A STUDY OF EXTENDED CARE FACILITIES AT SAINT JOSEPH HOSPITAL, FORT WORTH, TEXAS

A Problem Solving Thesis

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Hospital Administration

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August, 1971

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DATE: August, 1971

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CHAPTER I

INTRODUCTION

General Information

In the 1970's, probably no other problem in the health care field looms more significantly than that of long-term care. Traditionally, facilities for such services have been investor-owned. Until recently, they have represented very small, uneconomical operations.

The long-held tradition that hospitals provide only acute care has toppled during the past decade. For many reasons hospitals are now accepting the responsibility for long-term care. One of the most challenging problems facing today's hospital is to find ways to give adequate care to the growing number of the chronically ill and physically handicapped, many of whom are in need of rehabilitation. More and more of the 17,000,000 Americans who are over 65 are being admitted to our general hospitals. It is estimated that by 1980, the population over 65 will double.[1]

New significance has been attached to the problem of long-term care for a number of reasons. For one, the concept of the general hospital as a community health center offering a total range of care is slowly but surely taking hold throughout the nation. The growth of prepayment plans, the

public's awareness of long-term care, and most recently, the passage of the historic Medicare Act (Title XVIII, Public Law 89-97), have all resulted in increased admissions to the general hospital of those patients requiring extended care.

Not only are these long-term patients overcrowding general hospitals, but frequently they do not even belong there. The type of care they require is often not available in a general hospital which is designed for acute care. Particularly because of Medicare, the general hospital is now forced to look at its lack of organized facilities for the long-term patient and decide what course it desires to take. Medicare recognizes three kinds of providers of service: hospitals, extended care facilities, and home health agencies. A hospital may qualify for all three programs if it chooses to do so.[2]

Long-term or extended care in facilities other than hospitals can usually be provided at far less cost, but this kind of care usually needs to be near a hospital. According to most health authorities, long-term care should take place in the mainstream of medicine, which means near a general hospital or in a facility affiliated with it. Not only is this most convenient for the medical staff, but in the long run it saves time and money for the patient, his family, the hospital, and the community, while making possible a better standard of care. Because a hospital is organized to provide professional services, it can and indeed

should take responsibility for the rehabilitative and restorative care of long-term patients.

Most general hospitals, whether or not they operate an organized unit or a separate facility devoted to long-term patient care, do in fact have a considerable long-stay population. National Health Survey data show that more than one-fourth of the total hospital days for patients discharged from short-term general hospitals represented stays exceeding one month. The conclusion that general hospitals are in the business of serving long-term patients is inescapable.[3]

The Hospital Setting and History

Saint Joseph Hospital is located in Fort Worth, Texas, the state's fourth largest city and the county seat for Tarrant County. The rapid growth and industrialization of this area is evidenced by the fact that the population for Tarrant County has more than doubled in the last twenty years.

TABLE 1

POPULATION OF FORT WORTH AND TARRANT COUNTY

	1950	1960	1969	1970
Fort Worth	277,047	356,268	417,248	424,024
Tarrant County	361,253	538,495	720,532	740,773

Source: Fort Worth Chamber of Commerce, January, 1970.

The Sisters of Charity of the Incarnate Word established Fort Worth's first hospital in 1889 and have expanded

their services ever since. The hospital has at present 500 operational beds throughout twelve floors of their medical complex. The latest expansion program was undertaken in 1965 as a part of St. Joseph's continuing efforts to meet the health needs of a growing Fort Worth Community. On March 11, 1967 this program culminated with the addition of 290 new beds in seven new floors and improved facilities throughout the hospital.

St. Joseph's is oriented toward both education and patient care. The hospital has maintained full accreditation by the Joint Commission on Accreditation of Hospitals in both hospital services and medical education for interns and residents. In addition, St. Joseph Hospital has accredited schools for Nurse Anesthetists, Medical Technologists, Professional Nurses, Radiologic Technologists, Vocational Nurses, and Medical Technologists. Administrative residents in hospital administration graduate programs also undergo training at this institution.

During the year ending 1969, the hospital admitted 15,920 patients for a total of 141,478 patient days.[4]

Conditions Which Prompted the Study

During the latter part of 1969, the average patient occupancy of St. Joseph's surpassed 90 per cent. High occupancy continued into 1970, with January's occupancy attaining 85 per cent and February 86 per cent. It is of particular interest that this high occupancy rate exceeded the national average of 81.6 per cent for all hospitals.[5]

The administrators, recognizing the critical shortage of acute beds, examined many proposed solutions to this problem. Expansion by means of establishing an extended care facility was both logical and in keeping with their desire for the best possible utilization of their resources while continuing to upgrade the quality of patient care.

Statement of the Problem

The problem is to determine the planning considerations to be taken by Saint Joseph Hospital, Fort Worth, Texas, in establishing an extended care facility.

Objectives

In order to demonstrate logical conclusions, the following objectives were established:

1. To study the major factors that influenced the evolution and development of extended care facilities in general hospitals.

2. To define the extended care unit as outlined in the literature and federal laws.

3. To evaluate the experiences of other general hospitals that have established extended care facilities.

4. To determine the effects on St. Joseph's in terms of:

   a. Acceptance by the medical staff of an extended care facility.

   b. Reduced costs to extended care patients.

   c. Efficient hospital administration.

5. To determine the optimum size of the proposed extended care facility.

Criteria

The following planning considerations will be defined for St. Joseph Hospital.

1. The statement of objectives and policies.
2. The admission and disposition policies.
3. The range of services.
4. The physicians' acceptance.
5. The staffing requirements.
6. The size of the facility.
7. The cost of construction.

Limitations

The following limitations were established by the hospital administrator.

1. Psychiatric patients admitted to the eighty bed psychiatric portion of the hospital will not be considered in this study.
2. The actual design, finance, and construction of an extended care facility are excluded from the scope of this study.

Assumptions

This study is based on the following assumptions:

1. That St. Joseph's current patient mix will not change significantly.

2. That the parent institution desires "certification" by the Department of Health, Education and Welfare and "accreditation" by the Joint Commission for the Extended Care Facility.

3. That the "Conditions of Participation for ECF's" outlined by the Social Security Administration will not change.

4. That there is an inadequate number of certified extended care beds operated by general hospitals in the Fort Worth Metropolitan area.

Definition of Terms

Progressive patient care (PPC) is a system of organizing nursing and medical facilities that provide each patient with the type and amount of care and nursing supervision that he needs according to his illness. PPC is implemented by grouping patients according to their illness and need.[6]

Extended care facility (ECF) is an institution or a distinct part of an institution primarily engaged in providing to patients: (1) skilled nursing care, or (2) rehabilitation of injured, disabled, or sick persons.[7] An expansion on this definition will be provided in Chapter II.

Research Methodology

During the month of February, 1970, an initial visit was made to Saint Joseph Hospital in Fort Worth, Texas. The general statement of the problem was defined in interviews

with Sister Mary James, Administrator, and Mr. Charles D. Maguire, Associate Administrator. A review of the literature was undertaken with primary emphasis on the implications of PL 89-97 on short-term hospitals in general, and the position of extended care facilities in the continuum of health services.

A study was undertaken to identify the major factors that influenced the evolution of long-term care in nursing or old-age homes to today's concepts of extended care. The conflicting or overlapping definitions of extended care found in the literature were assimilated and reviewed. Various project reports and studies, undertaken by the W. K. Kellogg Foundation, were evaluated. Demographic data were obtained from the Fort Worth Chamber of Commerce, and national figures were extracted from the Report of the National Health Survey to the President of the United States, published in 1967.

A return visit was made to Saint Joseph Hospital in April, 1970, for a two-week period. A survey of the physicians' attitudes toward the concept and rationale of extended care facilities in short-term hospitals was accomplished by means of a questionnaire. The questionnaire was distributed to all physicians, excluding psychiatrists, who admitted twenty-five or more patients the previous calender year.

Interviews were held with the Director and Assistant Director of Nursing Service. A patient-needs survey form was designed to indicate the number of patients who required

each level of nursing care. This form was administered by nursing personnel in three phases; it sampled all available hospital beds three different times over a nine-day period. Additional interviews were carried out with both the administrative and nursing staffs.

