Medical Accounting

- **Fee for Service vs Value Based Care Payment Models**
  Fee for Service vs Value Based Care Payment Models How HCC Coding Affects Risk Adjustment Scores DRGs and Their Role in Hospital Reimbursement Medicare Advantage and Risk Adjustment Strategies Addressing Disparities in Reimbursement Rates Understanding ESRD Risk Adjustment Models The Impact of Chronic Conditions on Reimbursement Optimizing Documentation for Risk Adjustment Challenges in Bundled Payment Models Auditing Risk Adjustment Coding Accuracy State Variations in Medicaid Reimbursement Future of Reimbursement in Telehealth Services
- **Improving Charge Capture Processes in Healthcare**
  Improving Charge Capture Processes in Healthcare Reducing Denial Rates Through Better Documentation Automating Claim Submission for Faster Payments Strategies for Efficient Payment Posting Managing Denials Due to Prior Authorization Using Analytics to Track Revenue Cycle Performance Training Teams for Revenue Cycle Efficiency Addressing Coding Errors in Claim Denials Streamlining Patient Registration Workflows The Role of Clearinghouses in Revenue Cycle Balancing Cost Control and Revenue Growth Case Studies in Revenue Cycle Turnaround
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services, procedures, diagnoses, and equipment into universal medical alphanumeric codes. These codes are crucial for billing purposes and ensure that healthcare providers are reimbursed correctly by insurance companies, government programs like Medicare and Medicaid, or patients themselves. However, as vital as this system is to maintaining a functioning healthcare economy, it has become increasingly apparent that disparities in reimbursement rates can significantly affect both providers and patients.

Addressing these disparities requires a nuanced understanding of how medical coding interacts with broader systemic issues within healthcare. Reimbursement rates can vary widely depending on several factors including geographic location, type of provider (such as hospitals versus independent practitioners), and the demographic characteristics of the patient population served. Accurate placement of medical staff enhances patient trust and satisfaction **medical staffing agencies** economics. These variations often reflect deeper inequities in access to care and resource allocation.

For instance, rural healthcare providers frequently face lower reimbursement rates compared to their urban counterparts due to regional differences in cost structures and payer mix. This discrepancy can contribute to a lack of financial viability for rural health facilities, exacerbating issues related to accessibility for populations already experiencing significant barriers to care. Moreover, areas with predominantly low-income or minority populations may also encounter lower reimbursement rates due to systemic biases within payer systems that undervalue certain types of care more commonly required by these communities.

To address these disparities in reimbursement rates effectively through medical coding practices, there must be concerted efforts at policy levels aimed at standardizing payments more equitably across different regions and populations. This could include revising fee schedules to better reflect the actual costs incurred by providers serving disadvantaged communities or implementing incentive programs that reward quality improvements rather than volume alone.

Moreover, accurate and comprehensive coding is imperative in ensuring fair reimbursement processes. Coding professionals must be trained adequately not only in technical skills but also in cultural competency to understand how social determinants of health might influence coding decisions. They should be equipped with tools necessary for capturing more detailed data about patient encounters which can then inform adjustments in reimbursement schemes that prioritize equity.

Furthermore, embracing technology such as artificial intelligence-driven coding tools might help reduce human error and bias inherent in manual coding processes while enhancing efficiency. Such innovations could potentially harmonize the ways we determine reimbursements by providing clearer insights into patterns of care delivery across diverse settings.

In conclusion, medical coding plays a pivotal role in shaping how resources are distributed within our healthcare system through its direct impact on reimbursement mechanisms. Addressing disparities therein demands an integrated approach that combines technical precision with an acute awareness of equity issues embedded within our current frameworks. By refining these processes thoughtfully alongside broader health policy reforms focused on equity considerations we can take meaningful strides towards building a more just healthcare system where every provider has equal opportunity for fair compensation regardless of external variables beyond their control-and every patient receives quality care irrespective of socio-economic factors influencing their community's infrastructure or demographics.

Title: Factors Contributing to Discrepancies in Reimbursement Rates

In the complex landscape of healthcare, reimbursement rates play a pivotal role in determining how resources are allocated and accessed. However, disparities in these rates often lead to unequal access to care and financial strain on both providers and patients. Understanding the factors that contribute to discrepancies in reimbursement rates is essential for addressing these inequalities and ensuring equitable healthcare delivery.

One of the primary contributors to discrepancies in reimbursement rates is geographical variation. Healthcare costs can vary significantly from one region to another due to differences in cost of living, availability of medical services, and regional health needs. For instance, urban areas may have higher operational costs than rural areas, which can affect the reimbursement rates set by insurance companies or government programs. This geographic disparity can result in rural healthcare providers receiving lower reimbursements despite facing unique challenges such as serving a more dispersed population with limited resources.

Another critical factor is the type of payer system involved, whether it be government-funded programs like Medicare and Medicaid or private insurance companies. Each payer has its own method for calculating reimbursement rates, often based on historical data, negotiated contracts, or policy mandates. Government programs might offer standardized rates that do not adequately account for local variations or changes in market conditions. On the other

hand, private insurers may negotiate different reimbursement terms with various providers based on their bargaining power, leading to significant disparities within the same geographic area.

The complexity of billing codes also contributes to discrepancies in reimbursement rates. The healthcare industry relies heavily on coding systems such as ICD (International Classification of Diseases) and CPT (Current Procedural Terminology) codes to categorize medical procedures and diagnoses for billing purposes. Inaccuracies or inconsistencies in coding can lead to underpayment or overpayment for services rendered. Moreover, smaller practices may lack the administrative support necessary to navigate these complex coding requirements effectively, resulting in further financial disadvantages compared to larger institutions with dedicated billing departments.

Provider characteristics also influence reimbursement rate discrepancies. Specialists often command higher reimbursements than general practitioners due to the perceived complexity and expertise required for specialized services. Furthermore, teaching hospitals may receive additional funding through graduate medical education payments that are not available to community-based facilities. These differences can create an imbalance where certain types of care are more financially sustainable than others, potentially skewing provider focus towards higher-paying specialties at the expense of primary care.

Lastly, socioeconomic factors play a crucial role in shaping reimbursement disparities. Providers who serve low-income populations might experience higher levels of unpaid bills or reliance on Medicaid-a program known for lower reimbursement rates compared to private insurance-leading them into financial precariousness despite high demand for their services.

Addressing these multifaceted contributors requires targeted interventions at both policy and practice levels. Policymakers should consider implementing flexible rate adjustments that reflect regional cost variations while ensuring fair compensation across different types of care settings regardless of size or specialization level offered by individual providers; meanwhile enhancing transparency around payer contracts so all parties understand how decisions impacting finances get made including patients themselves who ultimately bear burdens imposed upon them indirectly via increased premiums etcetera over time if left unchecked without intervention aimed specifically reducing inequities currently present today throughout system-wide operations affecting everyone involved directly/indirectly alike moving forward together collectively toward better future outcomes overall benefiting society whole rather than isolated segments alone only really mattering truly end day after all said done once dust settles finally conclusion reached then hopefully soon enough before too late prevent further damage already caused thus far continuing unabated unchecked otherwise indefinitely until something changes drastically eventually someday soon ideally sooner later possible still

Impact of Fee for Service on Medical Coding Practices

The impact of disparate reimbursement on healthcare providers and patients is a multifaceted issue that underscores the need for addressing disparities in reimbursement rates. At its core, this issue reflects an imbalance in how healthcare services are valued and compensated, leading to a cascade of consequences that affect both providers and patients.

