FIGURE 8.1 Hospital organizational structure.

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center
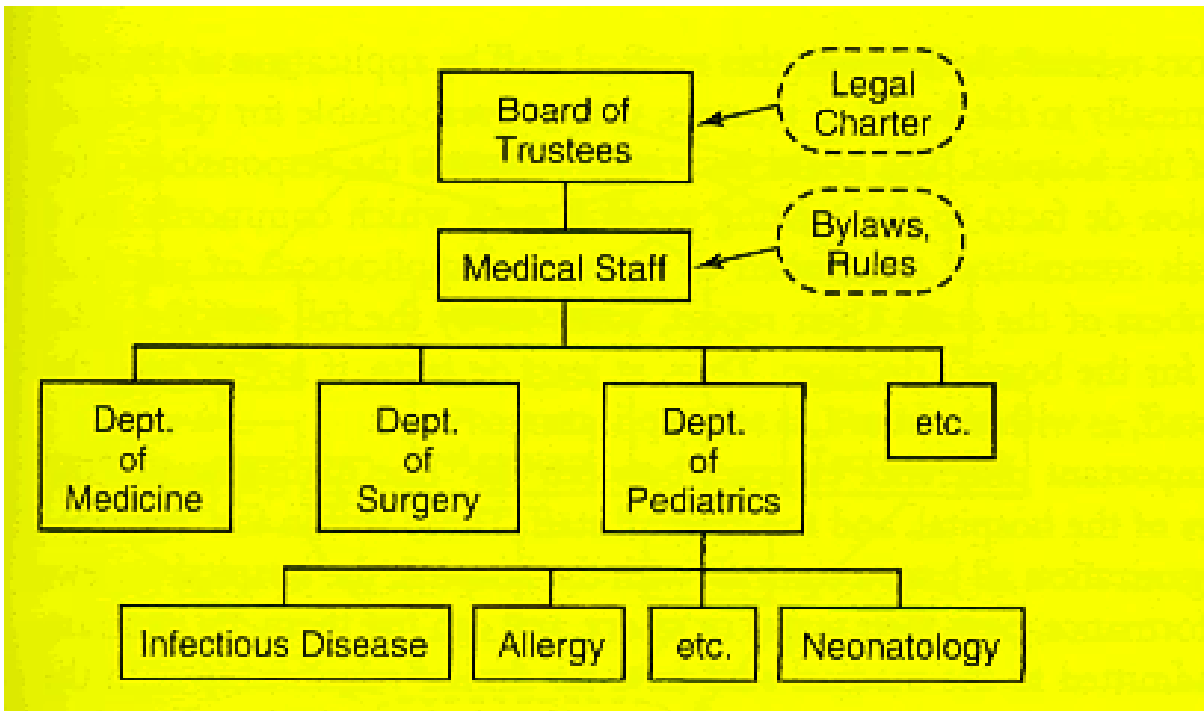
Stanford University School of Medicine
Lucile Packard Children's Hospital

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Administration

The purpose of the Stanford Hospital and Clinics' Administration is:

- To serve our internal and external customers (patients, families, employees, volunteers, medical staff, board of directors, local and referring communities and fellow teaching university hospitals).
- To work cooperatively in supporting the missions of the Stanford University School of Medicine and the Lucile Packard children's Hospital.
- To lead, manage and monitor all processes and programs within the organization.
- To facilitate communication to and from senior management.
- To support and communicate to the Board of Directors.
- To oversee all organization-wide initiatives.

Contact Information

Hospital Administration
300 Pasteur Drive, Room H3200
Stanford, CA 94305

General Hospital/Patient Information: (650) 723-4000
Hospital Administration Phone: (650) 723-8542
Fax: (650) 723-0074

Hours: Monday - Friday, 7:30 am - 5:00 pm.
On-call administrator 24 hours a day.

Stanford Hospital & Clinics Senior Management Group

President and Chief Executive Officer
Martha Marsh

Interim Chief Operating Officer
Mike Peterson

Interim Vice President, Clinical Services
Nancy Lee

Chief Of Staff
Larry Shuer, MD

Medical Director of OR Services
Richard Whyte, MD

Vice President, Patient Care Services
Cindy Day

Vice President, Clinics/Ambulatory Care
Linda Cook

Chief Information Officer*
Carolyn Byerly

Chief Financial Officer*
Roy Santarella

Vice President, General Services*
Lou Saksen

Vice President, Laboratory Services*
Susie Lu

Vice President, Physician Organization & Business Planning
Kenneth Sharigian

Vice President, Human Resource Services*
John Barbadian

Vice President, Materials Management* and Customer Service
Nick Gaich

Chief Hospital Counsel*
Sarah DiBoise

* Shared Services Staff with Lucile Packard Children's Hospital

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Richard Hoppe, MD
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Martha Marsh, President and CEO, SHC
Philip Pizzo, MD, Dean, Stanford University School of Medicine
Norman Rizk, MD, Senior Associate Dean for Clinical Affairs