Literature Review

Organized treatment programs for patients with illnesses or disabilities requiring non-acute care over an extended period of time have emerged as one of the major problems facing the voluntary health system.[8] Proponents of the institutional concept for the delivery of health are demanding a continuum of patient care. The philosophy of "comprehensive care" implies that a wide variety of facilities must be provided to care for the patients' needs. The concept is used with two separate but related meanings. In the first place, it means the totality of desirable health services--promotion of health, prevention of disease, diagnosis, treatment, and rehabilitation.[9] In practice they merge into one another and ideally form a continuum. Second, comprehensive care means a "total" approach to the individual patient, an approach that is not confined to organic pathology and its treatment, but encompasses the patient's emotional and family problems, and his socio-economic environment.[10] An outgrowth of this thinking led to the concept of Progressive Patient Care, the basic elements of which are outlined in Appendix A.[11]

Progressive Patient Care has many broad implications for the health field. It encourages the continuation of patient care as the hospital's responsibility, until the patient is completely well. Thus, the long-term patient, who makes the greatest demands on the health care system, requires many kinds of institutional units to carry him through the progress of his illness.[12]

General hospitals have long been urged to provide and welcome extended care patients, yet no regular procedures have been set up. Unfortunately the common practice has been to give the same services and facilities to all patients regardless of the degree of illness, a procedure which is most inefficient.[13]

This study is concerned with one specific type of extended care facility: the extended care unit of a short-term, general hospital. The differentiation between such a unit and an acute care unit is based on: (1) the phase of illness or disability of the patient served, and (2) the scope and intensity of medical and nursing care provided.[14] Extended care, in itself, cannot be narrowly defined. In the complete spectrum of independent services there is always an overlap of adjacent types of care. The dimensions of the program of an extended care facility can be as flexible as necessary, provided the program meets the needs of the patients.[15]

Providing special types of hospital facilities and services to meet the needs of various categories of patients

is not a new concept in hospital care. In responding to the needs of the long-term patient, however, the hospital has been slow at best. The American Hospital Association points out that most general hospitals, whether or not they operate an organized unit devoted to long-term patient care, do, in fact, have a considerable long-stay population.[16] If the doctrine is accepted that extended care is neither nursing home care nor a substitute for home care, then it would seem logical to assume that the patients admitted to such a facility would, in its absence, have been admitted instead to a short-term, acute general hospital.[17]

Recently, a revolution has taken place in the hospital field affecting the extended care patient.[18] The major impetus given to this emergency was Public Law 89-97. Medicare now pays up to 100 days of post acute care for patients transferred to certified extended care facilities following a minimum of three days' hospitalization. To qualify for these payments, however, hospitals must meet the eighteen conditions of participation outlined in current Social Security regulations, delineated in Appendix B.[19]

It is generally accepted that an extended care facility, ideally integrated with and operated by a general hospital, is essential to any progressive, organized system of care.

Footnotes

[1]Richard Nice, "Psychology, Extended Care Facility and the Community," Journal of Psychiatric Nursing, VII (May-June, 1969), 136.

[2]Lucy Freeman, The Improvement of Long-Term Care, An Experience Brochure (Battle Creek, Mich.: W. K. Kellogg Foundation, 1967), p. 2.

[3]American Hospital Association, The Extended Care Unit in a General Hospital (Chicago: American Hospital Association, 1966), p. 1.

[4]Saint Joseph Hospital, Analysis of Hospital Services (computerized).

[5]American Hospital Association, Hospitals, Guide Issue, XLII, Part 2 (August 1, 1969), 476.

[6]U.S., Department of Health, Education, and Welfare, Public Health Service, Elements of Progressive Patient Care (Washington, D.C.: Government Printing Office, 1962).

[7]Sr. M. Karen, "Reorganizing for Extended Care," Hospital Progress (May, 1968), p. 56.

[8]Donald Wegmiller, "Extended Care," Hospitals, XLI (April 1, 1967), 63.

[9]Herman Miles Somers and Anne Ramsey Somers, Medicare and the Hospitals (Washington, D.C.: The Brookings Institute, 1967), p. 35.

[10]Ibid.

[11]Public Health Service, Elements of Progressive Patient Care.

[12]Duane Richard Vorseth, "A Study of Extended Care Units Operated by Short-Term General Hospitals" (unpublished M.A. dissertation, University of Chicago, 1967), p. 30.

[13]Louis J. Lonni and Yvonne Lonni, "The Extended Care Problem," Hospital Management, CIII (March, 1967), 47.

[14]American Hospital Association, Extended Care Unit, p. 2.

[15]Ibid., p. 3.

[16]Wegmiller, "Extended Care," p. 64.

[17]Albert R. Hanna, "A Plan for Continuing Patient Care," Hospitals, XLIII (January 1, 1969), 55.

[18]Robert W. Beckwith, "Extended Care Facilities," Hospitals, XL (April 1, 1966), 65.

[19]U.S., Department of Health, Education and Welfare, Social Security Administration, Conditions of Participation for Extended Care Facilities (Washington, D.C.: Government Printing Office, 1966).

CHAPTER II

DISCUSSION

Defining the Extended Care Facility

What is extended care? Why does the definition remain so cloudy? It is hoped that eventually its description will be more definitive than that which has evolved for long-term care.[1] It is not this author's intent, however, to introduce still another definition into the myriad already facing the administrator.

The "extended care" provision is spelled out in Title XVIII, Public Law 89-97 (Medicare) and implies additional requirements in providing this type of care. One is the importance of rehabilitation for the patient. The institution is not only expected to provide a high level of nursing care, but a positive restorative program as well. In addition, in order to qualify for participation in the program as an extended care facility, a distinct part of the institution must be physically separated from the rest of the institution. The distinct part may, for example, consist of several floors, or wards, or it may be a separate building. In every case, however, extended care patients would have to be located in units that are physically separated from those units housing all other patients of the institution.[2]

The Joint Commission on Accreditation of Hospitals, in newly issued standards, refers to the extended care category as:

> Establishments with organized medical staff and with continuous professional nursing service that are established to provide comprehensive inpatient care (which is usually post acute hospital care), for the most part of relatively short duration, and to serve convalescent patients who are not in an acute episode of illness or in a stable stage of illness and who have a variety of medical conditions.[3]

From this definition it is evident that the extended care facility is neither the traditional nursing home nor a home for the aged, but a facility providing skilled post hospital care.

In June of 1966, the American Hospital Association, with the cosponsorship of the United States Public Health Service and the Social Security Administration, initiated a conference on the classification of health care facilities and definitions of terms encountered in the health care field.[4] The classification scheme for extended care institutions originating out of the conference is found in Appendix C and D.

An acceptable definition for the purpose of this study is one that embodies all the significant elements specified by Medicare, the Joint Commission, and the A.H.A. The following paragraph meets that requirement.

> An extended care unit of a hospital may be defined as an inpatient nursing unit designed primarily for those patients whose conditions are not acute, but who still need an active medically oriented program of care that involves the regular and convenient availability of the resources of the

hospital, such as its organized medical staff, its paramedical services, and its diagnostic and treatment facilities.[5]

It now appears that there is general agreement on some aspects of extended care: there should be skilled nursing care at a somewhat less intensive level than in acute care hospitals; there should be direct medical supervision; and there should be an attempt at early rehabilitation.

Factors Influencing the Development of Extended Care Facilities

There are essentially four major factors that have accentuated the development of long-term care and extended care facilities since 1900. First, people live longer so more of them reach old age. Second, people's attitudes have changed regarding health care. Third, people can afford to demand more health services. Fourth, the specific implication for long-term care is contained in Public Law 89-97. It is these last three factors which have had the most profound influence on the general hospital's role in providing facilities for long-term care.[6]

The aging population

The number of elderly persons in the United States has almost quadrupled since 1900, and now represents almost 10 per cent of the total population. Regardless of our personal opinions of the aged, the fact remains that they cannot be ignored. A baby born in this country in 1850 could expect to live for only 39 years; one born in 1900 had a life

expectancy of 49 years; whereas, one born in 1967 can expect to live 70.5 years.[7]

As the life expectancy of the human being has increased due to technological, scientific, medical, and socio-economic advances, so have the infirmities of the aged and many associated problems that occur with aging. The declining death rate in our society is a mere side effect caused by elimination of many of the more lethal diseases in the environment and by better nourishment. When does a person become "aged"? Chronology, although not a very reliable measure to be sure, remains a convenient and customary way to distinguish the aged. It is common practice to consider aged anyone over sixty-five. To generalize about the aged is a mistake, since it tends to place the spry person of sixty-five in the same category with the individual who has reached the century mark and is bed-ridden. The elderly are not and should not be thought of as a homogeneous group.[8] Contrary to popular belief, only about 4 per cent of the aged population are in institutions. These include geriatric facilities, mental hospitals, nursing homes, and prisons.

If the hospital is to become the focus of the total health care system in a community, it must be involved in all of the medical problems of that community. Any other course of action will continue to frustrate the development of high quality care for the chronically-ill aged.

Changing social attitudes

When the Social Security Act became effective in 1935, technology was accelerating rapidly and social progress was beginning to alleviate the despair of many of the poor, underprivileged, and infirm. The availability of public assistance funds spurred the transformation of the traditional patterns of caring for aged parents and relatives. With the shift away from the large, extended multigeneration unit, families began to place their aged kin in newly organized boarding homes, nursing homes, rest homes, homes for the aged, and convalescent homes and hospitals.[9]

Hospital beds and facilities for chronic care were at first difficult to secure and the owners of many boarding homes were unwilling to lose a major source of revenue by having their "boarders" transferred to other facilities. To forestall this, the boarding homes quickly employed one or more nurses and evolved into "nursing homes" or whatever category was most appropriate under the state statute. Such facilities began to mushroom across the country with very little standardization or control.[10]

The end result of these sociological factors has been that many non-acutely ill persons are being cared for in a myriad of institutional health facilities. The nature of the doctor-patient relationship is as changed as the shape of the health care system itself. Better educated, more affluent, and more questioning than his father or grandfather, today's

patient looks to the medical care system for a wider variety of services than previous generations.[11]

Increased ability to pay

The third factor which has more recently had a greater impact is the increased use of collective methods of financing health services by insurance. In 1960 about 130 million people (70 per cent) in a population of 180 million were covered by some form of health insurance.[12] At the end of 1968, over 169 million Americans were protected by one or more forms of private health insurance. This total now represents 85 per cent of the civilian resident population.[13] These range from cash-indemnity commercial plans which exert no control over quality or quantity of service to the Blue Cross-Blue Shield service plans that exert partial controls. Of more significance are the tightly administered, independent, pre-paid consumer health plans. These plans control the quantity and quality of health service. In addition they provide control utilization and quality by means of health education, prevention and early diagnosis, provision and support of adequate facilities and comprehensive services in health centers as well as a constant evaluation of results.