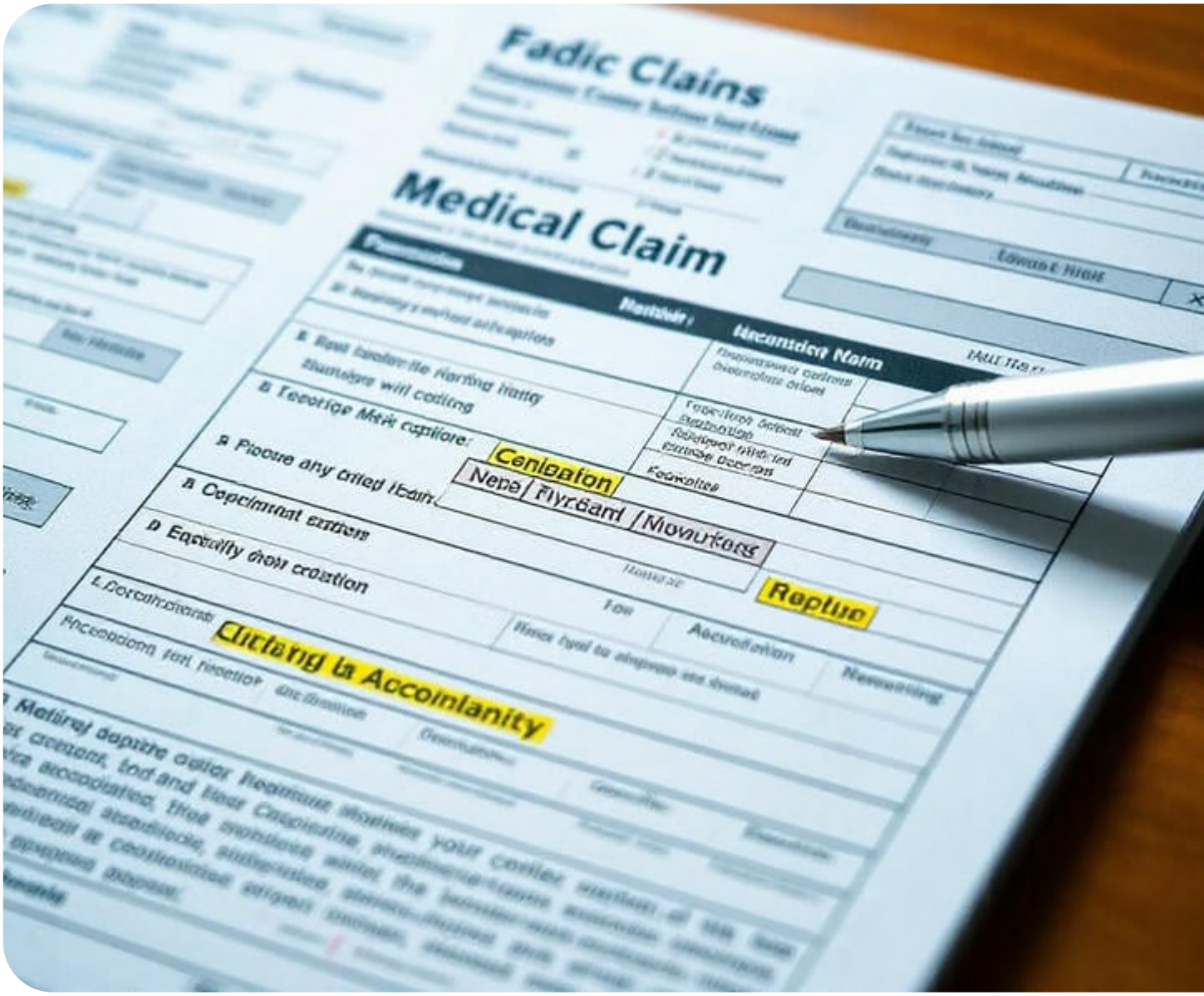
For healthcare providers, disparate reimbursement rates can create significant financial strain. Providers who serve low-income or underserved communities often receive lower reimbursements compared to those operating in affluent areas. This discrepancy is largely due to variations in insurance coverage and the prevalence of government-funded programs like Medicaid, which typically offer lower reimbursement rates than private insurers. As a result, providers may struggle to cover their operational costs, invest in necessary medical technologies, or even retain skilled staff. In extreme cases, this financial pressure can lead to reduced service offerings or the closure of facilities, further exacerbating access issues for vulnerable populations.

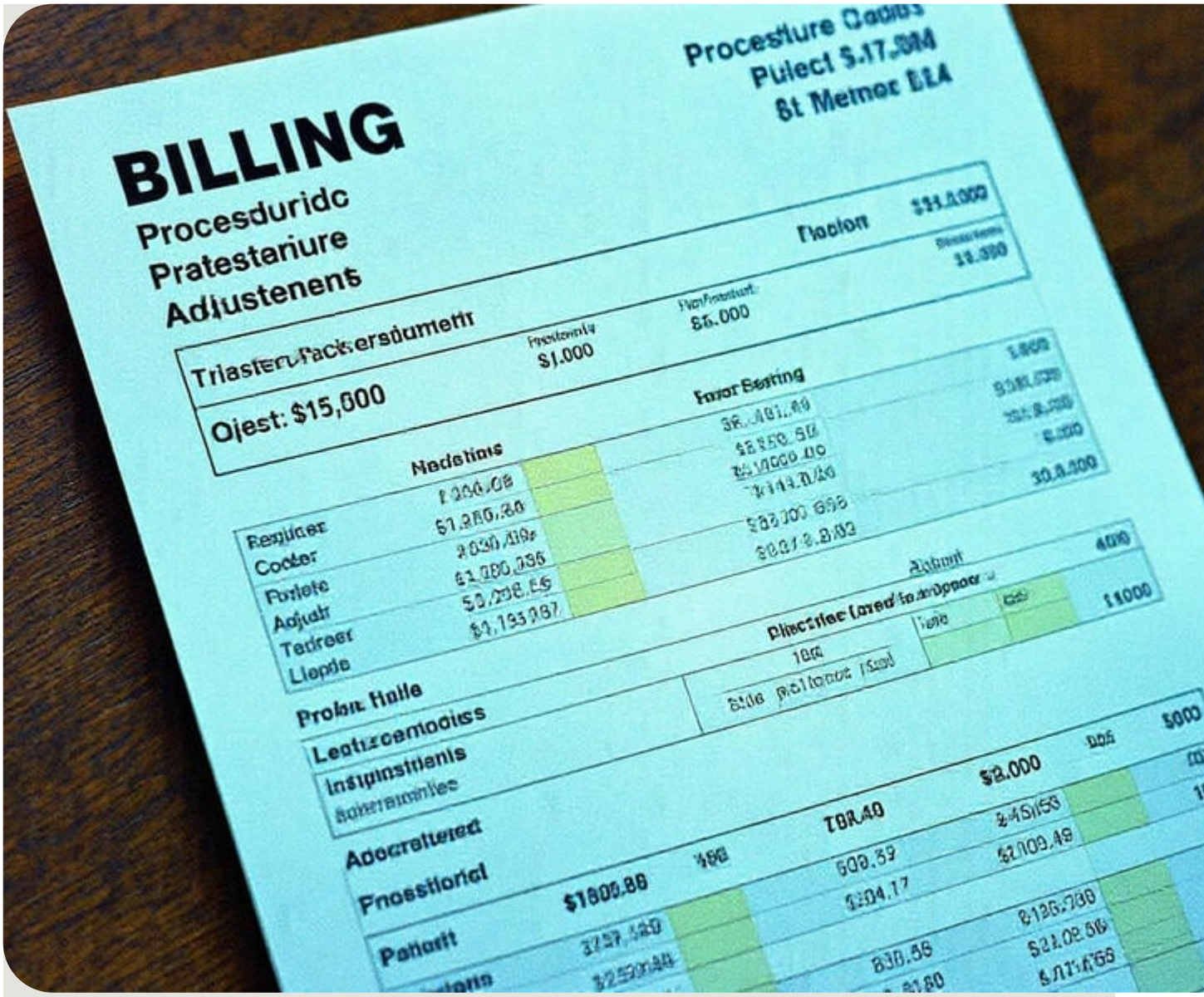
On the patient side, these disparities can result in limited access to quality care. When providers are under-reimbursed, they may be less inclined to accept patients from certain insurance plans or geographic areas synonymous with lower payments. Consequently, patients may encounter longer wait times for appointments or have fewer specialists available within their network. The disparity also fosters inequities in health outcomes; individuals from marginalized communities may not receive timely or comprehensive care due to economic disincentives faced by their local healthcare providers.

Addressing these disparities requires a concerted effort at multiple levels. Policymakers must rethink reimbursement models to ensure fair compensation across different regions and patient demographics. This could involve adjusting payment structures so that they account for social determinants of health and incentivize care in underserved areas. Additionally, there is a need for greater transparency in how reimbursement rates are determined and distributed across various healthcare settings.

Healthcare systems themselves can play a role by adopting value-based care models that reward quality over quantity of services provided. Such models encourage efficient use of resources while prioritizing patient outcomes-potentially offsetting some negative effects of unequal reimbursements.

In conclusion, the impact of disparate reimbursement on healthcare providers and patients is profound and far-reaching. It highlights structural inequities within our healthcare system that demand urgent attention and reform. By addressing these disparities head-on through policy changes and innovative care models, we can work towards a more equitable system where all individuals have access to high-quality healthcare regardless of their economic circumstances or geographic location.





How Value Based Care Influences Medical Coding and Documentation Requirements

In recent years, the healthcare industry has increasingly turned its focus toward identifying and addressing inequities within its systems. One area that has garnered significant attention is medical coding practices and their profound impact on reimbursement rates. The disparities in how different demographics are reimbursed can exacerbate inequalities in healthcare access and quality. Addressing these disparities requires a multifaceted approach, targeting both systemic biases and the technical nuances of medical coding.

