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# Stress on the Ward: Evidence of Safety Tipping Points in Hospitals

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Do hospitals experience safety tipping points as utilization increases, and if so, what are the implications for hospital operations management? We argue that safety tipping points occur when managerial escalation policies are exhausted and workload variability buffers are depleted. Front-line clinical staff is forced to ration resources and, at the same time, becomes more error prone as a result of elevated stress hormone levels. We confirm the existence of safety tipping points for in-hospital mortality using the discharge records of 82,280 patients across six high-mortality-risk conditions from 256 clinical departments of 83 German hospitals. Focusing on survival during the first seven days following admission, we estimate a mortality tipping point at an occupancy level of 92.5%. Among the 17% of patients in our sample who experienced occupancy above the tipping point during the first seven days of their hospital stay, high occupancy accounted for one in seven deaths. The existence of a safety tipping point has important implications for hospital management. First, flexible capacity expansion is more cost-effective for safety improvement than rigid capacity, because it will only be used when occupancy reaches the tipping point. In the context of our sample, flexible staffing saves more than 40% of the cost of a fully staffed capacity expansion, while achieving the same reduction in mortality. Second, reducing the variability of demand by pooling capacity in hospital clusters can greatly increase safety in a hospital system, because it reduces the likelihood that a patient will experience occupancy levels beyond the tipping point. Pooling the capacity of nearby hospitals in our sample reduces the number of deaths due to high occupancy by 34%.

**Keywords:** hospital occupancy; hospital mortality; safety tipping point; capacity pooling; flexible staffing

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## 1. Introduction

Avoidable deaths occur in hospitals as the direct or indirect consequence of avoidable adverse events, such as medication errors, infections, delayed treatments, or technical complications during operations. The scale of the problem was prominently highlighted by the influential Harvard Medical Practice Study in the early 1990s (Brennan et al. 1991, Leape et al. 1991), which estimated that 6,895 of the 2,671,863 patients hospitalized in New York State in 1984 had died in hospitals as a consequence of preventable adverse events—more than three times the New York State traffic death toll in the same year (U.S. Department of Transportation 2012). The U.S. Institute of Medicine responded in 1999 with the publication of the report *To Err is Human: Building a Safer Health System* (Kohn et al. 2000), which started a major global effort to improve hospital safety. Much of this effort focused on the prevention of individual

human errors through process redesign and the use of technology. For example, Bates et al. (1999) report an 81% reduction in medication errors through the introduction of computerized physician order entry systems. Leape et al. (1999) and Kucukarslan et al. (2003) report that the inclusion of pharmacists in ward rounds on intensive care units and general medicine wards led to a reduction of 66% and 78%, respectively, in preventable adverse drug reactions. Comprehensive surgical safety checklists reduced the total number of surgical complications in a Dutch hospital from 27.3% to 16.7% (de Vries et al. 2010). Despite such impressive improvements, advances appear to be isolated and system-wide progress in reducing avoidable death rates remains slow (Leape and Berwick 2005, Landrigan et al. 2010).

The mortality effects of intervention at the level of a hospital or hospital system are less well understood than those of intervention at the process level,

despite the fact that the former are less dependent on the specific organizational context and therefore more easily scalable and more likely to help achieve the desired system-wide progress. A case in point is hospital capacity pooling, where nearby hospitals agree to short-term admission diversion or staff relocation protocols in response to local occupancy surges. Although pooling does not affect average hospital utilization in the system, it reduces the variability in utilization levels of individual hospitals. Does capacity pooling reduce avoidable death rates in the system? The answer depends on the nature of the relationship between occupancy levels and mortality. If this relationship is linear, avoidable deaths in the system are not affected by pooling: Any reduction in mortality by avoiding further occupancy increases in a busy hospital is offset by an increase in mortality due to increased occupancy in the hospital that admits the diverted patients. However, if the relationship is nonlinear, capacity pooling can have a significant effect on avoidable deaths. In this paper, we will argue that bed occupancy has a highly nonlinear effect on mortality: Mortality remains unaffected by occupancy up to a tipping point, beyond which it deteriorates rapidly with further increased occupancy levels. As a consequence, capacity pooling has the potential to reduce avoidable death rates across a health system, because patient diversion reduces the propensity of a hospital to exceed the safety tipping point. At the same time, mortality in a less busy receiving hospital is not affected as long as its occupancy level remains below the tipping point.