Secretary of the Board: Michele Sanchez (650) 723-6642

Stanford Hospital & Clinics, easily reached from anywhere in Northern California, is approximately 20 miles north of San Jose, CA and 40 miles south of San Francisco, CA.
Stanford Hospital & Clinics | 300 Pasteur Drive | Stanford, California 94305 | (650) 723-4000

TABLE 17.1 Short-Stay and Long-Term Hospital Data

	1970	1980	1992
All Hospitals (beds)	7,030 (1,599,229)	6,787 (1,346,228)	6,066 (1,135,350)
Short-Stay Hospitals (beds)	6,193 (935,724)	6,229 (1,080,164)	5,619 (996,112)
Federal	334 (87,492)	325 (88,144)	298 (73,370)
Nonfederal	5,859 (848,232)	5,904 (992,020)	5,321 (922,742)
Nonprofit	3,386 (591,937)	3,339 (692,929)	3,182 (656,355)
Proprietary	769 (52,739)	730 (87,033)	723 (98,760)
State-local government	1,704 (203,556)	1,835 (212,058)	1,416 (167,627)
Size			
6–199 beds	—	4,389 (358,282)	3,861 (325,317)
200–499 beds	—	1,466 (456,248)	1,421 (434,734)
500 or more beds	—	374 (265,634)	337 (236,061)
Occupancy Rate (percent)	77.9	75.6	66.2
Admissions (thousands)	30,706	38,140	32,640
Average Length of Stay (days)	8.7	7.8	7.4
Outpatient Visits (thousands)	173,058	255,320	408,507
Outpatient Surgeries (% of total)	—	16.4	53.6
Long-Term Hospitals (beds)	837 (663,505)	558 (266,064)	447 (139,238)
Federal	72 (73,260)	33 (28,433)	26 (17,220)
Nonfederal	662 (570,308)	515 (236,131)	418 (121,713)
Nonprofit	166 (21,530)	113 (16,683)	78 (9,545)
Proprietary	41 (3,500)	68 (7,233)	67 (5,442)
State-local government	418 (534,112)	326 (211,167)	257 (104,561)
Tuberculosis	103 (19,937)	10 (1,500)	3 (305)
Occupancy Rate (percent)	81.2	85.5	87.0

Numbers in parentheses are number of beds.

Source: U.S. DHHS, *Health United States 1994* (Tables 90, 108, and 109).

Source: Folland, Stano, and Goodman, 2nd edition

TABLE 17.2   Hospital and Nursing Home Costs

	1960	1970	1980	1993
Health Care Spending ($ billion)	27.1	74.3	251.1	884.2
Hospital Care ($ billion)	9.3	28.0	102.7	326.6
% of total spending	34.3	37.7	40.9	36.9
Percent of Hospital Care Paid by				
Out-of-pocket	20.7	9.0	5.2	2.8
Private health insurance and other private	36.8	37.5	42.6	41.3
Government	42.5	53.5	52.3	56.0
Average Cost ($)				
Per day	—	74	245	881
Per stay	—	605	1,851	6,132
Nursing Home Care ($ billion)	1.0	4.9	20.5	69.6
% of total spending	3.7	6.6	8.2	7.9
Percent of Nursing Home Care Paid by				
Out-of-pocket	80.0	48.1	38.3	33.0
Private health insurance and other private	6.4	5.2	4.2	4.4
Government	13.6	46.6	57.6	62.6

Sources: U.S. DHHS, *Health United States 1994* (Table 125) and *Statistical Abstract of the United States 1995* (Table 186).

Source: Stano, Folland, and Goodman, 2nd edition

Table 1. Patient Characteristics by Annual Physician and Hospital Medicare PCI Volume*

	Physician Medicare PCI Volume per Year				Hospital Medicare PCI Volume per Year			
	<30	30-60	>60	P Value†	<80	80-160	>160	P Value†
Providers, No. (%)	3562 (54.5)	1767 (27.0)	1205 (18.5)		263 (26.2)	254 (25.3)	486 (48.5)	
Patients, No. (%)	33539 (20.0)	51519 (30.8)	82150 (49.2)		8381 (5.0)	22620 (13.5)	136207 (81.5)	
Age, mean, y	73.4	73.6	73.7	<.001	73.6	73.6	73.6	.64
Age >75 y, %	39.6	40.5	41.7	<.001	40.3	40.9	40.9	.49
Women, %	45.0	44.4	43.5	<.001	47.2	44.8	43.8	<.001
African American, %	4.9	4.4	3.8	<.001	7.0	4.2	4.0	<.001
AMI, %	30.3	28.6	24.4	<.001	34.5	29.9	25.9	<.001
Multivessel procedure, %	9.5	10.7	12.7	<.001	10.4	9.9	11.8	<.001
Charlson score >1, %	14.0	15.4	16.2	<.001	15.4	14.4	15.7	<.001
Stent use, %	50.6	56.9	61.1	<.001	48.4	53.4	59.0	<.001

*PCI indicates percutaneous coronary intervention; AMI, acute myocardial infarction.
†Comparisons among physician or hospital strata.