Medical coding is the backbone of healthcare billing; it translates complex medical services into standardized codes used for documentation and reimbursement. However, this seemingly straightforward process is fraught with challenges that can lead to inequities. For instance, certain demographic groups may receive less accurate or inadequate coding due to implicit biases or lack of awareness among healthcare providers about specific conditions prevalent in those populations. This can result in lower reimbursement rates for services rendered to these groups, ultimately affecting their access to necessary care.

One effective strategy for addressing these inequities involves comprehensive training programs for healthcare providers and coders. Such programs should emphasize cultural competence and highlight common biases that could lead to miscoding or undercoding services for minority populations. By fostering an environment of awareness and education, we can begin to dismantle the prejudices that inadvertently permeate coding practices.

Additionally, leveraging technology offers promising solutions in mitigating disparities in medical coding. Advanced data analytics and machine learning algorithms can identify patterns indicative of bias or inaccuracies in coding practices. These tools can serve as an audit mechanism, flagging potential discrepancies for further review by human experts. By integrating such technologies into the workflow, organizations can ensure more consistent and equitable application of codes across diverse patient demographics.

Furthermore, policy reform plays a crucial role in rectifying reimbursement rate disparities linked to medical coding practices. Policymakers must advocate for standardized guidelines that promote equity and transparency within the system. This includes revisiting existing coding frameworks to ensure they adequately capture the diversity of patient experiences without penalizing particular groups through lower reimbursements.

Community engagement is another vital component of addressing these issues effectively. Healthcare institutions should actively involve patients from marginalized communities in discussions about their experiences with medical billing and coding processes. This feedback loop can provide valuable insights into areas needing improvement while also empowering

patients as active participants in shaping equitable healthcare practices.

Ultimately, addressing inequities in medical coding not only requires technical adjustments but also a commitment to systemic change within the healthcare industry at large. By adopting strategies that combine education, technology integration, policy reform, and community involvement, we move closer toward a more just system where all individuals receive fair compensation reflective of their care needs irrespective of race or socioeconomic status.

In conclusion, tackling disparities stemming from medical coding practices necessitates concerted efforts across multiple fronts-from individual awareness-building initiatives among practitioners to broader structural changes driven by data-driven insights and inclusive policymaking processes-ensuring equitable reimbursement rates becomes not just an aspirational goal but a tangible reality within our healthcare landscape today.

Challenges and Benefits of Transitioning from Fee for Service to Value Based Care in Medical Coding

Addressing disparities in reimbursement rates has become a pressing concern within the healthcare sector, as these inconsistencies contribute to broader inequalities in access and quality of care. The term "Policy Interventions to Standardize Reimbursement Rates" refers to strategic actions taken by governmental or regulatory bodies aimed at harmonizing the payment structures across different healthcare providers and services. Such interventions are crucial for bridging the gaps that currently exist between various demographic groups and geographic locations.

Disparities in reimbursement rates often reflect deeper systemic issues, including socioeconomic inequities and regional disparities in healthcare funding and resources. For instance, rural areas frequently receive lower reimbursement rates compared to urban centers, despite having higher operating costs due to their geographic isolation. Similarly, minority-serving healthcare facilities might be reimbursed at lower rates than their counterparts serving more affluent populations. These discrepancies not only strain the financial viability of such institutions but also limit patients' access to essential services.

To address these challenges effectively, policy interventions can take several forms. One approach involves setting standardized baseline rates that ensure equitable compensation for similar services regardless of location or patient demographics. Such standards could be established by federal agencies like the Centers for Medicare & Medicaid Services (CMS), which already play a central role in determining reimbursement policies.

Another strategy might focus on value-based payment models that incentivize quality and efficiency over volume of services provided. By aligning financial incentives with patient outcomes rather than service quantity, this model encourages providers to offer high-quality care across all settings. Moreover, implementing transparent pricing mechanisms can help demystify billing practices for consumers and make it easier to identify unjustified variations in reimbursement rates.

However, policy interventions must be carefully crafted to avoid unintended consequences. For example, while standardization is necessary to reduce disparities, it should not stifle innovation or create new barriers for providers who may need flexibility in tailoring their services to meet unique community needs. Therefore, stakeholder engagement becomes vital; policymakers must work collaboratively with healthcare providers, insurers, and patient advocacy groups to design comprehensive reforms that balance fairness with practical considerations.

In addition to national initiatives, state-level policies can also play a pivotal role in addressing local disparities through targeted reforms tailored to specific regional contexts. States have the ability to pilot innovative approaches that could later be scaled up if successful.

Ultimately, standardizing reimbursement rates is about ensuring fairness and promoting equity within our healthcare system-a goal that benefits everyone by creating a healthier society overall. By addressing existing disparities head-on through thoughtful policy interventions, we can make significant strides toward achieving a more just and inclusive healthcare landscape where all individuals have equal access to high-quality medical care regardless of their background or where they live.

Case Studies Highlighting the Effects of Different Payment Models on Medical Coding

Efficiency

Title: Case Studies Demonstrating Successful Mitigation of Disparities in Reimbursement Rates

In the realm of healthcare, the issue of disparities in reimbursement rates presents a significant challenge, impacting both providers and patients. These disparities often arise from systemic inequalities that affect minority and underserved communities disproportionately. Addressing these disparities is crucial for ensuring equitable access to high-quality healthcare services. Several case studies illustrate successful strategies employed to mitigate these inequities, offering valuable insights into effective approaches.

One notable case study involves a community health center network in California that identified substantial discrepancies in reimbursement rates between urban and rural clinics. By conducting a thorough analysis, they uncovered that rural clinics serving predominantly low-income populations received lower reimbursement rates due to outdated cost-reporting methods that failed to account for the unique challenges faced by rural providers. To address this, the network engaged with state policymakers and advocated for the adoption of a new reimbursement model tailored specifically for rural areas. This model included adjustments for transportation costs and workforce shortages, leading to increased funding for rural clinics. As a result, these clinics were able to expand their services and improve patient outcomes significantly.

Another case study highlights efforts by a large hospital system in New York City to tackle racial and ethnic disparities in reimbursement rates. The hospital conducted an internal audit which revealed that facilities serving higher proportions of minority patients were consistently receiving lower reimbursements compared to those serving more affluent areas. To rectify this disparity, the hospital implemented several initiatives including cultural competency training for staff, partnerships with community organizations, and targeted outreach programs aimed at increasing awareness about available health services among minority populations. Additionally, they collaborated with insurance companies to develop value-based care models that rewarded hospitals based on patient outcomes rather than volume of services provided. This shift not only improved financial incentives but also enhanced the quality of care delivered across diverse communities.

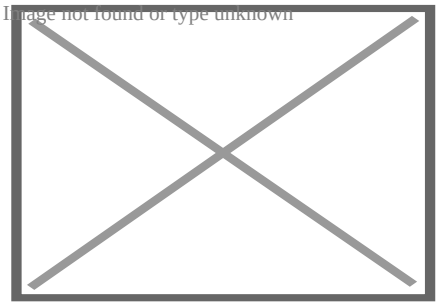
A third example comes from a state-wide initiative in Massachusetts where policymakers recognized disparities affecting small practices operating in economically disadvantaged neighborhoods. These practices often struggled with administrative burdens associated with complex billing systems and inconsistent payment schedules from insurers. In response, the state introduced reforms simplifying billing processes and standardizing payment timelines across all insurers participating in Medicaid programs. Furthermore, technical assistance was offered to small practices to help them transition smoothly to electronic health records systems which streamlined operations while reducing errors related to claims submissions.

These case studies underscore several key elements necessary for addressing disparities in reimbursement rates effectively: collaboration between stakeholders including healthcare providers, insurers, policymakers; comprehensive data analysis identifying root causes; advocacy for policy changes reflecting local needs; implementation of culturally competent care models; simplification of administrative procedures benefiting smaller practices; focus on outcome-based reimbursement structures promoting equity.

By examining these successful interventions collectively-tailored responses addressing specific regional dynamics-we gain invaluable lessons applicable beyond individual contexts alone: proactive engagement coupled with strategic reformulation yields tangible progress toward equitable distribution within healthcare financing mechanisms nationwide-ensuring no community remains underserved or overlooked anymore amidst prevailing systemic imbalances today!

About hospital

For other uses, see **Hospital (disambiguation)**.



The exterior of **Bellvitge University Hospital** in **L'Hospitalet de Llobregat**, Spain, with entrance and parking area for ambulances.