It was not until July 1, 1966, however, that the most dramatic effect on health facilities and services of the general hospital was to begin. This was Medicare. The impact of Medicare on the financing of institutional and non-institutional services for the care of the aged was most

important. The federal government has filled a void in the financing of health care for the aged.

The broad implications of Medicare for the health industry are many. With a wide variety of insured alternatives, the physician can choose the care he thinks best for the patient on the basis of medical need rather than being restricted by the consideration of whether the patient can really afford it.

Two health insurance programs were established for persons aged sixty-five and over: Part A--a hospital insurance plan providing protection against the cost of hospital and related care; Part B--a voluntary medical insurance plan covering payments for physician service and certain other medical and health services.[14] Briefly stated, post-hospital extended care requirements stipulate that a beneficiary who has been an inpatient in a hospital for three days or more may have payments made for his care in an extended care facility to which he is transferred. Post-hospital extended care benefits under Part A, the hospital insurance program, would be payable for the reasonable cost of services rendered to this patient. The benefits are payable for 100 days during a "spell of illness." The first twenty days are paid in full by the program; the patient pays a coinsurance amount for each day after the first twenty days.

If a patient also has Part B coverage--the supplementary medical insurance--then he could also be reimbursed for 80 per cent of the reasonable and customary charges of

physicians and certain other covered medical and health services rendered to him while he is a patient in the extended care facility.

One has only to examine the statistics concerning those eligible to participate in the Medicare program to realize the specific impact on the hospital and health care field. On July 1, 1966, the official opening day of the program, 92 per cent of the then approximately nineteen million older citizens had voluntarily signed up for the supplementary benefit program under Part B. Nearly all had their identification cards for Part A.[15]

Implications of Public Law 89-97 for long-term care

With the passage of Medicare in 1965 the long-term patient and the extended care facility were brought into the main stream of modern medicine. The fundamental aspect of Medicare is that it conceives of health care as a total system.

Recognizing the necessity of providing facilities to serve as a midway point between the acute care services of a general hospital and no care at all, Congress provided for a new type of institution called the extended care facility. Although this facility provides a newer and higher level of nursing care than many traditional nursing homes, some existing nursing homes and long-term care units of the general hospital have only to meet the requirements established for the new level of service to be eligible to participate in

the benefits. These requirements for certification as an extended care facility are embodied in the publication entitled Conditions of Participation for Extended Care Facilities and are applied on a nationwide basis in an attempt to maintain uniformity and equality of patient care in all such facilities.[16]

It was the intent of the Medicare bill to accomplish such long familiar concepts as "continuity of care" and provision of the appropriate service at the appropriate time. In addition, the bill emphasized the importance of areawide planning of all health and medical care facilities. Public Law 89-97 especially enhanced the development of a more rational pattern of care in chronic disease. As Dr. I. S. Falk has said:

> Congressional policies imply that the functional organization of medical and hospital services under the programs inaugurated by PL 89-97 will be responsive to the forces of scientific explosion, technological progress, economic needs, and public demands the same forces that are shaping the organization of health services for our whole society. The key element in that general organization toward which we are now moving is the conversion of the traditional general hospital into the community health center for comprehensive services.[17]

Although Congress established a uniform code of rules for every institution to meet in order to participate in Medicare, it left sufficient flexibility in the regulations so that several different types of institutions could qualify. Congress believed that this flexibility was necessary in order to assure that there would be an extended care facility in virtually every area of the United States. What was

lacking, however, was the assurance that the quality of various types of health care would eventually be standardized.[18]

Fortunately, however, in the years since the original passage of Medicare, Congress has added to the legal provisions for quality standards.

Advantages of Hospital Operated Extended Care Units

Attaching extended care units to the acute general hospital is generally believed to insure many advantages to the patient and hospital. These advantages fall into three major categories; first, continuity of care for the patient; second, a savings in per diem cost for the patient; third, improved utilization of personnel by the hospital.

Continuity of care

The long-held tradition that hospitals should provide only acute care has toppled during the past decade. Hospitals are now being asked to take up the responsibility for long-term or extended care as well. The hospital's role in modern health services can hardly be exaggerated. Physical and intellectual center of the medical world, it is the doctors' indispensable workshop, where the three essential elements of scientific medicine--patient care, research, and teaching--are increasingly focused. By law, and sometimes by default, the hospital is also gradually becoming a community health center, the one institution with the potential for encompassing and integrating the wide range of continuous medical services.[19]

The American Hospital Association, in its book The Extended Care Unit in a General Hospital, writes: "The development of organized programs for patients with illnesses or disabilities requiring non-acute care over an extended period of time has emerged as one of the major problems facing the voluntary health system."[20] Census data, National Health Survey studies, special community studies, and individual hospital population studies combine to furnish abundant evidence that the needs for care of this increasingly large group of patients are not being met.

Many problems exist in the care of the chronic and aged sick under our present system of personal health services. These patients require all the facilities of a general hospital plus other services, including rehabilitation medicine, speech and hearing therapy, psychological, social, and vocational assistance, recreational and educational therapy, and diversional occupational therapy.[21] The importance of providing rehabilitation for the extended care patient is recognized and commented upon throughout the literature. The incorporation of rehabilitation into extended care by all levels of nursing personnel is continually reemphasized.

Recent statistics, however, show that of the more than 5,500 short-term general and other special hospitals in the United States, only 6 per cent reported having separate rehabilitation units.[22]

A new philosophy has come into being, one that refuses to accept the pessimistic view that people, no matter what their ages, are doomed to live in hopeless despair after they suffer trauma--either physical or psychological or both (for these often go hand in hand). The community has begun to recognize the value of rehabilitative services and to request them. Thus, because of public demand, the general hospital is confronted with the responsibility to provide rehabilitative care for the chronically ill and physically handicapped. Also, the doctrine of rehabilitation is inherent in the Medicare law. It does not finance simple custodial care for the very practical reason that it would bankrupt the nation.[23]

If the administrator deals with the subject of extended care, not in the limited sense of post hospital care, but in its broadest interpretation, then the following statement by the National Commission of Community Health Services is most convincing:

> The widest gap in health care facilities in most parts of the United States today is the lack of sufficient places to meet the long-term illness requirements of the increasing number of older persons in our society . . . . The construction of extended care facilities under voluntary, nonprofit auspices physically or functionally related to a general hospital is a top priority . . . as it assumes responsibility to transfer a patient who no longer needs acute hospital care to an appropriate setting.[24]

It is to the hospital's advantage to recognize that some rather formidable problems and hurdles may be encountered. Such problems include: (1) lack of experience in

long-term care by administrators and medical staff members; (2) a gap in the application of knowledge; (3) scarcity of rehabilitation specialists; (4) inflexible patterns of practice in the hospital and community; (5) lack of physician interest in the chronically ill; and (6) a preponderance of hospital admissions that do not need continuing care of any type.[25]

Problem areas notwithstanding, many authors comment on the growing need for long-term care services. They disapprove of the use of acute care facilities for extended care purposes, and they call for general hospitals to consider the provision of extended care services in order to insure true continuity of care.

Hospitals can fulfill this responsibility in three ways:

1. By building an extended care facility as part of the hospital complex.

2. By making the hospital administrative and medical expertise available to interested persons or groups.

3. By assisting facilities in upgrading services.[26]

Perhaps in the final analysis the philosophical justification for general hospital involvement in extended care was best summarized by the American Hospital Association in its Background Statement on Role of Hospitals in Long-Term Care:

> Community hospitals must become even more comprehensive or 'general' extending the range and the depth of their services to include short-term psychiatric care, social services, and effective

> rehabilitation programs . . . . We believe that these are best provided either directly under the auspices of, or in affiliation with, a general hospital . . . . A planned program for providing post acute care, either within the framework of the general hospital or closely related to it, is essential . . . .[27]

Savings to the patient

Medical care prices have risen rapidly in the recent past. The outlook is for continued increases unless strong action is taken to alter current trends. One might legitimately ask: who cares? Why should we be so concerned about this particular set of prices? The obvious answer is that given our present system of financing medical care, rapid increases in medical prices cause real hardship to many people. Those who pay their own medical bills either directly or through insurance premiums--and most of the population is in this category--find the price of medical care rising faster than their incomes. The hardships are more acute than those associated with rises in the prices of most other commodities. Medical care is often a necessity--it cannot be postponed without dangerous consequences to health.[28]

Impelled by changes in the concept of hospital care and in the very nature of the hospital industry, hospital costs have mounted steadily and at an accelerating rate. The increase in 1966 alone was in excess of 16 per cent, compared to yearly increments of 6 to 8 per cent over several previous years, and the 1967 increase was even greater. Projections based on current trends indicate that average hospital costs

per patient-day will increase by approximately 9 per cent a year until 1975--reaching $100 a day by 1975.[29] Many authors feel that this figure is conservative at best.

The concept of extended care implies that the patient can be cared for at a lower cost than in a general hospital. If he is a patient in the hospital, he can be transferred from a regular hospital bed when his condition warrants it. Ideally, this would free a hospital bed and reduce health care costs. In this sense, extended care fits in with the concept of Progressive Patient Care, in which patients are assigned to areas of care according to their needs and are transferred to the proper units as their conditions change.[30]

The literature is replete with articles that substantiate the unquestionable cost savings of extended care. The following statements, taken from three different journals, are typical.