Table 2. Rates of CABG or 30-Day Mortality Following PCI According to Annual Physician PCI Volume Among Medicare Beneficiaries*

	Unadjusted Rates, Physician Medicare PCI Volume					Adjusted Rates, Physician Medicare PCI Volume				
	<30	P Value†	30-60	P Value†	>60	<30	P Value†	30-60	P Value†	>60
CABG following PCI	2.39	<.001	2.14	<.001	1.48	2.25	<.001	2.08	<.001	1.55
30-day mortality	3.52	.004	3.33	.14	3.19	3.25	.27	3.20	.10	3.39
CABG or 30-day mortality following PCI	5.66	<.001	5.24	<.001	4.50	5.26	.002	5.06	.03	4.75

*All rates and percentages. CABG indicates coronary artery bypass graft; PCI, percutaneous coronary intervention. Adjusted for age, sex, race, acute myocardial infarction as primary diagnosis, comorbidity score, urgency of admission, multivessel PCI, and hospital volume.
†P values compared to reference group (>60 category).

Source: McGrath et al (2000)

Table 3. Rates of CABG or 30-Day Mortality Following PCI According to Annual Hospital PCI Volume Among Medicare Beneficiaries[*]

	Unadjusted Rates, Hospital Medicare PCI Volume					Adjusted Rates, Hospital Medicare PCI Volume				
	<80	P Value[†]	80-160	P Value[†]	>160	<80	P Value[†]	80-160	P Value[†]	>160
CABG following PCI	2.26	<.001	2.36	<.001	1.76	1.83	.96	2.09	.04	1.83
30-day mortality	4.88	<.001	3.86	<.001	3.11	4.29	<.001	3.75	<.001	3.15
CABG or 30-day mortality following PCI	6.88	<.001	5.94	<.001	4.68	5.87	<.001	5.59	<.001	4.78

[*]All rates are percentages. CABG indicates coronary artery bypass graft; PCI, percutaneous coronary intervention. Adjusted for age, sex, race, acute myocardial infarction as primary diagnosis, comorbidity score, urgency of admission, multivessel PCI, and physician volume.
[†]P values compared to reference group (>60 category).