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Infrastructure

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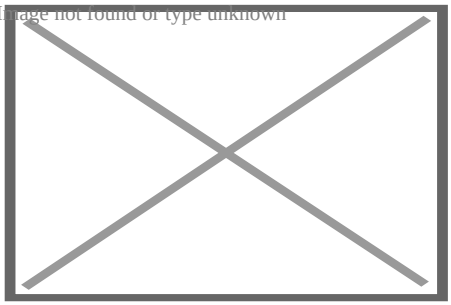

Grand Coulee Dam

Assets and facilities

Airports
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Broadband
Canals
Coastal management
Critical infrastructure
Dams
Electricity
Energy
Hazardous waste
Hospitals
Irrigation schemes
Levees
Lighthouses
Parks
Pipeline transport
Ports
Mass transit
Public housing
State schools
Public spaces
Rail
Roads
Sewage treatment
Sewerage
Sluices
Solid waste
Telecommunication
Trail
Utilities
Water supply
Weirs

Concepts
Asset management
Appropriation
Lindahl tax
Build–operate–transfer
Design–bid–build
Design–build
Earmark
European green infrastructure
Fixed cost
Engineering contracts
Externality
Government debt
Green infrastructure
Life-cycle assessment
Maintenance
Monopoly
Property tax
Public–private partnership
Public capital
Public finance
Public good
Public sector
Renovation
Replacement (upgrade)
Spillover
Supply chain
Taxation

Issues and ideas

Air traffic control
Brownfield
Carbon footprint
Containerization
Congestion pricing
Ecotax
Ethanol fuel
Fuel tax
Groundwater
High-speed rail
Hybrid vehicles
Land-use planning
Mobile data terminal
Pork barrel
Rapid bus transit
Recycling
Renewables
Reverse osmosis
Smart grid
Smart growth
Stormwater
Urban sprawl
Traffic congestion
Transit-oriented development
Fuel efficiency
Waste-to-energy
Weatherization
Wireless technology

Fields of study

Architecture
Chemical engineering
Civil
Electrical
Mechanical engineering
Public economics
Public policy
Urban planning

Examples

Akashi KaikyÃ…Â• Bridge
Trans-Alaska pipeline
Autobahn
Bicycle parking station
Brazilian energy independence
Brooklyn Bridge
Channel Tunnel
Chicago wastewater
China's high-speed rail
Curtiba rapid bus transit
Cycling infrastructure (**history**, **safety**)
Danish wind-power
British offshore wind-power
Nuclear power in France
Solar power in Germany
Hoover Dam
Hong Kong Int'l Airport
Intercity Express
Interstate highways
Jamnagar Refinery
Kansai Int'l Airport
Levee
Offshore wind port
Panama Canal
Port of Shanghai
San Francisco Bay Bridge
Three Gorges Dam
Shinkansen
Spanish high-speed rail
French TGV rail
Spanish autovias and autopistas
Transcontinental Railroad
Power transmission in the USA
Wind farm

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A **hospital** is a healthcare institution providing patient treatment with specialized **health science** and auxiliary healthcare staff and medical equipment.**[1]** The best-known type of

hospital is the general hospital, which typically has an **emergency department** to treat urgent health problems ranging from fire and accident victims to a sudden illness. A district hospital typically is the major health care facility in its region, with many beds for **intensive care** and additional beds for patients who need long-term care.

Specialized hospitals include **trauma centers**, **rehabilitation hospitals**, **children's hospitals**, **geriatric** hospitals, and hospitals for specific medical needs, such as **psychiatric hospitals** for **psychiatric** treatment and other disease-specific categories. Specialized hospitals can help reduce **health care costs** compared to general hospitals.**[2]** Hospitals are classified as general, specialty, or government depending on the sources of income received.

A **teaching hospital** combines assistance to people with teaching to health science students and **auxiliary healthcare** students. A health science facility smaller than a hospital is generally called a clinic. Hospitals have a range of departments (e.g. surgery and **urgent care**) and specialist units such as **cardiology**. Some hospitals have **outpatient departments** and some have chronic treatment units. Common support units include a **pharmacy**, **pathology**, and **radiology**.

Hospitals are typically funded by **public funding**, health organizations (**for-profit** or nonprofit), **health insurance** companies, or charities, including direct charitable donations. Historically, hospitals were often founded and funded by **religious orders**, or by charitable individuals and leaders.**[3]**

Hospitals are currently staffed by professional physicians, surgeons, nurses, and **allied health practitioners**. In the past, however, this work was usually performed by the members of founding religious orders or by **volunteers**. However, there are various Catholic religious orders, such as the **Alexians** and the **Bon Secours Sisters** that still focus on hospital ministry in the late 1990s, as well as several other Christian denominations, including the Methodists and Lutherans, which run hospitals.**[4]** In accordance with the original meaning of the word, hospitals were original "places of hospitality", and this meaning is still preserved in the names of some institutions such as the **Royal Hospital Chelsea**, established in 1681 as a retirement and nursing home for veteran soldiers.

Etymology

[**edit**]

During the Middle Ages, hospitals served different functions from modern institutions in that they were **almshouses** for the poor, **hostels** for **pilgrims**, or hospital schools. The word "hospital" comes from the **Latin** *hospes*, signifying a stranger or foreigner, hence a guest. Another noun derived from this, *hospitium* came to signify hospitality, that is the relation between guest and shelterer, hospitality, friendliness, and hospitable reception. By

metonymy, the Latin word then came to mean a guest-chamber, guest's lodging, an **inn**.**[5]** *Hospes* is thus the root for the English words *host* (where the *p* was dropped for convenience of pronunciation) ***hospitality***, ***hospice***, *hostel,* and *hotel*. The latter modern word derives from Latin via the **Old French** romance word *hostel*, which developed a silent *s*, which letter was eventually removed from the word, the loss of which is signified by a **circumflex** in the **modern French** word *hôtel*. The German word *Spital* shares similar roots.

Types

[**edit**]

Some patients go to a hospital just for **diagnosis**, treatment, or therapy and then leave ("**outpatients**") without staying overnight; while others are "admitted" and stay overnight or for several days or weeks or months ("**inpatients**"). Hospitals are usually distinguished from other types of medical facilities by their ability to admit and care for inpatients whilst the others, which are smaller, are often described as **clinics**.

General and acute care

[**edit**]
"General hospital" redirects here. For the American soap opera, see **General Hospital**. For other uses, see **General Hospital (disambiguation)**.

The best-known type of hospital is the general hospital, also known as an acute-care hospital. These facilities handle many kinds of disease and injury, and normally have an emergency department (sometimes known as "accident & emergency") or **trauma center** to deal with immediate and urgent threats to health. Larger cities may have several hospitals of varying sizes and facilities. Some hospitals, especially in the United States and Canada, have their own ambulance service.

District

[**edit**]
Main article: **Regional hospital**
See also: **Rural general hospital in Scotland**

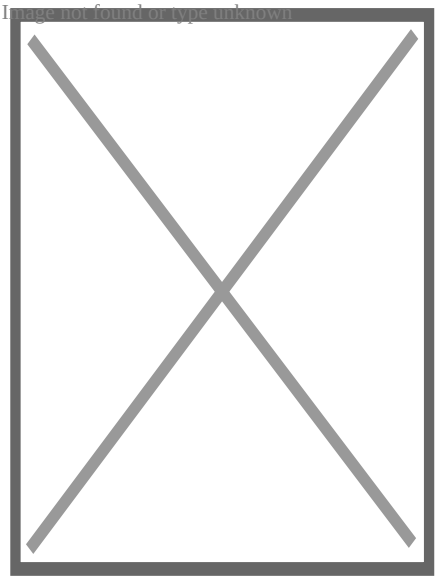
A district hospital typically is the major health care facility in its region, with large numbers of beds for **intensive care**, **critical care**, and long-term care.

