bed capacity</u> <u>at December 31,</u> <u>1970</u>	<u>Increase</u> <u>in beds</u> <u>1971-75</u>	<u>Projected</u> <u>bed capacity</u> <u>by 1975</u>
Chronic-disease hospitals	1,016	-	1,016	13	1,029
Long-term-care units of hospitals	815	-	815	32	847
Nursing homes	<u>5,054</u>	<u>617</u>	<u>5,671</u>	<u>557</u>	<u>6,228</u>
Total	<u>6,885</u>	<u>617</u>	<u>7,502</u>	<u>602</u>	<u>8,104</u>

^aBased on State agency's statistics and information.

CHAPTER 4CONTROL OVER THE DEVELOPMENTOF MEDICAL FACILITIES

If a proposed hospital or skilled-nursing-care facility project is to be financed with a Hill-Burton grant, the State agency must determine that there is a need for the project before the grant can be made. The Federal Housing Administration and the Small Business Administration recently have instituted procedures whereby financial assistance will not be provided by these agencies unless a certificate of need has been issued by the State agency. The certificate of need is issued by the State agency on the basis of the need for the medical facility as shown in the State plan. Thus the State agency can prevent Federal financing for the construction of medical facilities which it considers to be in excess of the needs of an area.

Recognizing that overbuilding of health facilities is wasteful of public funds and results in higher patient-day costs, Partnership for Health legislation, discussed on page 6, and the Health Facilities Certification and Licensure Program in Maryland have sought to establish control over the development of unneeded privately funded medical facilities.

The Maryland Health Facilities Certification and Licensure Program became effective July 1, 1970. This law requires the review and approval of all hospitals and related nonprofit health facilities by the areawide or State comprehensive health-planning agency before licenses to operate may be granted by the State Department of Health and Mental Hygiene. (See pp. 6 to 8.) Health-related proprietary facilities, such as skilled-nursing-care facilities operated for a profit, are exempt from review by the areawide or State comprehensive health-planning agency.

Although the organization and concept of comprehensive health planning is new, the Maryland Comprehensive Health Planning Agency and the Baltimore Regional Planning Council have developed criteria for determining the need for medical facilities. Officials of both agencies told us that they

did not fully accept the planning concepts used by the State Department of Health and Mental Hygiene in preparing the State plan, and consequently the planning agencies did not use the estimates of future bed needs contained in the State plan in their evaluations of the need for a proposed medical facility. We noted one instance, discussed below, where the construction of a hospital was approved by the Baltimore Regional Planning Council although the hospital was considered unnecessary according to the 1970 State plan.

APPROVAL OF COLUMBIA HOSPITAL

In November 1969 the Columbia Hospital and Clinics Foundation applied to the State agency for a Hill-Burton grant to assist in the construction of a 180-bed hospital and an outpatient clinic in Howard County. (See p. 11.) The State agency denied the request for a Hill-Purton grant because the 1970 State plan showed that no additional hospital beds were needed in the Baltimore area. The Columbia Hospital and Clinics Foundation arranged for private financing and in January 1970, because the Certification and Licensure Program was to become effective on July 1, 1970, requested the Baltimore Regional Planning Council to review its project plans for the purpose of certifying to its need.

The Baltimore Regional Planning Council approved the project in June 1970 because (1) Howard County had no hospital, (2) the population of eastern Howard County was expected to increase from 60,000 to 200,000 during the period 1980-85, and (3) the proposed facility would emphasize preventive treatment on an outpatient basis.

PLANNING FOR MEDICAL FACILITIES

As we noted previously, officials of the Baltimore Regional Planning Council told us that they did not fully accept the planning concepts used by the State agency in preparing the State plan and consequently did not use the estimates of future bed needs contained in the State plan in the evaluation of the need for medical facilities.

In analyzing the concepts underlying the State plan, officials of the Baltimore Regional Planning Council noted that a major part of Hill-Burton funds was allocated for

the construction and modernization of inpatient facilities and that, as a result, the current health-care delivery system, with its emphasis on inpatient treatment of illnesses, was perpetuated.

Officials of the Baltimore Regional Planning Council informed us that they evaluated each project, such as the Columbia Hospital, on the basis of how well the proposed facility would meet specific needs of the community, namely, the need for (1) providing preventive care, especially on an outpatient basis, (2) delivery of health services to the medically indigent, the chronically ill, and the elderly, and (3) development of relationships with other institutions to facilitate the coordination of services to be offered.