Source: McGrath et al (2000) "Relation Between Operator and Hospital Volume and Outcomes Following Percutaneous Coronary Interventions in the Era of the Coronary Stent" JAMA 284(24): 3139-3144
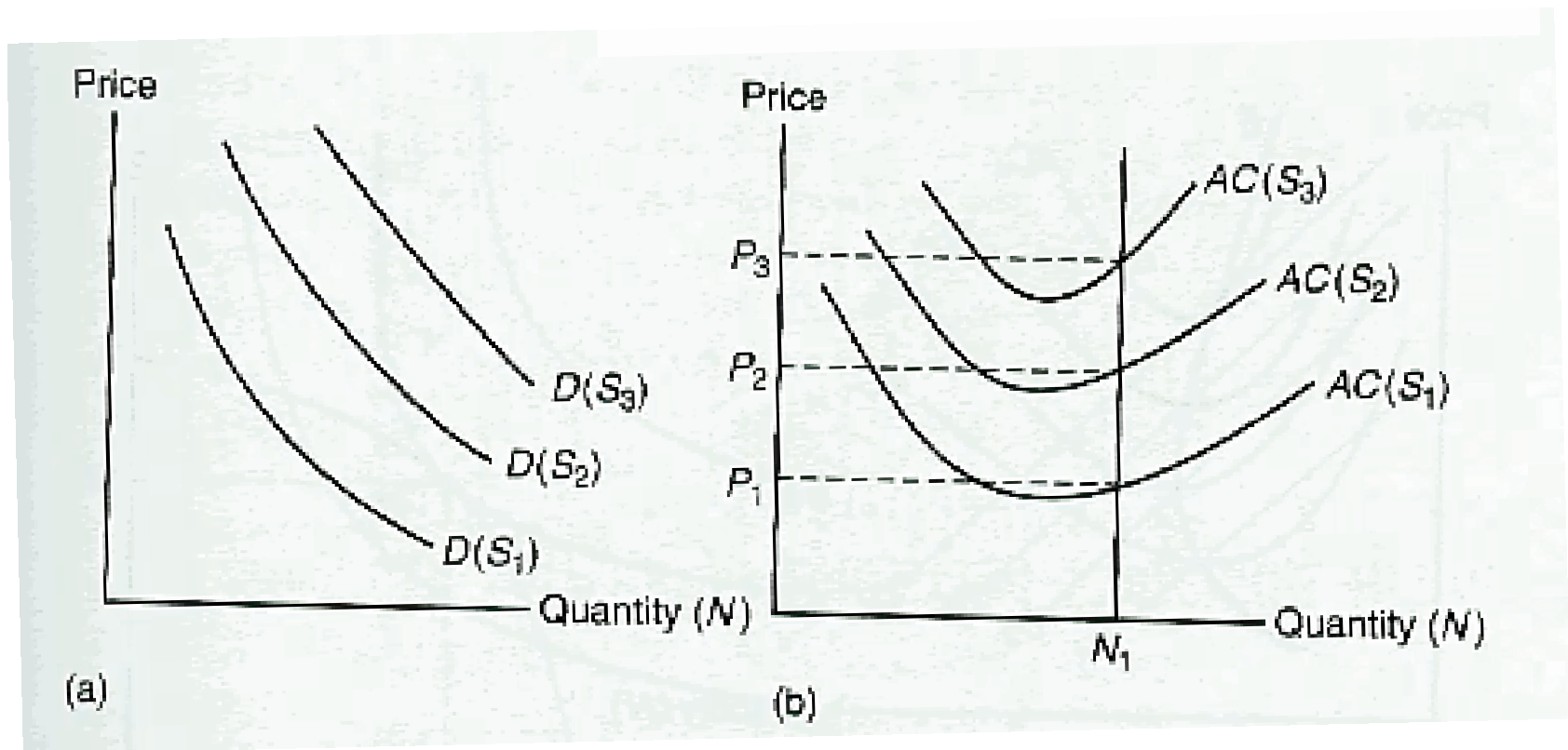