> One of the most important reasons for creating extended care units is to reduce the high cost of care for patients whose condition does not currently require acute hospital care.[31]

> Experience at Dettmer Hospital has shown costs in the extended care unit to be 50 to 55 per cent of those in acute care units . . . .[32]

> Economy for the patient. Obviously, the patient will have a less expensive daily rate in an extended care facility than in a general hospital.[33]

Obviously, the administration must weigh many considerations before the method of charging and the rate of charges is decided. The choice must be made between inclusive rates and separate charges for individual services.

Establishing charges for extended care involves other factors, too. For example, both physicians and patients expect the extended care unit to cost less. This expectation forms the basis for the success of the unit in terms of utilization by the physician and the attitude of the patient. If per diem charges do not pass on a cost savings, it will be difficult to promote the use of extended care facilities.[34]

Improved utilization of personnel

The greatest advantage that a general hospital can receive from the establishment of extended care facilities is that it can depend heavily on ancillary medical personnel, thereby reducing the overall demand on the professional manpower pool. Because growing demands for hospital care and changes in medical technology have combined to strain the supply of skilled professional personnel, driving up wages and prices, literature on the subject is unanimous in recommending increased dependence on paramedical or ancillary personnel wherever possible.

By itself, the growth in demand for hospital services would have overtaxed the supply of skilled hospital personnel. Recently the strain has been heightened by changes in hospital practice that have increased the required number of personnel per patient. As a result, personnel employed in short-term, general hospitals increased nearly 30 per cent between 1960 and 1965.[35] Nursing service (professional and nonprofessional) constitutes the largest single group of

employees in hospitals, and many hospitals must operate with a severe, sometimes critical, shortage of qualified nurses.

Expansion into the area of extended care facilities, however, would meet the increased requirement for hospital beds while placing a minimum demand on the supply of professional nursing personnel. By transferring the extended care patient from the acute general hospital to the adjacent extended care facility, the professional nurses in the main hospital would be freed for the professional level of care for which they were trained.

Planning Considerations for Establishing an Extended Care Facility

A hospital, like St. Joseph's, that is contemplating a new extended care facility must provide for extensive and continuous planning. Among its most important considerations must be: (1) overall objectives, (2) admission and disposition policies, (3) range of services, (4) acceptability to physicians, (5) nursing staff requirements, (6) optimum size of the facility, and (7) the cost of construction.

Determining objectives

Developing the philosophy and defining the objectives of the extended care unit is obviously the first job of any hospital considering the addition of such a unit. All other variables depend, in one way or another, on this first task.

When establishing a preliminary planning group or committee, on extended care, the administrator should include

representatives of the medical staff, including both general practitioners and specialists from the various services likely to be involved in extended care--medicine, orthopedics, surgery, physical medicine, and rehabilitation, to name a few. The nursing staff, the administrative department, and the trustees should also be represented. All of these people should have a voice in determining the objectives of the program.

According to literature, the underlying philosophy of an extended care unit should be the belief that post acute patients need a total care program and will achieve their optimum potential more rapidly in a unit geared to their total needs--a unit in which the individual is not overlooked and in which the patient who is getting well receives just as much attention as the one who is more seriously ill. The broad objective of such a unit would be to provide post acute care to selected patients who still need an active medically-oriented, hospital-based program to prepare them for discharge to their own homes or to a personal care facility.[36]

A study, financed by the W. K. Kellogg Foundation, resulted in a survey of all of the institutions in Wisconsin participating in long-term or extended care. The administrators of these hospitals were asked why their institution had decided to add such a unit to their operation. In almost every case, the answer was that the unit was developed in response to a community need for long-term beds. The

hospitals further replied that they were being forced to keep the aged chronic and convalescent patient in a hospital bed far beyond his need for acute hospital care.

In her book, The Improvement of Long-Term Care (financed by the Kellogg Foundation), Freeman was more pragmatic:

> While care in facilities other than the hospital can usually be provided at far less cost, the long-term patient usually needs to be near a hospital. . . . Not only is this most convenient for those giving care to the patient but, in the long run, it saves time and money for the patient, his family, the hospital, and the community, and provides better care.[37]

The objectives of Saint Joseph's extended care facility must be both pragmatic and realistic; they should be developed through planning conferences with the medical staff and all those departments of the hospital directly concerned with patient care; and, finally, these objectives must be promulgated in writing.

Admission and disposition policies

The first question to be considered in planning admission policies is what types of patients should be accepted for extended care. Different institutions have taken different approaches in this matter.

The Division of Hospital and Medical Facilities of the Michigan Department of Public Health distinguishes three types of patients suitable for long-term care facilities:

1. Those who can benefit from a program of active treatment involving rehabilitation services--between 35 to 50 per cent.

2. Those who require a high level of maintenance nursing care and who have no rehabilitation potential--between 25 and 30 per cent.

3. Those who require only supervisory care--about 30 per cent.[38]

One author, after defining the extended care unit as an "inpatient nursing facility," denoted the following types of patients who may appropriately be admitted to the unit:

1. Those who have a potentially recurrent disease, such as bronchial asthma or congestive heart failure and who need careful observation in anticipation of a sudden attack.

2. Those who have a potentially progressive disease and such as diabetes mellitus. . . .

3. Those who have a static or terminal handicap, such as that resulting from an amputation or stroke.

4. Those patients whose convalescence is prolonged for one or another of a variety of reasons.

5. Those patients with a non-acute psychiatric condition.[39]

Still another administrator stated: "Any patient who is rehabilitative to any degree, who can benefit from skilled nursing care and other hospital services . . . may be admitted to the extended care unit."[40]

The Patient Care Committee of St. Ann's Home reporting on the primary admission diagnosis to their six month old extended care unit, showed (in descending order): (1) fractures, (2) strokes, (3) myocardial infractions, (4) convalescence from surgery, (5) arthritis, (6) amputations, and (7) other.[41]

In making decisions concerning the type of patients to be cared for in the unit, the administration must determine whether certain patients will be ineligible--those with chronic conditions, perhaps. Also, planners should consider the age range of the patients. Then, too, the source of admissions requires a policy statement. Will transfers from another hospital, a nursing home, or other health care facilities in the community be accepted, and if so, which ones will have priority?

Underlying the entire decision making process on admission policies must be the realization that if the unit admits patients for convalescent or diagnostic stays of only a few days, it may end up being little different from the acute care units of the hospital. On the other hand, if the unit admits or retains patients who need only custodial care, it could rapidly become only a glorified nursing home.[42]

Range of services

One of the basic problems facing extended care units cojoined with general hospitals is the provision of services. For each type of service, the decision must be made whether to have it provided by the extended care unit staff, by the hospital staff, by the combination staff, or from outside the institution. There is also the question of how extensive the service will be and how each service relates to the initial objectives. A physical therapy program, for example, may be headed by a registered physical therapist, by a

physical therapy aide, by a nurse trained in physical therapy, or by a staff nurse without training. In all cases, the patient receives physiotherapy, but in varying quality and quantity, dependent upon the staff provided and the general capability of the institution.

Patient rehabilitation is an important goal of any extended care program. Rehabilitation nursing under proper medical supervision is essential for any extended care unit. The staff should be trained to conduct its daily activities with particular emphasis on helping patients to maintain and improve their functions at all levels--physical, psychological, and social.[43]

As outlined by the American Hospital Association, good extended care programs--those that provide an adequate range of services--tend to get better, and programs handicapped by lack of resources and services tend to become less effective. To guard against the latter possibility, hospitals should focus simultaneously on: (1) accelerating the use of diagnostic and clinical services, and (2) developing basic restorative services either independently or through cooperative arrangements with other health care facilities. It would appear that an important measure of quality of care rendered in an extended care unit is the amount of time that elapses between a patient's readiness for rehabilitation services and his receiving them.

Of the institutions mentioned in an important study done in Wisconsin, nonprofessional services were in almost

all cases supplied by the parent hospital staff or by a combination of the hospital and extended care unit staff. Table 2 outlines the results.

TABLE 2

METHOD OF PROVIDING SERVICES TO THE LONG-TERM CARE UNIT

Service	Unit Staff	Hosp. Staff	Comb. Staff	Outside Staff	Not Provided
Pharmacy	-	16	-	23	-
Housekeeping	18	10	10	1	-
Maintenance	2	17	20	-	-
Dietary	3	18	18	-	-
Laundry	1	20	13	5	-
P.T.	2	12	5	4	16
O.T.	7	2	-	2	28
Social Work	1	1	-	12	25
Radiology	-	35	3	1	-
Laboratory	-	35	3	1	-
Dental	-	3	-	28	8
Optical	-	-	-	26	13
Spiritual	2	7	5	25	-

Source: John E. Mosher and Edward J. Conners, Hospital Based Long-Term Patient Units in Wisconsin (Battle Creek, Mich.: W. K. Kellogg Foundation, 1968), Table 1, p. 3.

