Practical Class 7

Hospital Care — Functions, Structure, Organization, Hospitalization, and Quality

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Conspectus topics (43, 44, 45)

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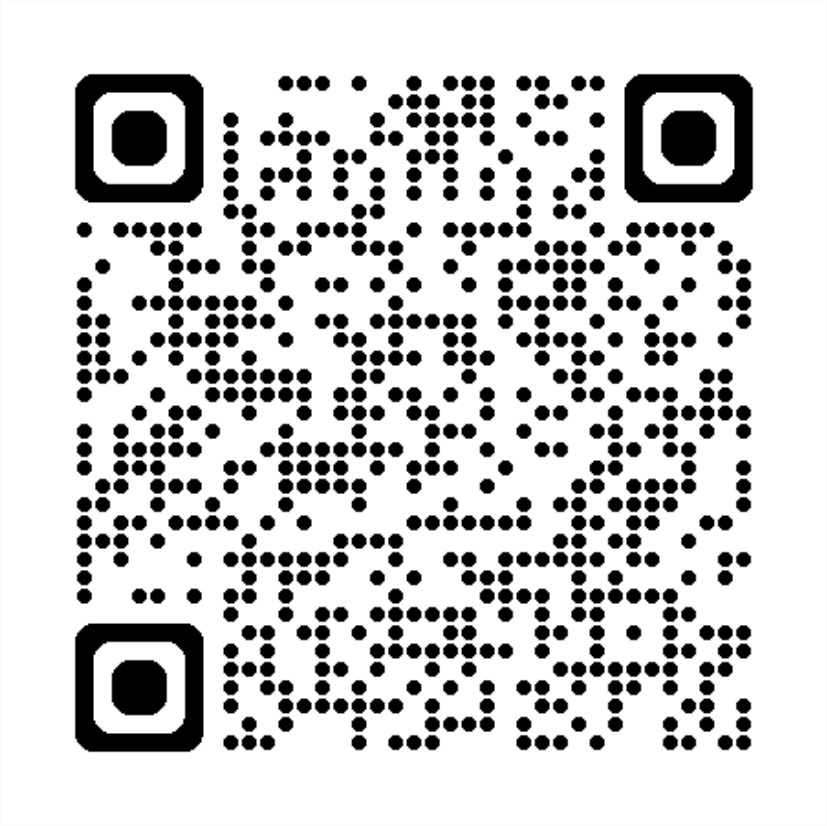
download the presentation from https://tinyurl.com/social-med-class-07

15-minutes reading assignment



https://kostadinoff.github.io/learning.html

Group tasks

https://kostadinoff.github.io/tasks.html

Outline

1. Definition and Activities
2. Classification of Hospitals
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5. Hospital Funding
6. Hospitalization
7. Factors and Indications
8. Access, Fees, Patient Choice

9. Rights and Obligations
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11. Quality of Hospital Care
12. Patient and Family Experience
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Definition and Activities

Hospital Medical Care — Definition (43)

- **Hospital medical care** is an integral component of the healthcare system, providing highly skilled and technologically advanced medical services to patients whose health needs cannot be adequately addressed through other elements of the healthcare continuum.
- Hospitals serve as **referral destinations** for conditions requiring:
  - Specialized diagnostic capabilities
  - Intensive therapeutic interventions
  - Continuous monitoring beyond the capacity of primary or outpatient settings

Hospitals must ensure **continuous 24-hour performance** of medical activities across all specialties in their operating permit, including emergency care at all times.

Core Activities of Hospitals (43)

- Diagnosis and treatment of diseases when the therapeutic goal cannot be achieved in outpatient care
- Maternity care throughout pregnancy and childbirth
- Rehabilitation aimed at functional restoration
- Consultations requested by physicians or dental practitioners from other facilities
- Transplantation of organs, tissues, and cells
- Blood services — collection, storage, supply, and transfusion management
- Dispensary care — pharmaceutical support
- Clinical trials of medicinal products and medical devices
- Educational and scientific activities

Classification of Hospitals

By Duration of Treatment (43)

Type	Purpose and patient population
Active treatment	Acute illnesses, traumatic injuries, exacerbations of chronic diseases requiring surgery, and maternity care — rapid diagnostics, intensive intervention, brief stays
Continuous treatment	Prolonged health restoration; chronic diseases requiring ongoing care and maintenance of satisfactory physical and mental condition
Rehabilitation	Physical therapy, motor and mental rehabilitation, balneotherapy, climatotherapy, thalassotherapy
Continuous treatment and rehabilitation	Combines extended care with rehabilitation under coordinated clinical oversight