Figure 9.1: (from Phelps) (a) Demand curves for different quality levels; (b) Average cost curves of the hospital at different quality levels.
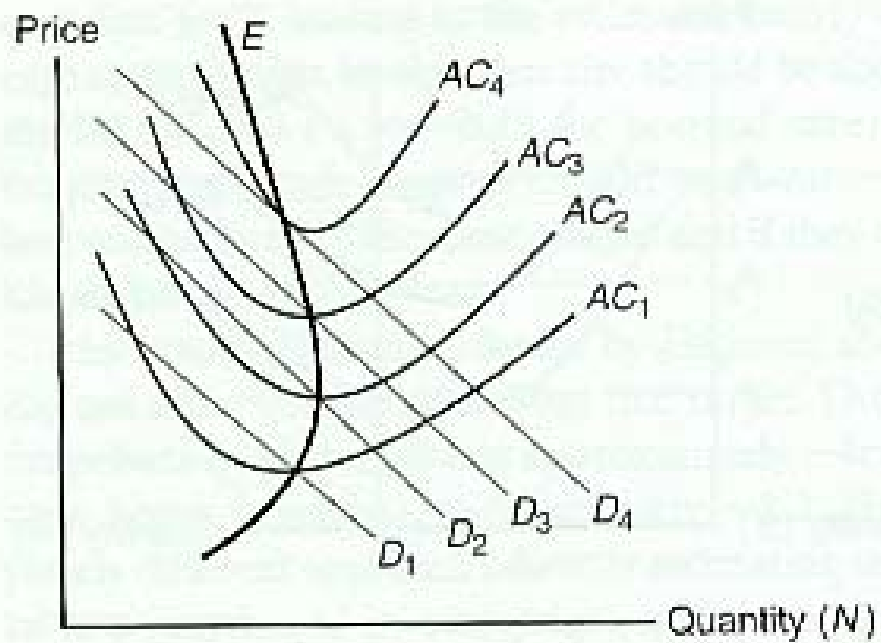
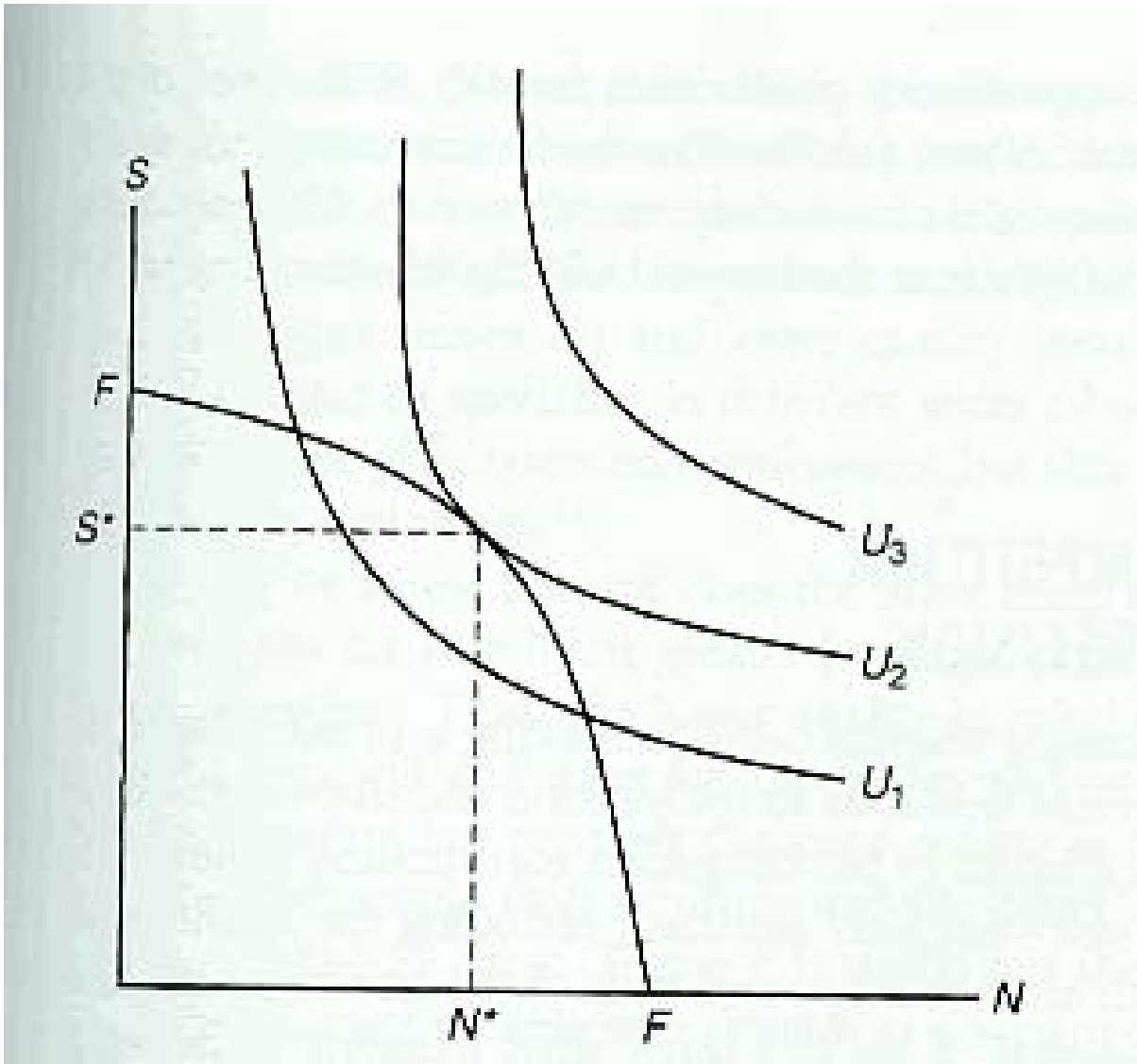Figure 9.2 (from Phelps): Equilibrium combinations of quality and quantity