One author feels that the social worker is one of the most significant persons on the extended care unit staff. (Note in the above table that most of the hospitals had no such position.) He explains that the social worker handles many items for personnel on the floor that the nursing staff does not have time to do, or is unable to do. If a patient has not signed up for Medicare, he explains, the social worker will see that the necessary signatures and paper work

is completed.[44] The social worker also works with patients and their families concerning the needs of both. Often the families experience tremendous guilt feelings because their parent is a patient in such a unit. Most times these feelings are not justified because the family is not capable of taking care of the patient. A major problem for the social worker is working with the families whose parent is "left" in the unit. This type of family rarely visits the parent, so there is little opportunity to influence it.[45]

Many general hospitals are not equipped to provide a full range of extended care services. There remains a real question whether the smaller hospitals should even consider the operation of an extended care program as such. Unless services requisite to the full range of the patient needs can be developed prior to or simultaneously with the opening of the unit, the hospital might well consider alternatives to establishing an extended care program.[46]

While certain limitations on the amount and type of services offered in the extended care unit merit careful thought, it should be generally understood that the medical and diagnostic services of the hospital are available to any patient who requires them. Experience indicates, however, that if an extended care patient requires surgery or if his condition becomes such that he is likely to need <u>intensive</u> nursing care for more than a short time, he should be transferred or readmitted to the hospital.

As mentioned previously, all planning considerations revolve around the predetermined objectives. Saint Joseph's is already functioning as a fully equipped and superbly staffed general hospital offering a full range of services. The basic question to be resolved by its administrators therefore is whether the individual services are to be provided by the unit staff, the hospital staff, or a combination of the two.

Acceptability to physicians

The physician's role in extended care is being more clearly defined and his responsibilities for care more generally accepted. The American Medical Association, the Canadian Medical Association, and other medical societies have all emphasized that physicians have a role beyond that of treating the medical aspects of the aging; they must consider social, economic, psychological, and even environmental factors as well.[47]

One author feels so strongly about the physician's role that he writes:

> It is really the physician, however, and not the hospital, that is responsible for continuing care of individual patients. The expanding role of the modern hospital as a health care resource has been mostly overrated. . . . The hospital role is rather narrow--in spite of the quality of inpatient care.[48]

Although this position may be considered extreme, one of the Kellogg studies identified the reluctance of the physicians to work with long-term patients as a major problem area.[49]

Physicians are not especially concerned, to any large degree, with plans for joint administration, data processing, purchasing, food service, or many other non-medical operations, but the physician's freedom to practice as he chooses, and his livelihood, may be directly involved when hospitals enlarge their services. Physicians whose personal convenience is adversely affected by such decisions can scarcely be expected to cheer about improvements in continuity of care.[50]

There may be a lack of enthusiasm and perhaps even some hostility exhibited by the medical staff toward the rationale of extended care facilities being operated by a short-term general hospital. The physician, after all, is the key to better health, and he must approve the goals of any plan for it to succeed. During the course of this study a questionnaire was mailed to certain physicians at Saint Joseph's in order to determine their acceptance or rejection of an extended care unit. The pertinent information on this questionnaire is attached as Appendices E through G.

Of the physicians sampled at Saint Joseph's the majority were overwhelmingly in favor of the rationale of an extended care facility being established as a distinct part, but adjacent to the hospital. Table 3 summarizes the actual survey results.

The results of this survey clearly demonstrate the acceptability of an extended care unit to Saint Joseph's medical staff. Their acceptance will certainly enhance the continuity of care concept previously discussed and also

TABLE 3

PHYSICIANS' SURVEY*

Type of Response#	Number of Responses	Per Cent
Favorably inclined	34	46.5
Enthusiastic	30	41.1
Opposed	6	8.2
No opinion	3	4.2
TOTAL	73	100.0

* For detailed explanation, refer to Appendix E.

\# The responses were predetermined by the hospital administrator.

promote full utilization of the facility, thereby assuring maximum savings to the patient and consequently optimum use. It is of prime importance, however, that the administrators of Saint Joseph's continue to encourage and even stimulate the medical staff to participate in the planning process from beginning to end. The acceptance of an idea does not necessarily insure the acceptance of the final product.

Nursing staff requirements

Staffing an extended care facility is made easier by the fact that these facilities usually require much more paramedical than medical personnel. A word of caution, however, is in order. Medicare payments are provided for patients needing skilled nursing care but not for those needing custodial care. In most instances, the need for skilled nursing services will depend on whether the individual's

condition is such that it requires that the services of a nurse be available to him at all times. Care would not necessarily be considered skilled merely because it is provided by a registered nurse. If a service can be safely rendered by the average, rational, nonmedical person without direct medical supervision, it is regarded as a non-skilled service regardless of who actually provides it.[51]

Recently, the custodial care guidelines issued by the Social Security Administration have been abandoned, but a new set of guidelines has been issued to help hospitals avoid returning money to Social Security for "noncovered" care.[52] The new guidelines provide assurances for payment to certified extended care facilities if: (1) the physician certifies that skilled services are needed; (2) the services are spelled out in orders to the extended care facility; and (3) the services prescribed are actually provided. Social Security's shift in referring to denied care as "noncovered" care rather than custodial care is designed to alleviate the pressure in some states where welfare and health officials had previously used this ruling to deny payments for skilled nursing care.[53]

The interchange between the general hospital staff and the extended care unit staff makes it extremely difficult to distinguish one staff from the other. As was mentioned previously, most nonprofessional services are supplied to the unit by the hospital staff or by a combination hospital and extended care unit staff. Ideally, an extended care

unit should be sufficiently large to permit the efficient organization and assignment of staff.

A universal guide or "rule of thumb" for nursing hours per patient per day is nonexistent. Experience, however, is worthy of consideration. Hanna reports that his experience was that each patient required 2.6 hours of nursing care per day; Sister Karen writes that as a result of a work sample study she determined that each patient received an average of 2.2 nursing hours per day (20 per cent of which should have been given by professional staff). The McPherson Experiment in continuing care states that the nurses in their units give five hours of care to each patient per day. The Allegan Health Center in Michigan reported that the nurses give 4.5 hours per day to each patient in their long-term unit. The Wisconsin study reports 2.34 nursing service man-hours per bed per day.[54] Regardless of the number of hours of service rendered, all agree that professional nursing supervision should be available around the clock.

Nursing care in an extended care unit is usually less technically complex than in an acute medical or surgical unit, and a lower ratio of registered nurses to licensed practical or vocational nurses and well-trained nursing aides is often possible. Because patients' need for care during night hours is usually limited, reduced staffing for that period is possible. In many ways the demands on staff in an extended care unit are different from those in an acute unit, but it does not follow that they are necessarily less.

The actual determination of the required number of registered nurses, in addition to a specially qualified nurse supervisor who has overall responsibility for the unit will, in the final analysis, depend upon the established goals of the unit, the nursing needs of the patient, and the degree of supervision necessary to the supportive personnel. The boundaries for nursing staff requirements should be to insure compliance with the previously mentioned requirements of the Social Security Administration. The nursing staff, per se, should be chosen not only for their nursing skill, but also for their ability to work with and relate to the extended care patient.

Size of the facility

There are several ways to define the actual size of any facility. Size may mean the number of square feet available in the physical structure, the number of patients served, or the size of the financial budget. The most widely used definition of size, however, is the total number of beds of an institution. When referring to the size of an extended care facility, only the total number of beds certified as extended care beds is considered.

The decision making process concerning the size of the extended care facility must be based on careful planning and deliberation. The need for beds and space will depend upon the nature of the program and the size and the location of the area to be served. The more active and successful

the rehabilitative efforts are, the greater the patient turnover per bed per year.[55] A range of thirty to sixty beds is generally considered proper in extended care facilities, according to the American Hospital Association. They quickly add, however, that the unit should be large enough to be economical and functional.[56]

A 1967 survey of Medicare certified extended care facilities reported a total of 3,865 facilities, in the United States, with 272,357 beds. The mean size for these facilities was 70.5 beds. In this same survey, Texas reported 192 certified extended care facilities with a total of 14,626 beds and a mean size of seventy-six beds.[57] (This last figure is confirmed by another recent study.) As of July 31, 1968, the Social Security Administration reported 4,696 certified extended care facilities, with a total of 329,353 beds and a new mean size of 70.1 beds, a decrease of .4 from 1967.[58]

In the previously mentioned Wisconsin survey of thirty-nine operational long-term care units, the median size was thirty-six beds, with a range of fifteen to 150 beds. Eighty-five per cent of these units were under fifty-five beds and only four were seventy-five beds or more. One conclusion of this study was that the size of the hospital bore no relation to the size of the long-term care unit.[59]

Another research project, which conducted a nationwide survey of all hospital operated extended care units,

reported that 83 per cent of the hospitals of 300 beds or more have extended care units of eighty-one beds or more.[60]

In an effort to logically determine the number of current patients who might more appropriately be cared for in an extended care facility, a survey was conducted at St. Joseph's from the 14th through the 20th of April, 1970.

Psychiatric patients and intensive care patients were excluded from this study thereby reducing the beds available to be sampled on any given day to 404. The director of nursing was consulted concerning the method of study to make sure that the census observations would not in anyway interfere with patient care. The survey methodology resulting from this consultation is outlined in Table 4.

A "patient care needs" questionnaire was used to gather the census data. It is attached as Annex H. The questionnaire was completed by the nursing supervisor on each ward between the hours of 8:00 A.M. and 3:00 P.M. An initial briefing or explanation was conducted for these supervisors by the Assistant Director of Nursing, with this writer present. Throughout the study, this writer was available to the nursing staff to answer questions. A total of 893 questionnaires was completed during the survey period.