By Specialization (43)

- Multiprofile hospital — departments or clinics in **at least two** medical specialties, enabling coordinated multidisciplinary care and resource sharing.
- Specialized hospital — departments or clinics in **one primary** medical or dental specialty and related profiles. Often functions as a referral center for complex cases (e.g., oncology, psychiatry).
- University hospital — multiprofile or specialized, designated by the **Council of Ministers** for clinical training of medical, dental, and pharmacy students, doctoral candidates, and postgraduate trainees. Fulfills dual missions: patient care and education.

By Territorial Scope (43)

Level	Service area
District	Geographically defined areas within larger municipalities — organized by neighbourhood in major cities
Municipal	Entire municipality — more comprehensive service arrays, referral destination for district facilities
Regional	Multiple municipalities in the region — primary referral centre with specialized capabilities
National	Entire territory — highest-level facilities, most specialized and complex services (e.g., National Cardiology Hospital)

By Ownership and Legal Form (43)

Ownership:

- Municipal — e.g., MHAT “St. Mina” SPLLC
- State-owned — under the Ministry of Health, Council of Ministers, Ministry of Defence, Ministry of Interior, Ministry of Transport
- Private — equal legal status, subject to same quality regulations

Commercial legal forms:

- Limited Liability Company (LLC)
- Sole Proprietorship LLC (SPLLC)
- Joint-Stock Company (JSC)
- Sole Shareholder JSC (SSJSC)

Structure and Organization

Hospital Structural Blocks (43)

Block	Components
Consultative-diagnostic	Registration area, consultative cabinets, medical-diagnostic and medical-technical laboratories, departments without beds, emergency department with beds for diagnostic clarification up to 24 hours
Inpatient (stationary)	Clinics and departments with beds — patient rooms, diagnostic cabinets, manipulation rooms; the core of hospital activity
Administrative-economic	Administrative, economic, and service units: hospital pharmacy, central sterilization, laundry, food services, maintenance, information systems

Bed Organization and Classification (43)

The basic structural unit is the **department or clinic with beds**.

Bed type	Subcategories
Active treatment	Intensive care, obstetric-gynecological, pediatric, therapeutic, surgical
Long-term care	Continuous treatment, palliative care
Rehabilitation	Functional restoration
Psychiatric	Mental health treatment

Minimum 5 beds per department/clinic (except ICU and obstetric care).

At least 10% of active treatment beds must be reserved for emergency admissions.

Competence Levels (43)

Hospital clinics, departments, and laboratories operate at **defined competence levels** determining the scope and complexity of activities they may perform:

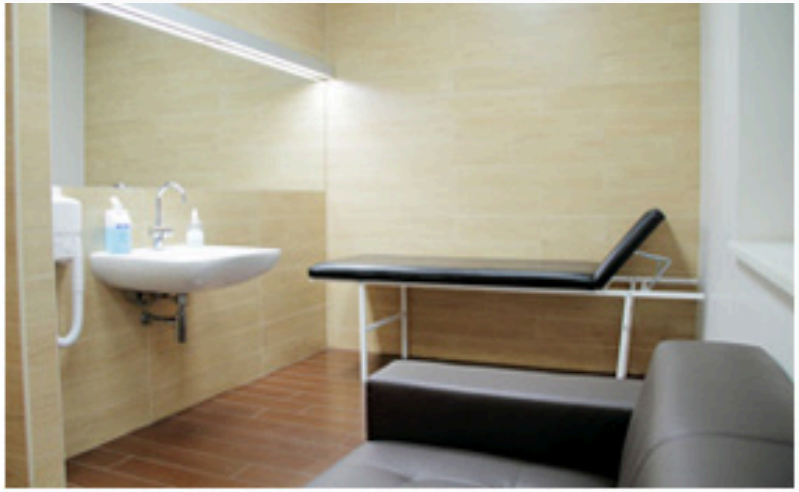
- First level — lowest scope
- Second level — intermediate
- Third level — highest, broadest scope

Level assignment considers:

- Minimum staffing with specialized physicians
- Minimum equipment requirements
- Minimum activity volume
- Support from other medical specialties
- Additional qualification requirements

These are specified per specialty in the approved **medical standards**.