To provide evidence for a safety tipping point, we must overcome three methodological challenges. First, avoidable in-hospital deaths are rare events. It is necessary to combine data from multiple hospitals and multiple patient segments to assemble a large sample of patients and obtain sufficient statistical power. In this study, we use patient-level data from 83 acute hospitals across six patient segments with high mortality risk.

Second, occupancy studies usually consider occupancy aggregated at the corporate hospital level. However, patients experience occupancy at the level of individual wards. Operational decisions in response to occupancy, such as the allocation of patients to specific wards, are mostly taken at the level of the clinical department. Therefore, departmental occupancy is more relevant for patient care than aggregate hospital occupancy. Unfortunately, hospital departments, as managerial units, are not standardized and are not recorded as part of U.S. or UK administrative patient records, which form the basis of most empirical studies of hospital operations. It is not possible, therefore, to reconstruct department-level occupancy from such data. Departments are, however, recorded in a standardized

way in the German discharge records that we use in this study.

The third methodological challenge is statistical in nature: When occupancy is high, doctors may choose to discharge relatively healthy patients earlier than they normally would to make space for newly arriving patients. They may well select patients for early discharge based on health-related factors that are not recorded in the discharge record and thus not observable to the researcher. As a consequence, patients in the hospital during periods of high occupancy are more unwell in an unobserved way, and the mortality risk among these patients is higher not as a consequence of high occupancy per se, but as a consequence of a changed risk set due to early discharge decisions in response to high occupancy. We account for this endogeneity in our econometric models.

Using a sample of 82,280 patients with a high risk of mortality, we estimate a tipping point at an occupancy level of 92.5%; 17.4% of these patients experienced occupancy levels above the tipping point. We estimate that one in 55 deaths (1.8%) in our sample is accounted for by high occupancy. However, 82.6% of patients in the sample never experienced occupancy above the tipping point. The effect on those patients who experienced occupancy above the tipping point is therefore considerably greater: occupancy accounts for one in seven deaths (14.4%) among these patients. This effect is clinically highly significant.

We discuss potentially beneficial interventions in tipping point systems and, specifically, the effect of flexible staffing and capacity pooling. In our sample, a counterfactual analysis suggests that a flexibly staffed capacity increase is 43% cheaper than rigid staffing for a commensurate mortality improvement. To estimate the effect of capacity pooling, we group nearby hospitals in our sample into hospital clusters and estimate that 34.4% of the deaths due to occupancy in our sample could have been avoided if nearby hospitals had pooled their capacity.

## 2. Related Literature

The nature of the association between system load and service quality in general, and hospital occupancy and mortality in particular, is not yet well understood, and the literature has hitherto produced inconsistent results. In an early paper, Oliva and Sterman (2001) built a dynamic model of a service organization to illustrate the complex interactions between service demand and managerial response and how these can lead to an erosion of service quality over time. More recently, a series of empirical studies have focused on operational efficiency and throughput in the context of hospitals. These studies acknowledge that a focus on throughput alone can have harmful

consequences for clinical quality and therefore recommend also investigating effects on clinical outcomes such as mortality rates (KC and Terwiesch 2009, 2012; Long and Mathews 2013; Berry Jaeger and Tucker 2012; Kim et al. 2013). KC and Terwiesch (2009), for example, complemented a throughput analysis of a sample of cardiothoracic patient records from a U.S. hospital with a study on the effect of workload on mortality. They found a significant effect of fatigue on mortality, but could not identify a significant effect of bed occupancy.

In contrast to these throughput studies, this paper focuses on system load as a cause of quality deterioration and complements recent studies that consider workload effects at the level of individual workers. Powell et al. (2012) show that doctors' discharge coding behavior is affected by workload, with a detrimental effect on hospital reimbursement. Green et al. (2013) show that absenteeism rates are correlated with anticipated future nurse workload. Drawing on the theory of stress, Tan and Netessine (2014) show that workload has a curvilinear effect on waiters' performance and illustrate that a reduction in staffing can in fact lead to an increase in revenues. In the same vein, Hopp et al. (2007) illustrate within a queuing model that when a server has discretion over service time in response to workload, increasing the number of servers may worsen congestion. We incorporate these insights into the development of the tipping point hypothesis, which integrates the effects of excess capacity, managerial actions, and individual worker responses to explain the organization-level effect of variation in system utilization on service quality.