In California, "district hospital" refers specifically to a class of healthcare facility created shortly after **World War II** to address a shortage of hospital beds in many local communities.**[6][7]** Even today, district hospitals are the sole public hospitals in 19 of

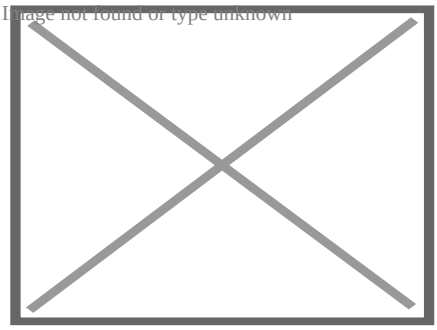
California's counties,[6] and are the sole locally accessible hospital within nine additional counties in which one or more other hospitals are present at a substantial distance from a local community.[6] Twenty-eight of California's rural hospitals and 20 of its critical-access hospitals are district hospitals.[7] They are formed by local municipalities, have boards that are individually elected by their local communities, and exist to serve local needs.[6][7] They are a particularly important provider of healthcare to uninsured patients and patients with **Medi-Cal** (which is California's **Medicaid** program, serving low-income persons, some **senior citizens**, persons with **disabilities**, children in **foster care**, and pregnant women).[6][7] In 2012, district hospitals provided $54 million in uncompensated care in California.[7]

Specialized

[edit]



Starship Children's Health, a **children's hospital** in **Auckland**, New Zealand



McMaster University Medical Centre, a teaching hospital in **Hamilton, Ontario**

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All India Institute of Medical Sciences, New Delhi, a large teaching hospital in **India**

A specialty hospital is primarily and exclusively dedicated to one or a few related **medical specialties**.**[8]** Subtypes include **rehabilitation hospitals**, **children's hospitals**, seniors' (**geriatric**) hospitals, **long-term acute care facilities**, and hospitals for dealing with specific medical needs such as **psychiatric** problems (see **psychiatric hospital**), **cancer treatment**, certain disease categories such as cardiac, oncology, or orthopedic problems, and so forth.

In **Germany**, specialised hospitals are called *Fachkrankenhaus*; an example is **Fachkrankenhaus Coswig** (thoracic surgery). In India, specialty hospitals are known as *super-specialty hospitals* and are distinguished from multispecialty hospitals which are composed of several specialties.[***citation needed***]

Specialised hospitals can help reduce **health care costs** compared to general hospitals. For example, **Narayana Health**'s cardiac unit in **Bangalore** specialises in cardiac surgery and allows for a significantly greater number of patients. It has 3,000 beds and performs 3,000 paediatric cardiac operations annually, the largest number in the world for such a facility.**[2][9]** Surgeons are paid on a fixed salary instead of per operation, thus when the number of procedures increases, the hospital is able to take advantage of **economies of scale** and reduce its cost per procedure.**[9]** Each specialist may also become more efficient by working on one procedure like a **production line**.**[2]**

Teaching

[**edit**]
Main article: **Teaching hospital**

A **teaching hospital** delivers healthcare to patients as well as training to prospective **medical professionals** such as **medical students** and student **nurses**. It may be linked to a medical school or nursing school, and may be involved in **medical research**. Students may also observe clinical work in the hospital.**[10]**

Clinics

[**edit**]

Clinics generally provide only **outpatient** services, but some may have a few inpatient beds and a limited range of services that may otherwise be found in typical hospitals.

Departments or wards

[**edit**]

A hospital contains one or more wards that house **hospital beds** for **inpatients**. It may also have acute services such as an **emergency department**, **operating theatre**, and **intensive care unit**, as well as a range of medical specialty departments. A well-equipped hospital may be classified as a trauma center. They may also have other services such as a **hospital pharmacy**, **radiology**, **pathology**, and **medical laboratories**. Some hospitals have outpatient departments such as **behavioral health** services, **dentistry**, and **rehabilitation services**.

A hospital may also have a **department of nursing**, headed by a **chief nursing officer** or **director of nursing**. This department is responsible for the administration of professional nursing practice, **research**, and policy for the hospital.

Many units have both a nursing and a medical director that serve as administrators for their respective disciplines within that unit. For example, within an intensive care nursery, a medical director is responsible for physicians and medical care, while the nursing manager is responsible for all the nurses and nursing care.

Support units may include a **medical records department**, **release of information department**, **technical support**, **clinical engineering**, facilities management, **plant operations**, dining services, and security departments.

Hospital beds per 1000 people 2013.

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  Hospital beds per 1000 people
  2013**[11]**
  Hospital beds per inhabitants

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  Hospital beds per inhabitants

- **Resuscitation room bed after a trauma intervention, showing the highly technical equip**

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Resuscitation room bed after a **trauma** intervention, showing the highly technical equipment of modern hospitals

Remote monitoring

[edit]

The **COVID-19 pandemic** stimulated the development of virtual wards across the British **NHS**. Patients are managed at home, monitoring their own oxygen levels using an oxygen saturation probe if necessary and supported by telephone. **West Hertfordshire Hospitals NHS Trust** managed around 1200 patients at home between March and June 2020 and planned to continue the system after COVID-19, initially for respiratory patients.**[12] Mersey Care NHS Foundation Trust** started a COVID Oximetry@Home service in April 2020. This enables them to monitor more than 5000 patients a day in their own homes. The technology allows nurses, carers, or patients to record and monitor vital signs such as blood oxygen levels.**[13]**

History

[edit]
Main article: **History of hospitals**

Early examples

[edit]
See also: **Ancient Egyptian medicine**, **Ancient Greek medicine**, **Medicine in ancient Rome**, and **Medical community of ancient Rome**

In early **India**, **Fa Xian**, a Chinese Buddhist monk who travelled across India c. AD 400, recorded examples of healing institutions.**[14]** According to the ***Mahavamsa***, the ancient chronicle of Sinhalese royalty, written in the sixth century AD, King **Pandukabhaya of Sri Lanka** (r. 437–367 BC) had lying-in-homes and hospitals (Sivikasotthi-Sala).**[15]** A **hospital and medical training center** also existed at **Gundeshapur**, a major city in southwest of the **Sassanid Persian Empire** founded in AD 271 by **Shapur I**.**[16]** In

ancient Greece, temples dedicated to the healer-god **Asclepius**, known as **Asclepeion** functioned as centers of medical advice, prognosis, and healing.**[17]** The Asclepeia spread to the **Roman Empire**. While public healthcare was non-existent in the Roman Empire, military hospitals called *valetudinaria* did exist stationed in military barracks and would serve the soldiers and slaves within the fort.**[18]** Evidence exists that some civilian hospitals, while unavailable to the Roman population, were occasionally privately built in extremely wealthy Roman households located in the countryside for that family, although this practice seems to have ended in 80 AD.**[19]**

- **View of the Askleipion of Kos, the best preserved instance of an Asklepieion**

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View of the *Askleipion* of **Kos**, the best preserved instance of an Asklepieion

Ruins of a two thousand-year-old hospital were discovered in the historical city of Anu

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Ruins of a two thousand-year-old hospital were discovered in the historical city of **Anuradhapura** **Mihintale** Sri Lanka.

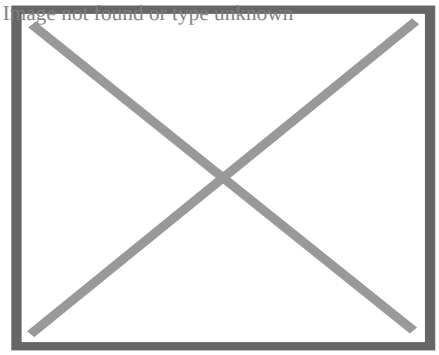
Middle Ages

[**edit**]

See also: **Byzantine medicine**, **Medieval medicine of Western Europe**, and **Medicine in the medieval Islamic world**

The declaration of **Christianity** as an accepted religion in the Roman Empire drove an expansion of the provision of care.**[20]** Following the **First Council of Nicaea** in AD 325 construction of a hospital in every cathedral town was begun, including among the earliest hospitals by **Saint Sampson** in **Constantinople** and by **Basil, bishop of Caesarea** in modern-day Turkey.**[21]** By the twelfth century, Constantinople had two well-organised hospitals, staffed by doctors who were both male and female. Facilities included systematic

treatment procedures and specialised wards for various diseases.[22]



Entrance to the **Qalawun complex** in Cairo, Egypt, which housed the notable Mansuri hospital

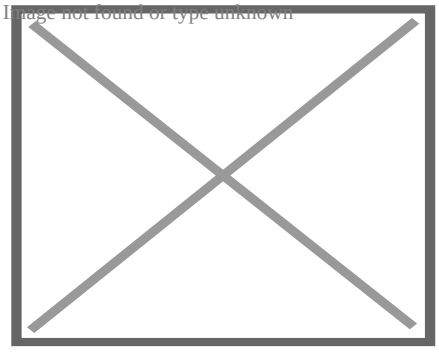
The earliest general hospital in the Islamic world was built in 805 in **Baghdad** by **Harun Al-Rashid**.[23][24] By the 10th century, Baghdad had five more hospitals, while **Damascus** had six hospitals by the 15th century, and **Córdoba** alone had 50 major hospitals, many exclusively for the military, by the end of the 15th century.[25] The Islamic **bimaristan** served as a center of medical treatment, as well **nursing home** and **lunatic asylum**. It typically treated the poor, as the rich would have been treated in their own homes.[26] Hospitals in this era were the first to require medical licenses for doctors, and compensation for negligence could be made.[27][28] Hospitals were forbidden by law to turn away patients who were unable to pay.[29] These hospitals were financially supported by **waqfs**, as well as state funds.[25]