Bulgaria’s Hospital Network (43)



Bulgaria’s Hospital Network (43)

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Hospital Functions | Governance

Hospital Functions (43)

- Clinical-medical — diagnosis, treatment, rehabilitation, obstetric care, organ transplantation
- Consultative — expert opinions and evaluations requested by physicians from other facilities
- Promotional — patient and family education during hospitalization to support health improvement
- Preventive — primary (health promotion), secondary (case-finding during hospitalization), tertiary (minimizing complications)
- Social — identifying social determinants, psychosocial adaptation, hospitalization for social indications, coordination with social services
- Qualification — professional development, specialization, continuing education
- Economic — provision, management, and investment of substantial financial resources

Social Functions — Detail (43)

Hospitals assess social determinants affecting illness and recovery at three stages:

- Upon admission — assessment of social status, contact with social services when needs are identified
- During treatment — stays may be prolonged when social circumstances would compromise recovery or safety following discharge
- At discharge — treatment regimens and medication therapy adapted according to social conditions; when family support is absent, the hospital informs the **Social Assistance Directorate** for social service placement

Internal Governance Structure (43)

- **Director / Executive Director** — Master's in medicine or dentistry + health management qualification; or Master's in economics and management + health management
- **Board of Directors** — state and municipal hospitals: single-tier management, 3 members, competitive appointment
- **Chief Nurse / Midwife / Rehabilitator** — Bachelor's or Master's in healthcare management; coordinates care quality, hospital hygiene, infection control, and postgraduate training
- **Clinical Unit Heads** — physicians with recognized specialty matching the unit's profile; clinic heads must hold an academic rank (docent or professor)

Mandatory Internal Bodies (43)

Established by order of the hospital director:

- Medical council — clinical policy and discussion
- Medical-control commission — quality of care oversight
- Commission on nosocomial infections — surveillance and prevention
- Healthcare advisory council — operational and quality matters
- Additional committees as needed: medical ethics, pharmaceutical policy, information systems

A **consultative council** of clinic and department heads also supports the director. Owners may establish a **hospital board** with public figures, donors, and NGO representatives for community outreach.

Hospital Funding

Funding Sources (43)

Source	Mechanism
NHIF (fund financing)	Primary purchaser of hospital care — reimburses services through clinical pathways, ambulatory procedures, and clinical procedures
State and municipal subsidies	Emergency care, inpatient psychiatric care, infectious disease readiness, capital investments, sustaining hospitals in remote areas
Budget financing	Educational missions, research activities, public health services beyond individual patient care
Own revenue	Patient co-payments, fees for additional services
Other sources	Voluntary health insurance, donations, EU subsidies, clinical trials

Clinical Pathways — The NHIF Reimbursement Model (43)

Clinical pathways represent the central reimbursement mechanism. Each pathway defines:

- A complete **diagnostic-therapeutic algorithm** for a specific disease category
- **ICD-10 codes**, required diagnostic criteria, and severity thresholds
- **Mandatory minimum hospital stay** (typically ≥ 48 hours)
- **Discharge criteria** with mandatory objective documentation
- Required structural units, equipment, and specialist qualifications

The NHIF pays hospitals a **regulated amount per documented case** of treatment delivered under agreed clinical pathways.

High-cost add-ons — specific implantable devices, oncology medications, and drugs for life-threatening haemorrhages — are reimbursed outside the standard pathway value.

Financing Methods (43)

Method	Characteristics
General budget	Based on previous year's expenditures — predictable but limited efficiency incentives
Retrospective payment	Reimbursement after services delivered
Prospective payment	Pre-determined rates per case (e.g., clinical pathways) — incentivizes efficiency
Combined	Mixed approaches integrating multiple methods

State-owned hospitals must conduct **financial monitoring**: current results, equity-to-attracted-capital ratio (financial autonomy coefficient), and liquidity coefficients.

Uninsured Patient Coverage (43, 44)

While uninsured individuals generally pay for their own care, the **state budget** directly reimburses hospitals for:

- Emergency care and intensive care for uninsured patients
- Obstetrical care for uninsured pregnant women
- Life-saving interventions regardless of insurance status

No medical establishment may refuse care to persons in life-threatening conditions, regardless of place of residence or insurance status.

Hospitalization

Hospitalization — Definition (44)

Hospitalization is the process of decision-making, admission, accommodation, and adaptation when patients transition from community or outpatient settings into inpatient hospital environments.