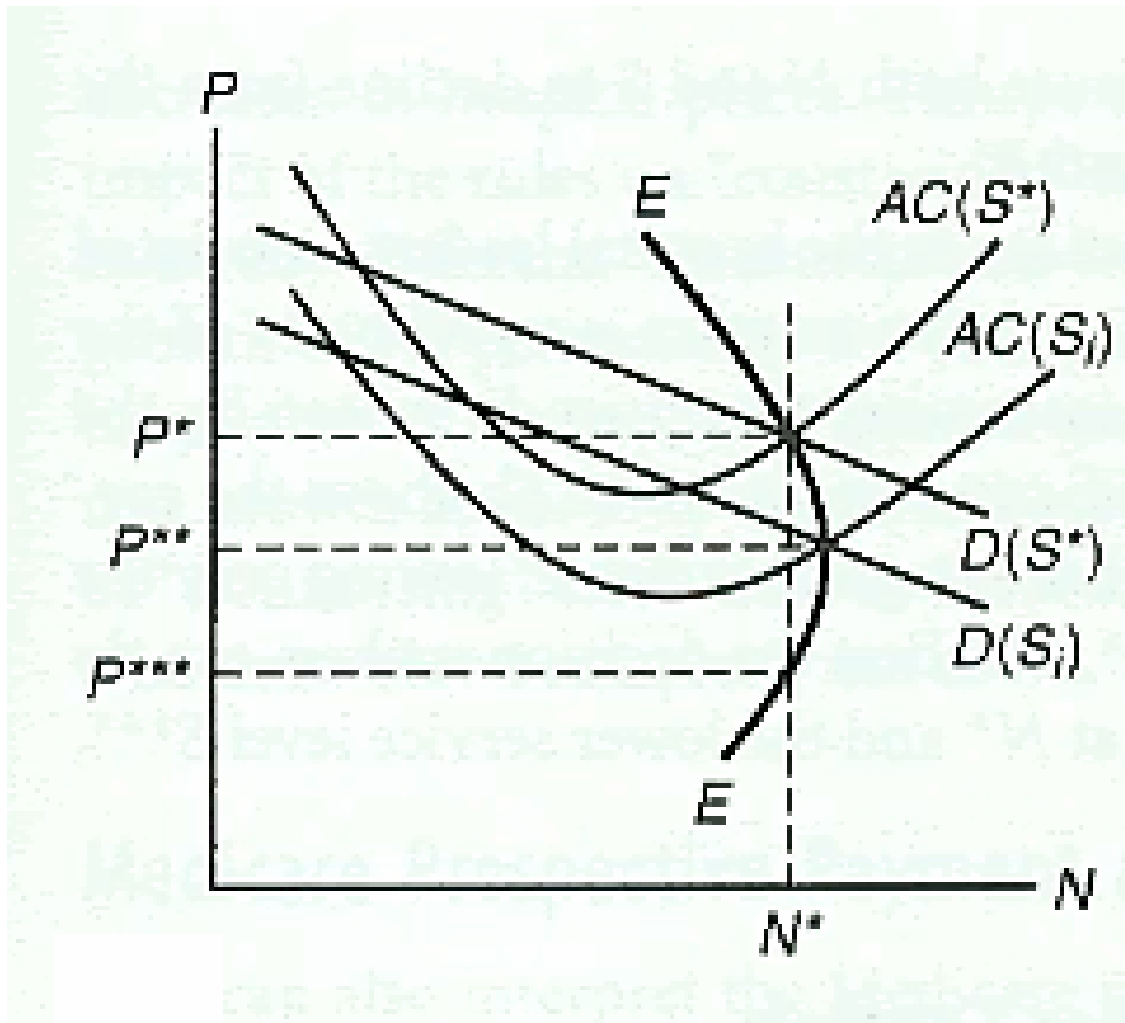Figure 9.3 (from Phelps) Indifference curves for quality and quantity