Several recent studies in the medical literature have identified a link between hospital activity levels and mortality (see Kane et al. 2007 for a review). Schilling et al. (2010) explore the effects of hospital occupancy on the day of admission, annual nurse staffing levels, and seasonal factors on hospital mortality and found that admission on days when the hospital is in the top tertile of its occupancy range is associated with elevated mortality risk. Needleman et al. (2011) study the effect of below-target nurse staffing levels using patient and staffing data from a U.S. medical center and conclude that registered nurse staffing below target levels is associated with increased mortality. These studies model workload with a dichotomous "high/low" variable, which does not rule out a linear relationship between occupancy levels and mortality. Our study goes further in that we estimate a continuous nonlinear occupancy model that supports the existence of a safety tipping point.

In summary, the main contribution of this paper is to point out that there are good operational reasons to expect the effect of occupancy on mortality to exhibit a threshold phenomenon: occupancy has no discernable effect on mortality up to a tipping point, beyond which

it affects mortality significantly. By not taking this phenomenon into account, previous studies either could not detect an effect or overestimated effects at low occupancy levels and underestimated the severity of very high utilization. We provide evidence for the existence of safety tipping points and discuss some managerial implications.

### 3. The Tipping Point Hypothesis

In most countries, hospital planning focuses on bed capacity as the primary metric for sizing hospital departments; requisite staffing and other resources are largely calculated on a per-bed basis, using ratios that depend on departmental characteristics (Rechel et al. 2010). Consequently, as the volume of patients in a department approaches full bed capacity, workload pressure builds up across the unit as all resources become stretched. Capacity utilization—measured as the percentage of beds occupied—is therefore a useful aggregate measure of workload pressure in hospital departments.

Occupancy levels in acute hospitals show significant variation because demand for urgent care is unpredictable. Such variation is managed by drawing on variability buffers. The first and most obvious buffer is built-in excess capacity: Hospital plans are typically based on average bed occupancy levels in the order of 85% to 90%, thus providing a capacity buffer for demand peaks (Green 2004). A second class of buffers relates to managerial actions when occupancy levels rise. Managers may ask staff to work overtime, deploy flexible staff from elsewhere in the hospital, or hire temporary staff from nursing banks or medical locum agencies. In 2004–2005, UK hospitals spent 9.4% of their nursing budget on temporary nursing staff (Department of Health (UK) 2007). In addition, hospitals can manage demand by canceling scheduled elective cases at short notice in response to unexpected surges in emergency admissions. UK hospitals, for example, cancel between 0.7% and 1.0% of elective patient admissions at the last minute for reasons unrelated to the circumstances of the scheduled patient (Department of Health (UK) 2012). The third class of buffers relates to responses by front-line staff. Doctors and nurses are willing to work harder and for longer in times of crisis (Scott et al. 2006). In fact, many nurses choose their profession based on an intrinsic motivation to care for people in need. Doctors undergo a substantial socialization process during their long professional training (Laine and Davidoff 1996). The values and professional norms of healthcare workers instill a strong motivation and willingness to go the extra mile, which provides an important human variability buffer.

As workload increases, healthcare professionals are forced to ration access to care and, in doing so, will give priority to sicker patients. KC and Terwiesch (2012) and

Long and Mathews (2013) provide evidence of active rationing at busy intensive care units (see also Berk and Moinzadeh 1998, Kaul et al. 2004). Although rationing can have a negative effect on those who are less sick, the ability to prioritize is an important variability buffer that helps to shelter the most critically ill. All these variability buffers are drawn on simultaneously as system load increases and allow a hospital department to cope with a wide variation in occupancy levels while safeguarding the most critical aspect of clinical care: the avoidance of death.