It encompasses:

- The determination that hospital care is the appropriate setting
- All activities implementing this decision
- The patient's subsequent **adaptation** to hospital conditions

Related concepts:

- **Transfer** — discharge from one hospital, transportation, and admission to another
- **Private nursing station** — supplementary individualized care by hospital nurses beyond routine care
- **Healthcare team** — the physician performing interventions + at least one additional specialist or healthcare professional

Types of Hospitalization (44)

Emergency hospitalization

- Life-threatening conditions, urgent surgical treatment, or severe conditions requiring apparatus-based monitoring of vital functions
- Arranged by the on-duty team in the emergency department
- Bypasses routine scheduling — delay would create unacceptable risk
- At least 10% of active treatment beds reserved for emergencies

Planned hospitalization

- Pre-scheduled admission date
- Scheduled surgeries, chronic disease management, comprehensive diagnostics, periodic treatments (transfusions, haemodialysis)
- Requires that delay does not compromise outcomes
- If capacity unavailable — **waiting list** with serial numbers and scheduled dates

Referral Requirements (44)

Hospital admission typically requires a **referral** issued by:

- General practitioners or outpatient specialists
- Emergency departments
- Consultative clinics
- Commission establishments (work capacity and disability assessment)

Referrals are valid for **30 calendar days** from issuance (NFC 2026–2028).

Exception: no separate referral needed if the patient was examined by physicians in the **consultative-diagnostic block** of the admitting hospital within 30 days before admission.

Pre-hospitalization test validity:

- Laboratory tests: up to 7 days
- Imaging examinations: up to 30 days

Factors and Indications

Determinants of Hospitalization Decisions (44)

- Disease nature and course — acute vs. chronic presentation, severity, infectious characteristics, public health considerations
- Patient personality factors — cultural expectations, stress tolerance, psychobiological traits, economic and family pressures
- Family and social conditions — availability of caregivers, housing conditions, occupational factors, social isolation
- Physician decision-making — training background, social medicine awareness, understanding of patient circumstances, medical ethics
- Hospital-related factors — bed capacity, department availability, institutional interests, financial incentives from reimbursement systems

Indications for Hospitalization (44)

- Medical indications — diagnosis, disease stage, comorbidities, or overall condition creates clinical requirements best met through inpatient care. Under the clinical pathway system, specific ICD codes and severity thresholds must be met.
- Social indications — the patient's condition may permit home treatment, but impossibilities regarding medication procurement, care provision, or environmental conditions necessitate hospitalization (poverty, absence of caregivers, inadequate housing, social isolation).
- Medico-social (mixed) indications — medical and social prerequisites intertwine inseparably. Example: an elderly patient living alone with moderate dementia who develops pneumonia — both the acute illness and inability to self-care justify admission.

Access, Fees, Patient Choice

Patient Access and Choice (44)

Patients have the right to:

- **Choose a hospital freely** — without geographic restrictions within Bulgaria
- **Choose a treating team** — exercise preferences regarding specific practitioners

During hospital stays, patients may purchase **additional services**:

- Improved living conditions — private rooms with enhanced amenities
- Additional care — private nursing stations, supplementary staff, tailored menus
- Choice of physician or team — specific doctor or surgical team for treatment

The **general practitioner** may visit the hospitalized patient and obtain information on their condition.

Upon discharge: 2 free follow-up examinations within 30 days.

Out-of-Pocket Payments and User Fees (44)

Item	Amount / rule
Daily user fee	€0.50 per day, capped at **10 days/year**
Choice of physician	Maximum €256
Choice of team	Maximum €460
Medical devices	Patient pays at hospital purchasing price if not NHIF-covered
Uninsured patients	Full cost at hospital-determined prices (except state-covered emergencies)

Prohibited: differential pricing by procedure complexity, physician rank, academic degree, or length of service.

Fee Exemptions and Anti-Corruption Measures (44)

User fee exemptions apply to: children (minors), pregnant women, socially disadvantaged individuals, war veterans and disabled veterans, medical professionals, patients with malignant tumours, individuals with >71% reduced work capacity, detained persons.