Figure 15.5 (from Phelps) Demand and cost curves for different qualities of output. The effect of price controls.

Note: Firms start out at P*. A price cap at P** can actually increase output in this model (while decreasing quality)! A drop in prices to P*** does not change N, but does reduce quality.
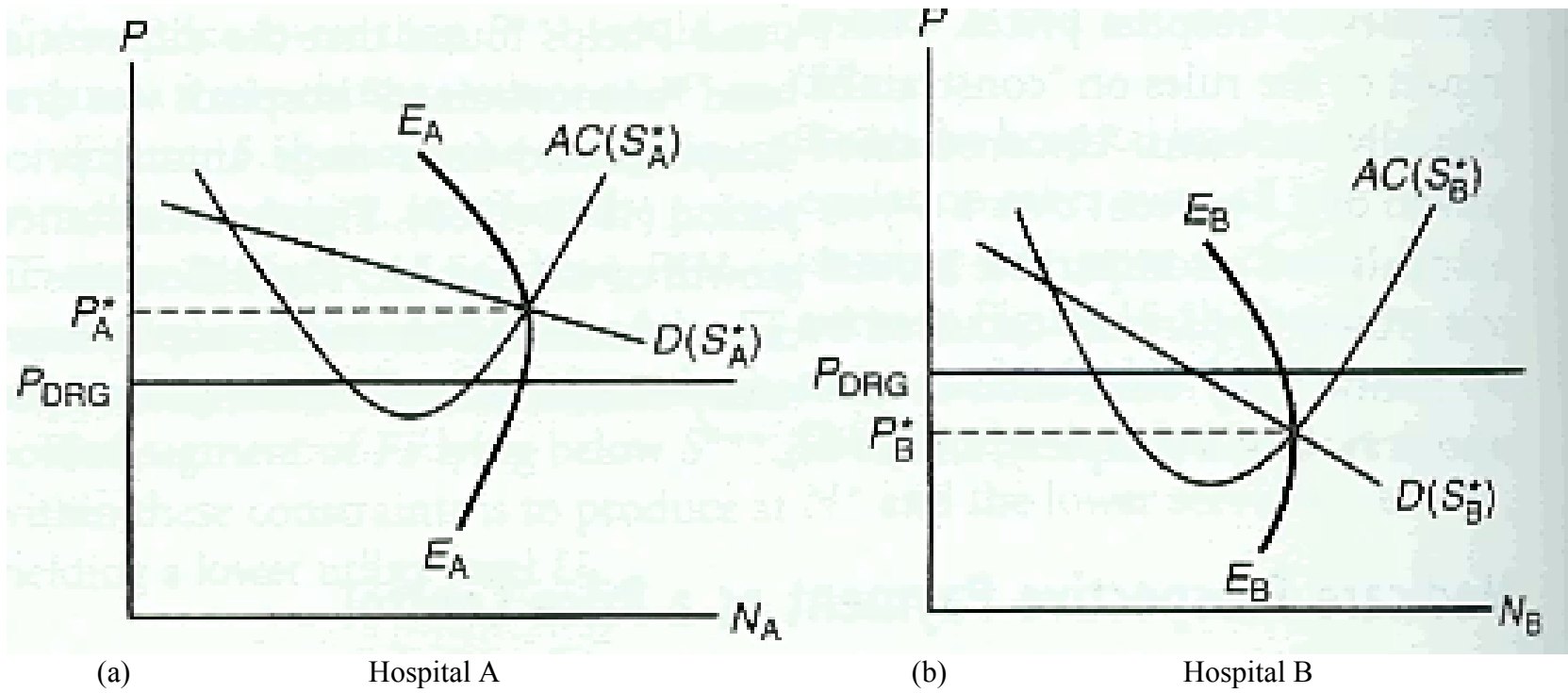
Figure 15.6 (from Phelps) Effects of DRGs (as a price control) for two prototype hospitals, one high priced and the other low priced
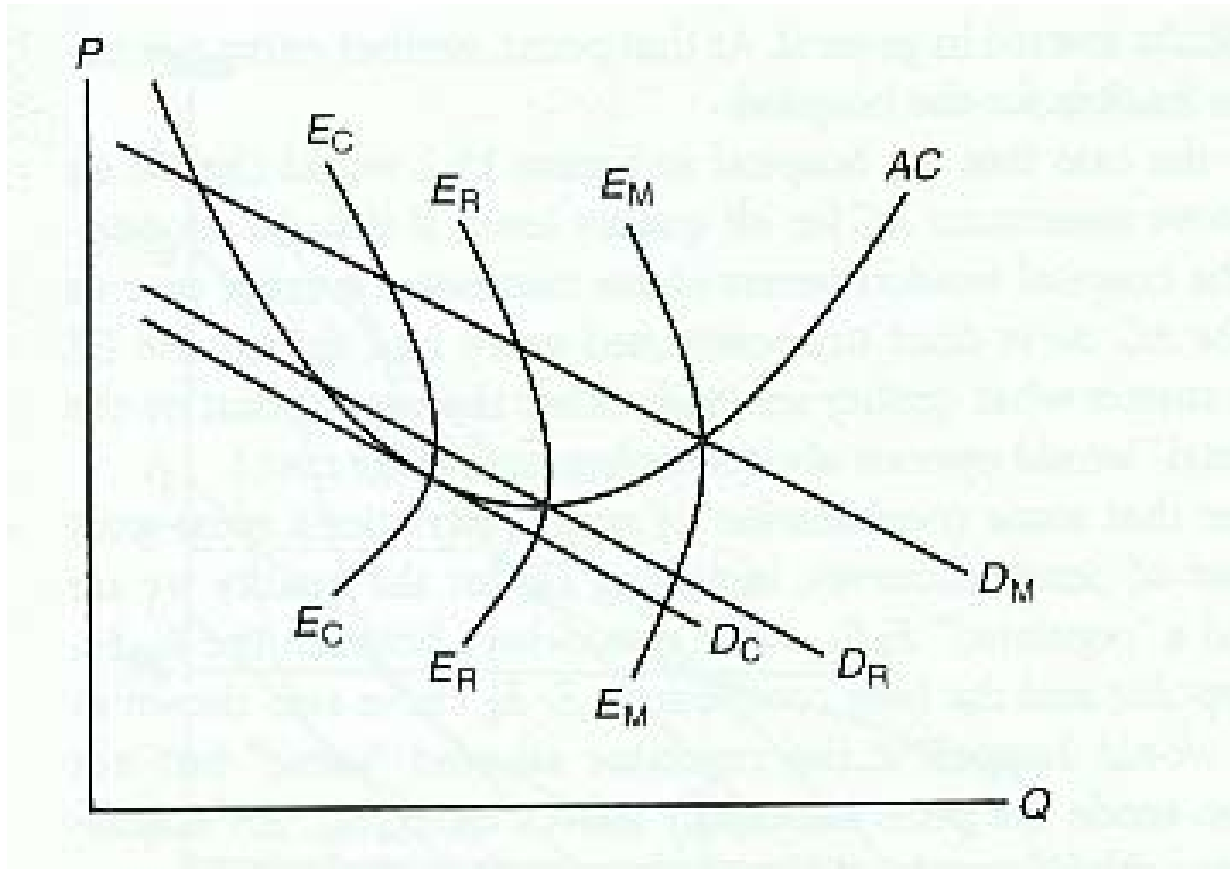
Figure 15.2 (from Phelps) Monopoly, competition, and ideal regulation to avoid excess capacity.