In India, **public hospitals** existed at least since the reign of **Firuz Shah Tughlaq** in the 14th century. The **Mughal** emperor **Jahangir** in the 17th century established hospitals in large cities at government expense with records showing salaries and grants for medicine being paid for by the government.[30]

In China, during the **Song dynasty**, the state began to take on social welfare functions previously provided by Buddhist monasteries and instituted public hospitals, **hospices** and **dispensaries**.[31]

Early modern and Enlightenment Europe

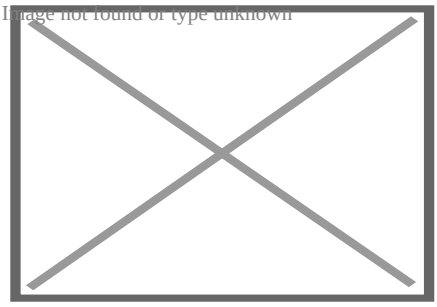
[edit]



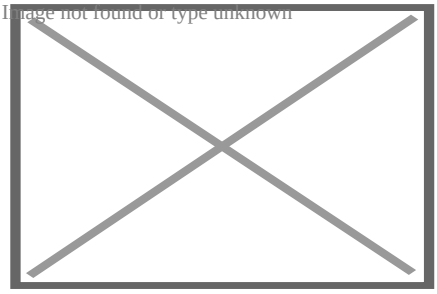
A hospital ward in 6th century **France**

In Europe the medieval concept of Christian care evolved during the 16th and 17th centuries into a secular one. In **England**, after the **dissolution of the monasteries** in 1540 by King **Henry VIII**, the church abruptly ceased to be the supporter of hospitals, and only by direct petition from the citizens of London, were the hospitals **St Bartholomew's**, **St Thomas's** and **St Mary of Bethlehem's** (Bedlam) endowed directly by the crown; this was the first instance of secular support being provided for medical institutions.

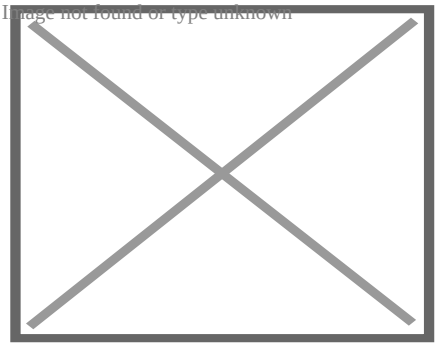
In 1682, **Charles II** founded the **Royal Hospital Chelsea** as a retirement home for old soldiers known as **Chelsea Pensioners**, an instance of the use of the word "hospital" to mean an **almshouse**.**[32]** Ten years later, **Mary II** founded the **Royal Hospital for Seamen, Greenwich**, with the same purpose.**[33]**



1820 engraving of **Guy's Hospital** in London, one of the first voluntary hospitals to be established in 1724



Ruins of the **Hospital San Nicolás de Bari** in **Santo Domingo**, **Dominican Republic**, recognized by UNESCO for being the oldest hospital built in the Americas.**[34][35]** Built between 1514 and 1541.



Pennsylvania Hospital (now part of **University of Pennsylvania Health System**). Founded in 1751, it is the earliest established public hospital in the United States.[36][37][a] It is also home to America's first surgical amphitheatre and its first medical library.

The **voluntary hospital** movement began in the early 18th century, with hospitals being founded in London by the 1720s, including **Westminster Hospital** (1719) promoted by the **private bank C. Hoare & Co** and **Guy's Hospital** (1724) funded from the bequest of the wealthy merchant, **Thomas Guy**.

Other hospitals sprang up in London and other British cities over the century, many paid for by private subscriptions. St Bartholomew's in London was rebuilt from 1730 to 1759,[38] and the London Hospital, Whitechapel, opened in 1752.

These hospitals represented a turning point in the function of the institution; they began to evolve from being basic places of care for the sick to becoming centers of medical innovation and discovery and the principal place for the **education** and training of prospective practitioners. Some of the era's greatest surgeons and doctors worked and passed on their knowledge at the hospitals.[39] They also changed from being mere homes of refuge to being complex institutions for the provision and advancement of medicine and care for sick. The **Charité** was founded in Berlin in 1710 by King **Frederick I of Prussia** as a response to an outbreak of plague.

Voluntary hospitals also spread to **Colonial America**; **Bellevue Hospital** in **New York City** opened in 1736, first as a workhouse and then later as a hospital; **Pennsylvania Hospital** in **Philadelphia** opened in 1752, **New York Hospital**, now Weill Cornell Medical Center[40] in New York City opened in 1771, and **Massachusetts General Hospital** in **Boston** opened in 1811.

When the **Vienna General Hospital** opened in 1784 as the world's largest hospital, physicians acquired a new facility that gradually developed into one of the most important research centers.[41]

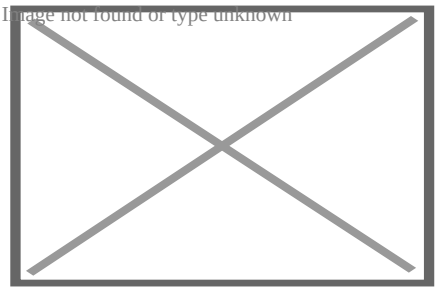
Another **Enlightenment** era charitable innovation was the dispensary; these would issue the poor with medicines free of charge. The London Dispensary opened its doors in 1696 as the first such clinic in the **British Empire**. The idea was slow to catch on until the 1770s,[42] when many such organisations began to appear, including the **Public Dispensary of Edinburgh** (1776), the Metropolitan Dispensary and Charitable Fund (1779) and the **Finsbury Dispensary** (1780). Dispensaries were also opened in New York 1771, **Philadelphia** 1786, and Boston 1796.[43]

The **Royal Naval Hospital, Stonehouse**, **Plymouth**, was a pioneer of hospital design in having "pavilions" to minimize the spread of infection. **John Wesley** visited in 1785, and commented "I never saw anything of the kind so complete; every part is so convenient, and

so admirably neat. But there is nothing superfluous, and nothing purely ornamented, either within or without." This revolutionary design was made more widely known by **John Howard**, the philanthropist. In 1787 the French government sent two scholar administrators, **Coulomb** and **Tenon**, who had visited most of the hospitals in Europe.**[44]** They were impressed and the "pavilion" design was copied in France and throughout Europe.

19th century

[**edit**]



A ward of the hospital at **Scutari**, where **Florence Nightingale** worked and helped to restructure the modern hospital

English physician **Thomas Percival** (1740–1804) wrote a comprehensive system of medical conduct, ***Medical Ethics; or, a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*** (1803) that set the standard for many textbooks.**[45]** In the mid-19th century, hospitals and the medical profession became more professionalised, with a reorganisation of hospital management along more bureaucratic and administrative lines. The **Apothecaries Act 1815** made it compulsory for medical students to practise for at least half a year at a hospital as part of their training.**[46]**

Florence Nightingale pioneered the modern profession of nursing during the **Crimean War** when she set an example of compassion, commitment to patient care and diligent and thoughtful hospital administration. The first official nurses' training programme, the Nightingale School for Nurses, was opened in 1860, with the mission of training nurses to work in hospitals, to work with the poor and to teach.**[47]** Nightingale was instrumental in reforming the nature of the hospital, by improving **sanitation** standards and changing the image of the hospital from a place the sick would go to die, to an institution devoted to recuperation and healing. She also emphasised the importance of **statistical measurement** for determining the success rate of a given intervention and pushed for **administrative reform** at hospitals.**[48]**

By the late 19th century, the modern hospital was beginning to take shape with a proliferation of a variety of public and private hospital systems. By the 1870s, hospitals had more than trebled their original average intake of 3,000 patients. In continental Europe the

new hospitals generally were built and run from public funds. The **National Health Service**, the principal provider of health care in the United Kingdom, was founded in 1948. During the nineteenth century, the Second Viennese Medical School emerged with the contributions of physicians such as **Carl Freiherr von Rokitansky**, **Josef Škoda**, **Ferdinand Ritter von Hebra**, and **Ignaz Philipp Semmelweis**. Basic medical science expanded and specialisation advanced. Furthermore, the first dermatology, eye, as well as ear, nose, and throat clinics in the world were founded in **Vienna**, being considered as the birth of specialised medicine.**[49]**

20th century and beyond

[**edit**]

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The examples and perspective in this section **deal primarily with the United States and do not represent a worldwide view of the subject**. You may **improve this section**, discuss the issue on the **talk page**, or create a new section, as appropriate. *(August 2020) (**Learn how and when to remove this message**)*

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Cabell Huntington Hospital located in **Huntington, West Virginia** (2014)

White H on blue background, used to represent hospitals in the US.