Anti-corruption safeguards:

- Patients and relatives cannot donate to the treating hospital from 1 month before hospitalization until completion of the diagnostic-treatment process
- Hospitals cannot charge co-payments for services already covered by the NHIF package

Accompanying persons:

- No charge for companions of children under 7, or under 18 if additional care needed
- No charge for companions of persons with disabilities who cannot self-care

Rights and Obligations

Patient Rights (44)

- Be visited by their **general practitioner** and the specialist who issued the referral
- Accept or refuse visitors
- Access services of a **psychotherapist, lawyer, or clergy**
- Education and activities meeting social, religious, and cultural needs
- Receive **information on costs** of each medical service, procedure, and medication
- Bring personal belongings (except in ICU / anaesthesiology)
- Receive **full hospital care and respect for human dignity**
- **Accept or reject** proposed treatment and care, except where prohibited by law
- Use **medical devices** at hospital purchasing price when NHIF coverage is absent

Patient Obligations (44)

- **Comply** with the diagnostic-treatment regimen and hospital internal rules
- **Cooperate** with physicians, nurses, and staff for timely examinations and procedures
- Be present in bed during medical rounds; silence phones and TVs; maintain quietude
- Strictly follow prescribed **dietary and activity regimens**
- Treat staff **with respect**; respect other patients' rights
- Maintain **personal hygiene**
- NOT bring alcohol, cigarettes, or gambling materials into clinical areas
- NOT smoke on hospital premises (except designated areas)
- Keep rooms, corridors, and toilets **clean**

These obligations represent reasonable requirements for **institutional communal living** serving therapeutic purposes.

Social Group of Hospitalized

Hospitalized Patients as a Social Group (45)

Inpatients form **small social groups** with continuous member turnover through admissions and discharges.

Key characteristics:

- Approximates a **domestic group** — needs extend to comfort, nutrition, privacy, social interaction, and family connection
- **Heterogeneous** in age, education, profession, marital status — homogeneous only in being "patients"
- Greater **physical dependence** on medical staff for care than in outpatient settings
- Persistent **family engagement** — separation anxiety, concern for dependants
- Susceptibility to **collective mood** — pessimistic ward atmospheres can spread regardless of individual clinical circumstances

The egrotogenic potential of hospitalization: social dynamics within the institution can generate illness-related distress beyond the physiological disease process.

Patient Categorization in Hospital (45)

By condition:

- Intensive care — continuous monitoring and emergency intervention
- General ward — regular oversight
- Infectious — isolation to prevent transmission

By gender: separate wards in psychiatric hospitals; typically mixed elsewhere

By patient orientation to hospitalization:

- Actively positive — desire hospitalization, cooperate fully
- Actively negative — refuse hospitalization despite recommendations (documented refusal required)
- Neutrally compliant — passive acceptance without strong personal opinion
- Passive — cannot assess their situation (e.g., severe illness, emergency admission)

The Therapeutic and Protective Regimen (45)

Each hospital department operates according to established rules governing the **therapeutic and protective regimen**:

- Daily schedules: meals, medication, diagnostics, visiting hours, rest
- **Staff attitudes** toward patients — first impressions, responsiveness, promptness
- **Communication quality** — psychotherapeutic approaches, discretion, awareness of **iatrogenic effect** from careless communication
- **Environmental factors** — interior design, lighting, temperature, noise control, conditions for restful sleep
- Fostering atmospheres of **trust and partnership** — patients as partners rather than passive recipients

Quality of Hospital Care

Quality Regulation and Control (43, 44)

Quality is regulated through **medical standards** and **rules for good medical practice**.

Regulatory bodies:

- Executive Agency "Medical Supervision" — primary state body for quality oversight; planned inspections every 2 years; issues mandatory prescriptions for corrective action
- National Health Insurance Fund — monitors pathway compliance, controls spending
- Regional Health Inspectorates — local oversight and health requirements
- Bulgarian Drug Agency — pharmaceutical quality
- National Audit Office — financial auditing
- Other bodies (Consumer Protection Commission, Medical Audit Executive Agency)

Three Pillars of Quality Assessment (45)

Pillar	Focus
Clinical effectiveness	Do treatments work as intended? — clinical outcomes, evidence-based protocols
Patient safety	Is care delivered without preventable harm? — 1 in 10 patients experiences harm, 50% preventable (WHO, 2024)
Patient experience	Is care respectful, responsive, and aligned with patient values? — satisfaction, communication, dignity

Technical excellence alone is insufficient — quality encompasses both clinical competence and humanistic dimensions.

Patient and Family Experience

Measuring Patient Satisfaction (45)

The primary method: **anonymous questionnaire surveys** — administered after discharge or during follow-up visits.