The complete analysis of the total survey is outlined in Table 5 and summarized by category in Table 6. Analysis of the data collected shows that, in the nurses' opinions, an average of fifteen patients qualified for transfer to an extended care facility (classification 4, Table 6).

TABLE 4

SURVEY METHODOLOGY

		PHASE I			PHASE II			PHASE III
Ward #	Beds	14th	15th	16th	17th	18th	19th	20th
Peds	16	X			X			X
2nd Main	30	X			X			X
2nd Annex	27	X			X			X
3rd Main	34	X			X			X
3rd Annex	26	X			X			X
4th Main	32		X			X		X
4th Annex	33		X			X		X
5th Main	18		X			X		X
6th Main	21		X			X		X
7th Floor	44			X			X	X
8th Floor	41			X			X	X
9th Floor	41			X			X	X
10th Floor	42			X			X	X

Notes: The "X" designates the date the ward indicated was actually surveyed.

This survey methodology assured that different ward nurses would complete the survey form, thereby reducing any personal bias.

It should also be noted that twenty-five additional patients were considered eligible for transfer to a nursing home (classification 5, Table 6).

It is difficult to generalize on the relationship between hospital size and the size of the extended care unit. It appears, rather, that the extended care facility size is most likely to be based on the judgment of the administrator of community needs, of available capital, or of the results of some type of survey. Even the latter allows for a wide range of judgment.

TABLE 5

PATIENT CARE NEEDS CLASSIFICATION

Date	PHASE I											PHASE II											PHASE III				
	14th			15th			16th					17th			18th			19th					20th				
Diag. Class.	M	S	O	M	S	O	M	S	O	To-tal	Per Cent	M	S	O	M	S	O	M	S	O	To-tal	Per Cent	M	S	O	To-tal	Per Cent
Cate-gories																											
1	7	0	0	1	5	0	6	14	2	35	11.0	5	0	0	3	6	0	8	0	0	22	7.7	9	15	0	24	8.2
2	19	3	22	21	30	0	27	23	1	146	45.9	21	2	22	5	14	0	23	21	0	108	38.0	56	49	12	117	40.2
3	3	0	16	2	15	0	28	11	1	76	23.9	8	1	14	2	7	0	21	16	0	69	24.6	28	18	15	61	21.0
4	0	1	2	1	0	0	5	3	0	12	3.8	0	1	2	3	2	1	6	0	0	15	5.2	13	2	3	18	6.2
5	7	0	6	4	1	0	3	1	0	22	6.9	7	3	4	7	2	0	7	0	0	30	10.6	15	4	4	23	7.9
6	4	1	0	0	0	0	3	1	0	9	2.8	1	0	0	1	1	0	4	1	0	8	2.8	10	1	0	11	3.8
7	2	1	5	1	1	0	1	7	0	18	5.7	1	0	8	2	9	0	4	7	1	32	11.1	13	15	9	37	12.7
										318	100.0										284	100.0				291	100.0

Notes: Diagnostic Classifications: M, Medical; S, Surgical; O, Orthopedic.

Categories refer to the seven choices of the patient care needs questionnaire (see Appendix H).

TABLE 6

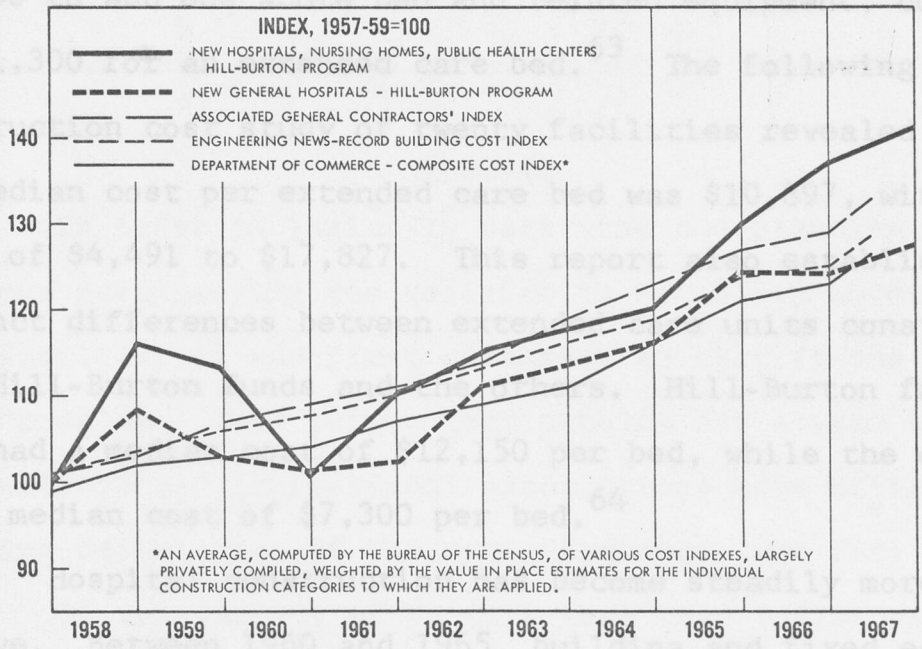
PATIENT CARE NEEDS CLASSIFICATION--SUMMARIZED

Categories	1		2		3		4		5		6		7		
	Total	Per Cent	Total	Per Cent	Total	Per Cent	Total	Per Cent	Total	Per Cent	Total	Per Cent	Total	Per Cent	Grand Total
Phase I	35	11.0	146	45.9	76	23.9	12	3.8	22	6.9	9	2.8	18	5.7	318
Phase II	22	7.7	108	38.0	69	24.6	15	5.2	30	10.6	8	2.8	32	11.1	284
Phase III	24	8.2	117	40.2	61	21.0	18	6.2	23	7.9	11	3.8	37	12.7	291
MEAN	27	9.0	124	41.4	69	26.5	15	5.1	25	8.5	9	3.1	29	9.8	298

Cost of construction

There has been a steady increase in construction costs over the years. The cost of health facilities has reflected this increase. In many cases, because of the use of intensive care facilities and expensive equipment, hospital construction cost increased at a more accelerated rate than other types of construction. The following graph of construction cost indicators--materials, skilled labor and unskilled labor--illustrates the yearly percentage rise from 1957 to 1967.[61] An attempt to combat these pressures can be made through careful consideration of design, type, construction, and location of extended care facilities.

Fig. 1--Construction Cost Indicators



Source: Report of the National Advisory Commission Health Facilities to the President of the United States, B. Jones, Chairman (Washington, D.C.: Government Printing Office, 1968), p. 55.

Costs of constructing and equipping an extended care unit vary greatly in relation to the services to be provided in the unit and in relation to the adequacy of the hospital's supporting services. If, for example, the dietary, laundry, X-ray, and clinical laboratory services of the hospital can serve the extended care unit without physical expansion, the per-bed costs of construction for the unit will be lower than the per-bed costs of a medical-surgical unit of comparable size. Other factors that can lower capital costs include the probable omission of piped-in oxygen, built-in suction apparatus, physiological monitoring equipment, and electronic bedside consoles.[62]

In 1966, Vorseth reported that it costs about $25,000 to add one acute bed and related equipment, compared to $11,300 for an extended care bed.[63] The following year a construction cost study of twenty facilities revealed that the median cost per extended care bed was $10,897, with a range of $4,491 to $17,827. This report also established distinct differences between extended care units constructed with Hill-Burton funds and the others. Hill-Burton facilities had a median cost of $12,150 per bed, while the others had a median cost of $7,300 per bed.[64]

Hospital construction has become steadily more expensive. Between 1960 and 1965, building and fixed equipment cost per square foot in new hospital construction went up about 4.1 per cent per year. In the same period, prices for nonresidential construction in general rose about 1.9

per cent per year. The increased plant and facilities of hospitals show up in hospital asset figures. The American Hospital Association estimates that plant assets of short-term hospitals increased from $12,976 to $16,615 per bed between 1960 and 1965.[65] Data are insufficient and do not permit further generalization about the cost per square foot for extended care units.

The actual cost of constructing an extended care facility at Saint Joseph's is, in reality, a moot point. All of the previously discussed planning considerations contribute to the final cost of the facility. Many other factors, not a part of this paper, such as interest rates, unemployment, and others also play an important part in the final cost. It does appear, however, that the cost per bed should be less than that required to construct an "acute bed."

Summary

In order to logically determine the planning considerations accompanying the decision to establish an extended care facility, it was first necessary to clarify the terminology problem. This terminology problem has arisen because many writers and professional associations have offered conflicting definitions of the term "Extended Care Facility."

Of the variety of factors that have influenced the development of extended care facilities in the United States, three are of major importance. They are: (1) the aging

population, (2) changing social attitudes, and (3) the consumers increased ability to pay for health services.

The year 1966 saw a tremendous interest in adding extended care to the spectrum of health services. Recognizing the necessity of providing facilities to serve as a half-way point between the acute care services of a general hospital and no care at all, Public Law 89-97 made provisions for a new type of institution called "the Extended Care Facility." This law had considerable impact on both the general hospitals and those over sixty-five years of age.

The literature outlines three prime advantages to the general hospital and its patients when the hospital establishes an extended care facility. These are: (1) the enhancement of the continuity of patient care, (2) the savings to the patient, and (3) the more efficient use of hospital personnel.

The administrators of St. Joseph's Hospital should consider: the overall objectives of the ECF; admission and disposition policies; specific range of services; acceptability of the ECF to physicians; nursing staff requirements; optimum size of the facility; and the cost of construction.