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During peacetime, hospitals are often marked by symbols. A white 'H' on a blue background is often used in the United States. During military conflicts, a hospital may be marked with the emblem of the **red cross, red crescent or red crystal** in accordance with the **Geneva Conventions**.

By the late 19th and early 20th centuries, medical advancements such as **anesthesia** and sterile techniques that could make surgery less risky, and the availability of more advanced diagnostic devices such as **X-rays**, continued to make hospitals a more attractive option for treatment.**[50]**

Modern hospitals measure various efficiency metrics such as occupancy rates, the average length of stay, time to service, patient satisfaction, physician performance, patient

readmission rate, inpatient mortality rate, and **case mix index**.[51]

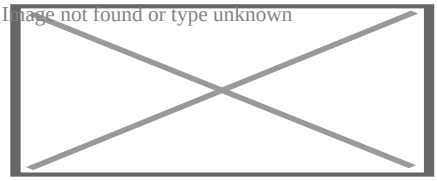
In the **United States**, the number of hospitalizations grew to its peak in 1981 with 171 admissions per 1,000 Americans and 6,933 hospitals.[50] This trend subsequently reversed, with the rate of hospitalization falling by more than 10% and the number of US hospitals shrinking from 6,933 in 1981 to 5,534 in 2016.[52] Occupancy rates also dropped from 77% in 1980 to 60% in 2013.[53] Among the reasons for this are the increasing availability of more complex care elsewhere such as at home or the physicians' offices and also the less therapeutic and more life-threatening image of the hospitals in the eyes of the public.[50][54] In the US, a patient may sleep in a hospital bed, but be considered outpatient and "under observation" if not formally admitted.[55]

In the U.S., inpatient stays are covered under Medicare Part A, but a hospital might keep a patient under observation which is only covered under Medicare Part B, and subjects the patient to additional coinsurance costs.[55] In 2013, the **Center for Medicare and Medicaid Services** (CMS) introduced a "two-midnight" rule for inpatient admissions,[56] intended to reduce an increasing number of long-term "observation" stays being used for reimbursement.[55] This rule was later dropped in 2018.[56] In 2016 and 2017, healthcare reform and a continued decline in admissions resulted in US hospital-based healthcare systems performing poorly financially.[57] Microhospitals, with bed capacities of between eight and fifty, are expanding in the United States.[58] Similarly, freestanding emergency rooms, which transfer patients that require inpatient care to hospitals, were popularised in the 1970s[59] and have since expanded rapidly across the United States.[59]

The **Catholic Church** is the largest non-government provider of **health careservices** in the world.[60] It has around 18,000 clinics, 16,000 homes for the elderly and those with special needs, and 5,500 hospitals, with 65 percent of them located in developing countries.[61] In 2010, the Church's **Pontifical Council for the Pastoral Care of Health Care Workers** said that the Church manages 26% of the world's health care facilities.[62]

Funding

[**edit**]
See also: **Health economics**



Clinical Hospital Dubrava in **Zagreb**, Croatia

Modern hospitals derive funding from a variety of sources. They may be funded by private payment and **health insurance** or **public expenditure**, **charitable donations**.

In the **United Kingdom**, the National Health Service delivers health care to legal residents funded by the state "free at the point of delivery", and emergency care free to anyone regardless of nationality or status. Due to the need for hospitals to prioritise their limited resources, there is a tendency in countries with such systems for 'waiting lists' for non-crucial treatment, so those who can afford it may take out private health care to access treatment more quickly.**[63]**

In the **United States**, hospitals typically operate privately and in some cases on a **for-profit** basis, such as **HCA Healthcare**.**[64]** The list of procedures and their prices are billed with a **chargemaster**; however, these prices may be lower for health care obtained within **healthcare networks**.**[65]** Legislation requires hospitals to provide care to patients in life-threatening emergency situations regardless of the patient's ability to pay.**[66]** Privately funded hospitals which admit uninsured patients in emergency situations incur direct financial losses, such as in the aftermath of **Hurricane Katrina**.**[64]**

Quality and safety

[**edit**]

As the quality of health care has increasingly become an issue around the world, hospitals have increasingly had to pay serious attention to this matter. Independent external assessment of quality is one of the most powerful ways to assess this aspect of health care, and **hospital accreditation** is one means by which this is achieved. In many parts of the world such accreditation is sourced from other countries, a phenomenon known as **international healthcare accreditation**, by groups such as **Accreditation Canada** in **Canada**, the **Joint Commission** in the U.S., the **Trent Accreditation Scheme** in **Great Britain**, and the ***Haute Autorité de santé*** (HAS) in **France**. In **England**, hospitals are monitored by the **Care Quality Commission**. In 2020, they turned their attention to hospital food standards after seven patient deaths from **listeria** linked to pre-packaged sandwiches and salads in 2019, saying "Nutrition and hydration is part of a patient's recovery."**[67]**

The **World Health Organization** reported in 2011 that being admitted to a hospital was far riskier than flying. Globally, the chance of a patient being subject to a treatment error in a hospital was about 10%, and the chance of death resulting from an error was about one in 300. according to **Liam Donaldson**. 7% of hospitalised patients in developed countries, and 10% in developing countries, acquire at least one **health care-associated infection**. In the U.S., 1.7 million infections are acquired in hospital each year, leading to 100,000 deaths, figures much worse than in Europe where there were 4.5 million infections and 37,000 deaths.**[68]**

Architecture

[**edit**]

Modern hospital buildings are designed to minimise the effort of medical personnel and the possibility of contamination while maximising the efficiency of the whole system. Travel time for personnel within the hospital and the transportation of patients between units is facilitated and minimised. The building also should be built to accommodate heavy departments such as radiology and operating rooms while space for special wiring, plumbing, and waste disposal must be allowed for in the design.[69]

However, many hospitals, even those considered "modern", are the product of continual and often badly managed growth over decades or even centuries, with utilitarian new sections added on as needs and finances dictate. As a result, Dutch architectural historian Cor Wagenaar has called many hospitals:

> "... built catastrophes, anonymous institutional complexes run by vast bureaucracies, and totally unfit for the purpose they have been designed for ... They are hardly ever functional, and instead of making patients feel at home, they produce stress and anxiety."[70]

Some newer hospitals now try to re-establish design that takes the patient's psychological needs into account, such as providing more fresh air, better views and more pleasant colour schemes. These ideas harken back to the late eighteenth century, when the concept of providing fresh air and access to the 'healing powers of nature' were first employed by hospital architects in improving their buildings.[70]

The research of **British Medical Association** is showing that good hospital design can reduce patient's recovery time. Exposure to daylight is effective in reducing depression.[71] Single-sex accommodation help ensure that patients are treated in privacy and with dignity. Exposure to nature and hospital gardens is also important – looking out windows improves patients' moods and reduces blood pressure and stress level. Open windows in patient rooms have also demonstrated some evidence of beneficial outcomes by improving airflow and increased microbial diversity.[72][73] Eliminating long corridors can reduce nurses' fatigue and stress.[74]

Another ongoing major development is the change from a ward-based system (where patients are accommodated in communal rooms, separated by movable partitions) to one in which they are accommodated in individual rooms. The ward-based system has been described as very efficient, especially for the medical staff, but is considered to be more stressful for patients and detrimental to their privacy. A major constraint on providing all patients with their own rooms is however found in the higher cost of building and operating such a hospital; this causes some hospitals to charge for private rooms.[75]

- **The medical center at the University of Virginia shows the growing trend for modern ar**

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The medical center at the **University of Virginia** shows the growing trend for modern architecture in hospitals.

The National Health Service Norfolk and Norwich University Hospital in the UK, showin

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The **National Health Service Norfolk and Norwich University Hospital** in the UK, showing the utilitarian architecture of many modern hospitals

Hospital chapel at Fawcett Memorial Hospital (Port Charlotte, Florida)

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Hospital chapel at **Fawcett Memorial Hospital** (**Port Charlotte, Florida**)

Hinduja National Hospital, Mumbai

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Hinduja National Hospital,

Mumbai
An intensive care unit (ICU) within a hospital

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  An **intensive care unit** (ICU) within a hospital
  Uniklinikum Aachen in Germany

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  Uniklinikum Aachen in Germany
- **Tampere University Hospital in Tampere, Finland**

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Tampere University Hospital in **Tampere**, Finland
All India Institute of Medical Sciences in Delhi, India

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  All India Institute of Medical Sciences in Delhi, India
- **Lehigh Valley HospitalÃ¢â‚¬â€œCedar Crest in Allentown, Pennsylvania, U.S.**

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Lehigh Valley Hospital–Cedar Crest in **Allentown, Pennsylvania**, U.S.