Complementary methods:

- Open-ended questions enabling patients to describe experiences in their own words
- **Deep interviews** — particularly for regulatory quality checks
- Real-time feedback mechanisms (electronic tablets, text message surveys, online portals)

Subjective care assessments benefit hospital management, funding institutions, accreditation bodies, and policymakers alike.

HCAHPS and Other Standardized Instruments (45)

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems):

- First national standardized publicly reported survey of patient hospital care perspectives
- 32 items including 22 core questions
- Domains: nurse/doctor communication, staff responsiveness, environment (cleanliness, quietness), medication communication, discharge information, care coordination, overall rating

Other instruments:

- Nordic Patient Experiences Questionnaire — core patient experience aspects
- Picker Patient Experience Questionnaire — 15 items; discharge information as top concern

Public reporting creates incentives for improvement and enhances healthcare accountability.

Discharge Planning — IDEAL Framework (45)

The **IDEAL Discharge Planning** framework (Agency for Healthcare Research and Quality):

- **I** — Include patients and families as full partners in discharge planning
- **D** — Discuss potential problems (≈20% of patients readmitted within 30 days)
- **E** — Educate about warning signs, medication management, activity restrictions
- **A** — Assess understanding through teach-back methods
- **L** — Listen to patients' and families' goals, concerns, and constraints

Upon discharge: **epicrisis in 3 copies** — patient, outpatient provider, hospital archive. Contains passport data, final ICD diagnosis, clinical pathway, therapeutic scheme, medications, and follow-up recommendations.

Readmission Risk Factors (45)

≈ 27% of 30-day readmissions are **potentially preventable**.

Key risk factors:

- Therapeutic errors — ≈20% of patients experience post-discharge adverse events; medication issues most common; two-thirds preventable or ameliorable
- Premature discharge — insufficient physiological reserve for home management
- Insufficient follow-up — only ≈50% of readmitted patients had post-discharge visits
- Inadequate post-discharge care — lack of home healthcare, absent caregiver support, poor medication adherence, limited specialist access

Evidence-based models addressing transitions: **Care Transitions Intervention** (4 pillars), **Project Reengineered Discharge** (≈30% reduction in hospital utilization), **Transitional Care Model** (reduced readmissions, improved quality of life).

Performance Indicators

Qualitative Indicators (43, 44)

- Overall mortality rate and **mortality within the first 24 hours** of admission
- Postoperative complications — suppurations, reoperations, hospital-acquired infections
- Percentage of **transfers** to another department or facility
- **Readmission frequency** — unplanned readmissions within 30 days
- Diagnosis concordance — outpatient vs. inpatient, clinical vs. pathological
- Waiting time for hospitalization or refusal of admission
- Hospitalization indications — ratio of medical, social, and mixed indications; expert-assessed justification
- Percentage of complaints and regulatory body inspections

Bed Provision Rate (43)

Bed provision rate = number of hospital beds per 1,000 population.

Classification	Beds per 1,000
Low	< 4
Medium	4 – 7
High	7 – 10
Very high	> 10

Optimal bed supply is a **balance point** — surplus imposes financial burdens and reduces efficiency; deficit prevents meeting population needs and generates delayed care.

Quantitative Indicators — Formulas (43, 44)

$$\text{Admission rate} = \frac{\text{Number of hospitalizations}}{\text{Population}} \times 1,000$$

$$\text{Average length of stay (ALOS)} = \frac{\text{Total patient-days}}{\text{Number of admissions}}$$

$$\text{Bed occupancy rate (\%)} = \frac{\text{Total occupied bed-days}}{\text{Number of beds} \times 365} \times 100$$

$$\text{Bed turnover} = \frac{\text{Number of patients treated}}{\text{Number of beds}}$$

$$\text{Readmission rate (\%)} = \frac{\text{Unplanned readmissions (30 days)}}{\text{Total discharges}} \times 100$$

National Hospital Data — Bulgaria 2024 (43)

Indicator	Value
Hospitals	341
Hospital beds	50,893
Overall bed occupancy	60.1%
Average bed turnover	45 patients/bed
Average length of stay	4.9 days
Patients discharged	2,277,856
Inpatient deaths	28,835
Surgical patients discharged	706,371
Total surgical procedures	944,243
Postoperative complication rate	0.5%
Postoperative mortality	0.7%

Thank you for your attention!