Note: In this figure, entry by more hospitals shifts the demand curve that each hospital faces to the left (along with the EE curves that trace out the locus of equilibrium quality and quantity possibilities for hospitals)
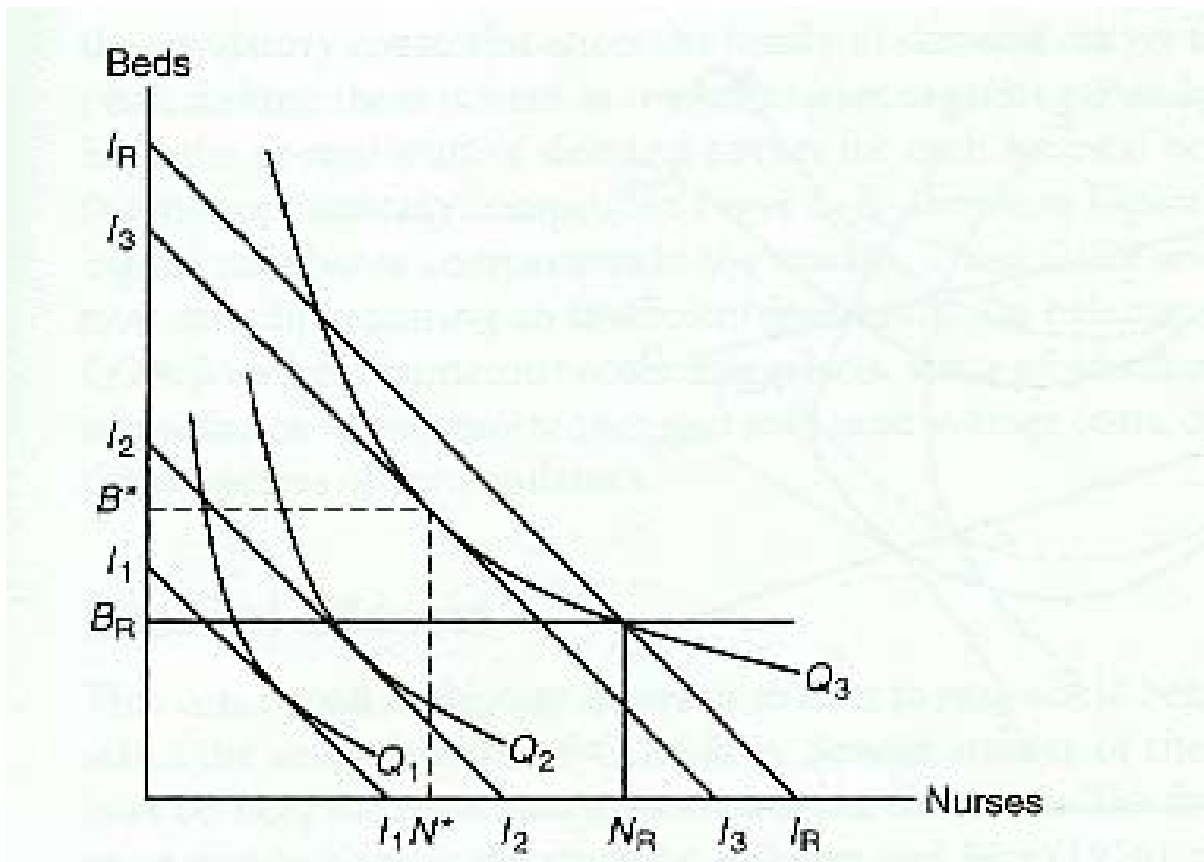
Figure 15.3 (from Phelps) Cost Minimization

Note: For small firms with isoquants Q_1 and Q_2, the constraint on beds, B_R, imposed by CON laws do not bind. However, for the firm with the isoquant Q_3, B_R binds since it is less than B^*. This third firm must produce at (B_R, N_R), which involves increasing costs from I_3 to I_R.