See also

[edit]

- Burn center
- History of hospitals
- History of medicine
- Hospice
- Hospital network
- Lists of hospitals
- Hospitals in Thailand
- Hospital information system
- Trauma center
- *The Waiting Room*
- Walk-in clinic
- GP Liaison

Notes

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1. ^ "Although Philadelphia General Hospital (1732) and Bellevue Hospital in New York (1736) are older, the Philadelphia General was founded as an almshouse, and Bellevue as a workhouse."

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Thabit to examine all those who practiced the art of healing. Of the 860 medical practitioners he examined, 160 failed. From that time on, licensing examinations were required and administered in various places. Licensing boards were set up under a government official called Muhtasib, or inspector general. The chief physician gave oral and practical examinations, and if the young physician was successful, the Muhtasib administered the Hippocratic Oath and issued a license to practice medicine."

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Articles about **hospitals**

History of hospitals, **Hospital network**, **Category:Hospitals**

Common hospital components	**Accreditation** **Bed** **Coronary care unit** **Emergency department** **Emergency codes** **Hospital administrators** **Hospital information system** **Hospital medicine** **Hospital museum** **Hospitalist** **Intensive care unit** **Nocturnist** **On-call room** **Operating theater** **Orderly** **Patients** **Pharmacy** **Wards**
Archaic forms	**Almshouse** **Asclepeion** (Greece) **Bimaristan** (Islamic) **Cottage hospital** (England) Hôtel-Dieu (France) **Valetudinaria** (Roman) **Vaishya** lying in houses (India) **Xenodochium** (Middle Ages)
Geographic service area	**Base hospital** (Australia) **Community hospital** **General hospital** **Regional hospital** or **District hospital** **Municipal hospital**

Complexity of services	○ **Day hospital** ○ **Secondary hospital** ○ **Tertiary referral hospital** ○ **Teaching hospital** ○ **Specialty hospital**
Unique physical traits	○ **Hospital ship** ○ **Hospital train** ○ **Mobile hospital** ○ **Underground hospital** ○ **Virtual Hospital**
Limited class of patients	○ **Military hospital** ○ **Combat support hospital** ○ **Field hospital** ○ **Prison hospital** ○ **Veterans medical facilities** ○ **Women's hospital**
Funding	○ **Charitable hospital** ○ **For-profit hospital** ○ **Non-profit hospital** ○ **State hospital** ○ **Private hospital** ○ **Public hospital** ○ **Voluntary hospital**
Condition treated	○ **Defunct** ○ **Cancer** ○ **Children's hospital** ○ **Eye hospital** ○ **Fever hospital** ○ **Leper colony** ○ **Lock hospital** ○ **Maternity hospital** ○ **Psychiatric hospital** ○ **Rehabilitation hospital** ○ **Trauma center** ○ **Verterinary hospital**

Century established	○ **5th** ○ **6th** ○ **7th** ○ **8th** ○ **9th** ○ **10th** ○ **11th** ○ **12th** ○ **13th** ○ **14th** ○ **15th** ○ **16th** ○ **17th** ○ **18th** ○ **19th** ○ **20th** ○ **21st**

Lists of hospitals in: **Africa**, **Asia**, **Europe**, **North America**, **Oceania**, **South America**

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Health care

- **Economics**
- **Equipment**
- **Guidelines**
- **Industry**
- **Philosophy**
- **Policy**
- **Providers**
- **Public**
- **Ranking**
- **Reform**
- **System**

Professions

- **Medicine**
- **Nursing**
- **Pharmacy**
- **Healthcare science**
- **Dentistry**
- **Allied health professions**
- **Health information management**

Settings	○ **Assisted living** ○ **Clinic** ○ **Hospital** ○ **Nursing home** ○ **Medical school** (**Academic health science centre**, **Teaching hospital**) ○ **Pharmacy school** ○ **Supervised injection site**
Care	○ **Acute** ○ **Chronic** ○ **End-of-life** ○ **Hospice** ○ **Overutilization** ○ **Palliative** ○ **Primary** ○ **Self** ○ **Total**
Skills / training	○ **Bedside manner** ○ **Cultural competence** ○ **Diagnosis** ○ **Education** ○ **Universal precautions**
Technology	○ **3D bioprinting** ○ **Artificial intelligence** ○ **Connected health** ○ **Digital health** ○ **Electronic health records** ○ **mHealth** ○ **Nanomedicine** ○ **Telemedicine**
Health informatics	○ **Medical image computing** and **imaging informatics** ○ **Artificial intelligence in healthcare** ○ **Neuroinformatics** in healthcare ○ **Behavior informatics** in healthcare ○ **Computational biology** in healthcare ○ **Translational bioinformatics** ○ **Translational medicine** ○ **health information technology** ○ **Telemedicine** ○ **Public health informatics** ○ **Health information management** ○ **Consumer health informatics**

By country

- United States
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Public infrastructure

Assets and facilities

- Airports
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- Hazardous waste
- Hospitals
- Levees
- Lighthouses
- Municipal solid waste
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- Rail transport
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- Town square
- Wastewater treatment
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Concepts

- Appropriation
- Infrastructure asset management
- Build–operate–transfer
- Design–build
- Earmark
- Engineering contracts
- Externality
- Fixed cost
- Government debt
- Infrastructure bond
- Life-cycle assessment
- Lindahl tax
- Maintenance, repair, and operations
- Natural monopoly
- Property tax
- Public capital
- Public finance
- Public good
- Public sector
- Public–private partnership
- Renovation
- Spillover
- Supply chain
- Taxation
- Upgrade

Issues and ideas	○ Air traffic control ○ Brownfield land ○ Bus rapid transit ○ Carbon footprint ○ Congestion pricing ○ Containerization ○ Ethanol fuel ○ Fuel efficiency ○ Fuel tax ○ Groundwater ○ High-speed rail ○ Hybrid vehicles ○ Land-use planning ○ Mobile data terminal ○ Pork barrel ○ Recycling ○ Renewable resources ○ Reverse osmosis ○ Smart grid ○ Smart growth ○ Stormwater ○ Sustainable urban infrastructure ○ Traffic congestion ○ Transit-oriented development ○ Urban sprawl ○ Waste-to-energy ○ Weatherization ○ Wireless
Fields of study	○ Architecture ○ Civil engineering ○ Electrical engineering ○ Mechanical engineering ○ Public economics ○ Public policy ○ Urban planning

Examples	○ Akashi KaikyÃ…Â• Bridge ○ Autobahn ○ Brooklyn Bridge ○ Bus rapid transit systems ○ Channel Tunnel ○ Controlled-access highway systems ○ Electric power transmission ○ High-speed trains ○ Hong Kong International Airport ○ Hoover Dam ○ Humber Bridge ○ Kansai International Airport ○ Millau Viaduct ○ Nuclear power ○ Offshore wind farms ○ Panama Canal ○ Port of Shanghai ○ San Francisco–Oakland Bay Bridge ○ Suez Canal ○ Solar power ○ Three Gorges Dam ○ Trans-Alaska pipeline ○ Transcontinental railroads

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Frequently Asked Questions

How do disparities in reimbursement rates impact healthcare providers financially?

Disparities in reimbursement rates can lead to financial strain on healthcare providers by creating gaps between the cost of delivering care and the revenue received. This may result in reduced resources for patient care, staffing challenges, and limitations on service offerings, particularly affecting smaller practices and those serving underserved populations.

What role does accurate medical coding play in addressing reimbursement rate disparities?

Accurate medical coding is crucial for ensuring that healthcare services are documented correctly and reimbursed fairly. It helps reduce discrepancies by providing precise data for claim submissions, which can improve payment accuracy from insurers and help identify patterns or systemic issues contributing to disparities.

What strategies can be employed to mitigate disparities in reimbursement rates linked to medical coding?

Strategies include investing in coder training programs to ensure proficiency, implementing robust auditing processes to catch errors early, advocating for policy changes that promote equitable payment models, and leveraging technology such as AI-driven coding tools to enhance accuracy and consistency across different healthcare settings.

Altrust Services

Phone : (813) 592-3807

City : Clearwater

State : FL

Zip : 33765

Address : 3000 Gulf to Bay Blvd Suite 313

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