In the 1970 State plan, the State agency noted that, because of mutual responsibilities of itself and the State comprehensive health-planning agency and the areawide comprehensive health-planning agencies, it was incumbent upon all to collaborate and to coordinate their information and planning. The State agency indicated that an initial step in the collaboration would be a study of the planning areas of the respective organizations with the objective of obtaining concurrence on regional boundaries.

As noted on page 6, the service area of the Baltimore Regional Planning Council encompasses the city of Baltimore and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. For planning purposes, the State agency has combined the city of Baltimore and Baltimore and Howard Counties as one service area; Anne Arundel, Carroll, and Harford Counties are separate service areas. At the time of our review, concurrence on regional boundaries had not been achieved.

Baltimore Regional Planning Council

CHAPTER 5

PLANNING FOR AND CONTROL

OF SPECIALIZED MEDICAL SERVICES

Health-planning officials have noted that one of the most promising opportunities for advances in hospital effectiveness may be expected to result from the combined efforts of health-care institutions, areawide planning agencies, and State licensing authorities to encourage and, when necessary, demand the development of cooperative programs among institutions for the sharing of specialized medical services and facilities.

As discussed on page 6, the Baltimore Regional Planning Council must approve all projects involving the construction of new hospitals and the expansion, alteration, and relocation of existing hospitals in the Baltimore area. In reviewing project applications, the Baltimore Regional Planning Council considers identification of the possible economies and improvements in service that may be derived from the operation of joint, cooperative, or shared health-care resources. In this way the council can control the establishment of new specialized medical facilities and services and encourage the sharing of available specialized services among hospitals in the Baltimore area.

Under the provisions of section 113 of Public Law 91-296, which amends the Public Health Service Act, States are entitled to receive, from Hill-Burton grant funds, up to 90 percent of a project's cost if the project offers potential for reducing health care cost "through shared services among health care facilities" or "through interfacility cooperation." It appears that this legislation, which provides for increased Federal financial participation in those projects that involve sharing, should provide hospitals seeking Federal grant funds with an incentive to share services.

We obtained information on the utilization of four specialized medical services--open-heart surgery, cardiac catheterization, radiation therapy, and hemodialysis--provided by

Baltimore area hospitals. We found that hospitals which provide open-heart surgery, cardiac catheterizations, and radiation-therapy services were sharing these services with other hospitals in the Baltimore area. Regarding hemodialysis, the Renal Disease Project Coordinator for the Maryland Regional Medical Program informed us that available hemodialysis facilities are not sufficient to treat all patients with renal disease. He noted that a study performed by Johns Hopkins University showed that each year in Baltimore city at least 150 people die from kidney failure who probably could have been helped by hemodialysis treatment.

In May 1970 three area hospitals had equipment, space, and staff to maintain a total of about 20 patients on dialysis. By the end of 1970, five hospitals were maintaining about 30 persons on dialysis. The Director of the Maryland Regional Medical Program informed us that he anticipated that eventually seven hospitals in the Baltimore area would have the capacity to maintain a total of 56 patients on dialysis.

The Renal Disease Project coordinator noted that in Baltimore most dialysis units operated on a 5- or 6-day week, one-shift-a-day basis, because there were not enough doctors, nurses, and technicians to operate the equipment 24 hours a day. He stated that personnel cost, not equipment cost, was the greatest inhibitor of an adequate treatment program.

At the time of our review, the Baltimore Regional Planning Council had initiated a study of specialized medical services, including hemodialysis, in the Baltimore area. This study was to include (1) identification of available specialized services, (2) utilization of existing facilities, equipment, and personnel, and (3) measurement of community need for these services. Officials of the council informed us that this data would better enable them to control and coordinate the establishment and use of specialized medical services, in the Baltimore area.

SCOPE OF REVIEW

We reviewed the coordination among Federal and State agencies and local organizations in planning and constructing acute-care hospitals and skilled-nursing-care facilities in the Baltimore area. We reviewed the planning for and construction of medical facilities financed with private funds or through Federal financial assistance. We compared the existing and planned capacity of acute-care hospitals and skilled-nursing-care facilities with projected needs as determined by the State agency. Although we verified the mathematical accuracy of the State agency's computation of future bed needs, we did not evaluate the appropriateness of the methodology prescribed by PHS for use by the State agency in determining future bed needs.

We also considered the actions taken to effect the sharing of certain facilities and equipment among the various hospitals.

Information was developed primarily on the basis of discussions with Federal, State, and local officials. We made our review at the Division of Medical Facilities Development, Maryland State Department of Health and Mental Hygiene; the Baltimore Regional Planning Council; and at Baltimore area hospitals, skilled-nursing-care facilities, and other health organizations.