Footnotes

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[25]Engelmohr, "Long-Term Care Gap," p. 82.

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[30]Weeks, "Extended Care Facilities," p. 88.

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[39]Richard W. Nice, "Psychology, Extended Care Facility and the Community," Journal of Psychiatric Nursing, VII (May-June, 1969), 136.

[40]Hanna, "Patient Care," p. 55.

[41]Sr. M. Karen, "Reorganizing for Extended Care," Hospital Progress, May, 1968, p. 64.

[42]American Hospital Association, General Hospital, p. 18.

[43]Hospital Consultants, Functional Planning, p. 226.

[44]Wentz, "Long-Term Facility," p. 3.

[45]Ibid., p. 29.

[46]American Hospital Association, General Hospital, p. 23.

[47]Robert W. Beckwith, "Extended Care Facilities," Hospitals, XL (April 1, 1966), 66.

[48]Engelmohr, "Long-Term Care Gap," p. 82.

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[51]R. C. Jordan, "Custodial Care or Skilled Nursing Care?", Texas Hospitals, XXIV (June, 1968), 19.

[52]"SSA Issues Guide on Noncovered Care in ECF's," Nursing Homes, XVII (August, 1968), 4.

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[58]Social Security Administration, Bulletin, p. 15.

[59]Mosher and Conners, Wisconsin, p. 8.

[60]Vorseth, "Study," p. 60.

[61]Report of the National Advisory Commission Health Facilities to the President of the United States, B. Jones, Chairman (Washington, D.C.: Government Printing Office, 1968), p. 55.

[62]American Hospital Association, General Hospital, p. 29.

[63]Vorseth, "Study," p. 50.

[64]Mosher and Conners, Wisconsin, p. 12.

[65]U.S., Department of Health, Education, and Welfare, A Report to the President on Medical Care Prices (Washington, D.C.: Government Printing Office, 1967), p. 31.

CHAPTER III

CONCLUSION

The planning considerations to be taken by Saint Joseph Hospital, Fort Worth, Texas, in establishing an extended care facility are:

1. The objectives and philosophy should be to provide post acute care to selected patients thereby enhancing continuity of care.

2. The admission and disposition policies must be commensurate with the objectives, be written, and adhere to the standards outlined by the Social Security Administration.

3. The patient services in the extended care facility should be supplied by the hospital staff except for a department of rehabilitation which should be organic to the extended care unit.

4. The ECF was determined by survey to be acceptable to the house staff; however, the physicians must be included in all aspects of the proposed addition to insure their continued acceptance.

5. The nursing staff requirements should be determined based on the most current Social Security regulations and for the individual nurse's ability to work with and relate to the extended care patient.

6. The size of the facility should be not greater than seventy-five beds and not less than fifty beds.

7. The actual cost of constructing the extended care facility is by its very nature dependent upon many outside factors; however, the cost per bed should be less than the cost to construct an acute bed in the same facility.

APPENDIX A

ELEMENTS OF PROGRESSIVE PATIENT CARE

THE SIX "LEVELS OF CARE"

Below are described the six "levels of care" which are the elements of Progressive Patient care.

Intensive Care

For critically and seriously ill patients who are unable to communicate their needs or who require extensive nursing care and observation. These patients are under close observation of nurses who have been selected because of their special skills, training, and experience. All necessary lifesaving emergency equipment, drugs, and supplies are immediately available.

Intermediate Care

For patients requiring a moderate amount of nursing care. Some of these patients may be ambulatory for short periods of time. Emergency care and frequent observation are rarely needed. Included in this group are those patients who are beginning to participate in caring for themselves. In addition, the terminally ill may be cared for here.

Self-Care

For ambulatory and physically self-sufficient patients requiring therapeutic or diagnostic services, or who may be convalescing. In this homelike atmosphere provision is made for relaxation and recreation. Here the patient is instructed in self-care within the limits of his illness.

Long-Term Care

For patients requiring skilled prolonged medical and nursing care. Rehabilitation, occupational therapy, and physical therapy services may be needed for these patients. In addition, emphasis is placed on instructing those patients who must learn to adjust to their illness and disability.

Home Care

For patients who can be adequately cared for in the home through the extension of certain hospital services. A hospital based home care program provides personnel and equipment from the hospital or through community agencies,

such as the local health department of the Visiting Nurse Association. The hospital, however, usually assumes responsibility for coordinating the services, whether they are furnished by the hospital or another agency.

Outpatient Care

For ambulatory patients requiring diagnostic, curative, preventive, and rehabilitative services.

Source: Public Health Service, Elements of Progressive Patient Care.

APPENDIX B

CONDITIONS OF PARTICIPATION FOR EXTENDED CARE FACILITIES

CONDITIONS OF PARTICIPATION

I. The extended care facility is in conformity with all applicable federal, state, and local laws, regulations, and similar requirements.

II. The extended care facility has an effective governing body legally responsible for the conduct of the facility, which designates an administrator and establishes administrative policies.

III. There are policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses.

IV. The extended care facility admits patients in need of skilled nursing care only upon the recommendation of a physician; their health care continues under the supervision of a physician; and the facility has a physician available to furnish necessary medical care in case of emergency.

V. The extended care facility provides 24-hour nursing service which is sufficient to meet the nursing needs of all patients. There is at least one registered professional nurse employed full-time and responsible for the total nursing service. There is a registered professional nurse or licensed practical nurse who is a graduate of a state approved school of practical nursing in charge of nursing activities during each tour of duty.

VI. The dietary service is directed by a qualified individual and meets the daily dietary needs of patients.

VII. Restorative services are provided under medical direction.

VIII. Whether drugs are generally procured from a community pharmacy or stocked by the facilities, the extended care facility has methods and procedures for its pharmaceutical services that are in accord with accepted professional practices.

IX. The extended care facility has an arrangement for obtaining required clinical laboratory, X-ray and other diagnostic services.

X. The extended care facility assists patients to obtain regular and emergency dental care.

XI. Services are provided to meet the medically related social needs of patients.

XII. Activities suited to the needs and interests of patients are provided as an important adjunct to the active treatment program and to encourage restoration to self care and resumption of normal activities.

XIII. A clinical record is maintained for each patient admitted, in accordance with accepted professional principles.

XIV. The extended care facility has in effect a transfer agreement (meeting the requirements of section 1861(1) of the Social Security Act) with one or more hospitals which have entered into agreements with the secretary to participate in the program.

XV. The extended care facility is constructed, equipped, and maintained to insure the safety of patients and provides a functional, sanitary, and comfortable environment.

XVI. The extended care facility provides the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

XVII. The extended care facility has a written procedure to be followed in case of fire or other disaster.

XVIII. The extended care facility has in effect a plan for utilization review which applies at least to the services furnished by the facility to individuals entitled to benefits under the law. An acceptable utilization review plan provides for: (1) the review on a sample or the basic, of admissions, duration of stays, and professional services furnished; and (2) review of each case of continuous extended duration.

Source: U.S., Department of Health, Education, and Welfare, Social Security Administration, Conditions of Participation for Extended Care Facilities (Washington, D.C.: Government Printing Office, 1966).

APPENDIX C

GENERAL EXTENDED CARE INSTITUTION

GENERAL EXTENDED CARE INSTITUTION

Definition: Extended Care Institutions, General: Establishments with organized medical staffs; with permanent facilities that include inpatient beds; and with medical services, including physician services and continuous nursing services, to provide treatment for patients who require inpatient care but are not in an acute phase of illness, who currently require primarily convalescent or restorative services, and who have a variety of medical conditions.

Essential Characteristics for Classification

1. The primary function of the institution is to provide treatment for patients who require inpatient care but who are not in an acute phase of illness; who currently require primarily convalescent or restorative services; and who have a variety of medical conditions.

2. There are arrangements for transfer of patients in need of hospital care for acute phases of illness.

3. The institution maintains inpatient beds.

4. There is a governing authority legally responsible for the conduct of the institution.

5. There is an administrator to whom the governing authority delegates the full-time responsibility for the operation of the institution in accordance with established policy.

6. There is an organized medical staff of the institution, or one that serves the institution through an affiliation, to which the governing authority delegates responsibility for maintaining proper standards of medical care.

7. A current and complete medical record is maintained for each patient.

8. Each patient is admitted on the medical authority of, and is under the supervision of, a physician.

9. Registered professional nurse supervision and other nursing services are continuous.

10. Diagnostic x-ray service and clinical laboratory service are regularly and conveniently available.

11. There is control of the storage and dispensing of narcotics and other medications.

12. Food served to patients meets their nutritional requirements, and special diets are regularly available.

Source: American Hospital Association, Classification of Health Care Institutions (Chicago: American Hospital Association, 1968).

APPENDIX D

SPECIAL EXTENDED CARE INSTITUTION

SPECIAL EXTENDED CARE INSTITUTION

Definition: Extended Care Institutions, Special: Establishments with organized medical staffs; with permanent facilities that include inpatient beds; and with medical services, including physician services and continuous nursing services, to provide treatment for patients who require inpatient care but are not in an acute phase of illness, who currently require primarily convalescent or restorative services, and who have specified medical conditions (e.g., cerebrovascular accident).

Essential Characteristics for Classification

1. The primary function of the institution is to provide treatment for patients who require inpatient care but who are not in an acute phase of illness; who currently require primarily convalescent or restorative services; and who have specified medical conditions.

2. There are arrangements for transfer of patients in need of hospital care for acute phases of illness.

3. The institution maintains inpatient beds.

4. There is a governing authority legally responsible for the conduct of the institution.

5. There is an administrator to whom the governing authority delegates the full-time responsibility for the operation of the institution in accordance with established policy.

6. There is an organized medical staff of the institution or one that serves the institution through an affiliation, to which the governing authority delegates responsibility for maintaining proper standards of medical care.

7. Each patient is admitted on the medical authority of, and is under the supervision of, a physician.

8. A current and complete medical record is maintained for each patient.

9. Registered professional nurse supervision and other nursing services are continuous.

10. Diagnostic x-ray service and clinical laboratory service are regularly and conveniently available.

11. There is control of the storage and dispensing of narcotics and other medications.

12. Food served to patients meets their nutritional requirements, and special diets are regularly available.

Source: American Hospital Association, Classification of Health Care Institutions (Chicago: American Hospital Association, 1968).

APPENDIX E

PHYSICIANS' ATTITUDE STUDY

SAINT JOSEPH HOSPITAL,

FORT WORTH, TEXAS

PHYSICIANS' ATTITUDE STUDY

The General Design

This study was undertaken to determine the acceptability of an extended care unit to the medical staff of St. Joseph Hospital. The text, Probability Sampling of Hospitals and Patients, by Hess, Riedel, and Fitzpatrick, served as the authoritative reference.[1]

Preparatory Work

The universe

Since the universe of medical staff members is changing constantly, it was defined and listed for a specific study period--the most recent calender year, 1969. A full year was a minimum requirement in order that the study reflect variations in physician admissions by days, weeks, months, and seasons. Appendix F delineates the universe statistics. A list of the hospital services performed during 1969 was obtained and reviewed.[2] Each staff member was classified according to the number of patients he had admitted during the year, broken down by age, diagnosis, service, length of patient stay, financial status, and sex.

The sample size

Sampling theory provides techniques to estimate sample size to produce maximum precision per dollar of cost of the study within administrative restrictions. The sample for this study, however, was arranged to encompass all physicians (excluding psychiatrists and dentists) who had admitted twenty-five or more patients during the calender year of 1969. There were several reasons for the selection of this sample: (1) cost was not a factor, (2) the limitations on time did not permit a pilot study to collect data for sample design, (3) the sample was logical. The required physicians' names were extracted from a recent administrative report[3] and the sample size was determined to be 106 physicians. This number was reduced to 104 because two physicians had expired since the report was published.

The survey instrument

A mailed questionnaire was used to gather the research data (Appendix G). Questionnaires were mailed to the 104 physicians previously identified.

In developing the questionnaire, two primary factors were considered: (1) one basic question which would provide a general view of the physicians' attitudes; and (2) clear, concise, and non-objectionable wording. The questionnaires were mailed on Tuesday, April 14, 1970.

Responses and data analysis

A total of seventy-four responses were obtained by the predetermined cut-off date of Monday, April 27, 1970. Of this number, one was declared invalid because of improper completion, i.e., checking "yes" on all three blocks.

Options one and two were assumed to show acceptance of the concept while option three was assumed to show rejection. The results are contained in Table 3, page 40, Chapter II.

Footnotes

[1]Irene Hess, Donald C. Reed, and Thomas B. Fitzpatrick, Probability Sampling of Hospitals and Patients (Ann Arbor: The University of Michigan, 1961), pp. 26-54.

[2]Saint Joseph Hospital, Analysis of Hospital Services, January 1, 1969 through December 31, 1969 (computerized).

[3]Sister Mary Therese, "Medical Staff Analysis" (unpublished administrative report submitted to the Department of Hospital Administration, Saint Louis University, 1970), pp. 2-7.

APPENDIX F

COMPOSITION OF ST. JOSEPH HOSPITAL'S MEDICAL STAFF

COMPOSITION OF ST. JOSEPH HOSPITAL'S
MEDICAL STAFF

January, 1970

Physician Departmental Classification

	Number of M.D.'s	Per Cent of Total Staff
Anesthesia	15	3.6
Medicine	118	28.0
Neuropsychiatry	20	4.8
Ophthalmology	16	3.8
Orthopedics	22	5.2
Pathology	8	1.9
Radiology	21	5.0
Surgery	201	47.7
TOTAL	421	100.0%

COMPOSITION OF ST. JOSEPH HOSPITAL'S
MEDICAL STAFF

January, 1970

Staff Physicians

	Number of M.D.'s	Per Cent of Total Staff
Active	129	30.2
Courtesy	265	62.2
Provisional	16	3.8
Dental - Provisional	2	0.5
Dental - Active	5	1.2
Dental - Courtesy	4	0.9
Honorary	5	1.2
TOTAL	426	100.0%

APPENDIX G

PHYSICIAN QUESTIONNAIRE

SAINT JOSEPH HOSPITAL,

FORT WORTH, TEXAS

saint joseph hospital
1401 SOUTH MAIN STREET • FORT WORTH, TEXAS 76104 • AREA CODE 817 336-9371

13 April 1970

Dear Doctor

St. Joseph's Hospital, Fort Worth, is cooperating in the Graduate Program conducted by the U.S. Army - Baylor University in Health Care Administration. In partial fulfillment of the requirements for the Master of Hospital Administration degree, I am conducting a research study which will provide the basic framework of my thesis. This study is concerned with the feasibility of extended care facilities operated by short-term, non-profit, voluntary hospitals.

The rationale for hospital operated extended care facilities as a distinct part of an institution is three fold: (1) continuity of care for the patient; (2) more effective use of personnel; and (3) increased economy for the hospital and patient. Patients admitted to such a facility should require skilled nursing and/or rehabilitative care. However, service areas such as Surgery, Emergency Room, and the like would be maintained only by the parent institution.

As you know, this concept of extended care facilities, in a short-term general hospital is a relatively new development in the health care field. A review of the literature has revealed many different physicians' perspectives concerning such a program.

I would appreciate your completing the attached form. You may be assured that the information you render will be held in strictest confidence.

Enclosed is a postage paid, self-addressed envelope for your convenience. Thank you for your kind assistance and consideration in making this study a success.

Respectfully yours,

James P. Creighton, Jr.
Major, MSC

JPC/kld

Specifically, if Saint Joseph Hospital were to establish an Extended Care Facility as a distinct part of, but adjacent to, their existing hospital:

A. Would you be favorably inclined toward the rationale of such a program? YES_____ NO_____

B. Would you be enthusiastic toward the rationale of such a program? YES_____ NO_____

C. Would you be opposed toward the rationale of such a program? YES_____ NO_____

APPENDIX H

PATIENT CARE NEEDS QUESTIONNAIRE

SAINT JOSEPH HOSPITAL

FORT WORTH, TEXAS

Nursing Unit _____

Date _____

Administration
ATTN: Maj. Creighton

PATIENT CARE NEEDS

Considering the medical condition of this patient RIGHT NOW, which level of care meets his need? (Check only one)

1. ____ The patient is critically, seriously or acutely ill, and requires constant observation and treatment with quick access to lifesaving drugs and equipment.

2. ____ The patient is moderately ill, extreme symptoms subsiding or absent; requires periodic observation or treatment and routine hospital services.

3. ____ The patient is ambulant and physically self-sufficient but requires nursing supervision and/or diagnostic or therapeutic services not feasible on an outpatient or office basis.

4. ____ The patient is expected to be hospitalized over 30 days; patient's condition is not stable and may improve slowly or deteriorate; requires rehabilitation or physical therapy services and skilled nursing care (extended care).

5. ____ The patient's condition is generally stable; requires a level of general nursing care and periodic medical supervision normally found in nursing homes.

6. ____ The patient is chronically ill and may be cared for under suitable home conditions, but requires periodic visits by a physician, nurse, social worker, etc.

7. ____ The patient requires the services of facilities normally found in a physician's office or outpatient facility.

Age:

1. ____ Under 12
2. ____ 13 - 15
3. ____ 16 - 19
4. ____ 20 - 29
5. ____ 30 - 39
6. ____ 40 - 49
7. ____ 50 - 59
8. ____ 60 - 64
9. ____ Over 64

Sex: ____ Male

____ Female

Diagnostic Classification:
(Check only one)

1. ____ Medical
2. ____ Surgical
3. ____ Orthopedic

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ABSTRACT

A STUDY OF EXTENDED CARE FACILITIES AT SAINT JOSEPH HOSPITAL, FORT WORTH, TEXAS

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Major James P. Creighton, Jr., MSC

August, 1971 88 Pages

The problem was to determine the planning considerations to be taken by Saint Joseph Hospital, Fort Worth, Texas, in establishing an extended care facility.

In resolving this problem it was first necessary to examine the major factors that influenced the evolution and development of extended care facilities in general hospitals. The conflicting or overlapping definitions of extended care found in the literature were assimilated and reviewed. A survey of the physicians' attitudes toward the concept and rationale of extended care facilities in short-term hospitals was accomplished by means of a questionnaire. A patient-needs survey was accomplished to determine the number of patients who would qualify for transfer to the extended care facility.

It was concluded that the planning considerations to be taken by St. Joseph's are: (1) to develop the philosophy and define the objectives of the extended care unit; (2) to determine the admission and disposition policies; (3) to determine the range of services to be provided by the extended care facility staff; (4) to determine the acceptability to physicians of such a course of action; (5) to develop the nursing staff requirements; (6) to determine the optimum size of the extended care facility; and (7) to examine the costs of construction.