However, as occupancy levels continue to rise, the organization's variability buffers become depleted: All beds are filled and additional patients need to "board" in other departments, no more elective patients can be canceled at short notice, and qualified agency staff are scarce or resources to hire them are limited. Yet demand for hospital care can be unrelenting. Acute care hospitals cannot turn emergency patients away. When the variability buffers are depleted, resources need to be rationed more aggressively; doctors and nurses begin to cut corners even for more seriously ill patients, using service quality as an implicit variability buffer (Oliva and Sterman 2001, Hopp et al. 2007).

In addition to cutting corners as a conscious response to excessive workload, doctors and nurses are at risk of developing workload-related stress, which causes their performance to deteriorate. According to Lazarus and Folkman (1984), stress results from an imbalance between demands and resources, occurring when demand pressure exceeds an individual's perceived ability to cope. This is precisely the case when workload becomes excessive and the ability to cope by exploiting buffers reaches its limits. This effect is observed by Piquette and Reeves (2009, p. 1251) in the context of critical care, where individual distress occurs "in unexpectedly high demands unmatched by appropriate resources." At the biological level, workload stress leads to elevated stress hormone levels, specifically those of cortisol (Dickerson and Kemeny 2004, Sonnentag and Fritz 2006), which impairs workers' cognitive abilities, especially memory and attention, and the quality of their decision making (Lupien et al. 2007). In addition, teamwork deteriorates: Piquette and Reeves (2009, p. 1251) observe that emotional distress is "strongly contagious to other team members, [...] disruptive for teamwork and deleterious for individual and collective performance." The consequent negative impact of stress on clinical outcomes is well documented in the medical literature. Dugan et al. (1996) show, for example, that nursing-related stress is associated with the propensity of adverse incidents; Buckley et al. (1997) show that haste and stress were causative factors in 17% of 281 critical incidents.

In summary, as system utilization increases to moderately high levels, managers respond by exploiting

resource buffers and well-motivated employees work harder. Quality of care can largely be maintained and safety is not negatively affected. However, at very high utilization levels, variability buffers are depleted and managerial response is inhibited. If utilization exceeds this critical tipping point, managers are unable to respond. The pressure is passed on to front-line staff, who are unable to escape it. They then respond in two ways: first, by consciously cutting corners, using quality as an implicit variability buffer; and second, by subconsciously committing more errors as a result of elevated stress hormone levels. As a consequence, quality of care and safety will deteriorate during periods of high utilization.

## 4. Context and Data

### 4.1. Data from German Hospital Departments

To provide empirical evidence for the hypothesized tipping point phenomenon, we make use of patient discharge records from German hospitals. The German context is particularly suited for a department-level analysis across multiple hospitals for two reasons. First, the organizational structure of German hospitals is tightly regulated, resulting in rigid and fairly homogeneous departmental organization across hospitals. The structural similarity begins at the top: Almost all German hospitals have the same top management team structure, consisting of a commercial director, a medical director, and a nursing director, each with well-defined roles and obligations within the hospital. The departmental structure below the executive team is also standardized, including general services, such as kitchens and laundry, large diagnostic divisions, such as radiology and pathology, and clinical departments, including general surgery and general medicine, as well as specialist departments. These bed-bearing clinical departments are the focus of our study, and system utilization is measured at the level of these organizational units. Importantly, every department has a clinical director—the *Chefarzt*—who, as lead physician, has ultimate clinical responsibility for all patients and is the superior of all other doctors in the department. The clinical director also has budgetary responsibility for the department. Although there is a cautious trend toward the use of interdisciplinary beds, the system remains rigid and the vast majority of patients and resources are managed at the level of these clinical departments. In particular, any responses to occupancy variations are most likely to be managed at departmental rather than hospital level.

Second, in contrast to those in the United States and the United Kingdom, German hospital discharge records contain standardized department codes, including departmental referrals during a hospital episode. Earlier multihospital mortality studies concentrated

on the effect of aggregate hospital occupancy (e.g., Schilling et al. 2010). By contrast, we measure daily occupancy at the level of departments within hospitals. This is important because managers and clinicians are most likely to respond to occupancy levels in their department. Aggregate hospital occupancy measures the departmental load that is relevant for a particular patient with significant error, which leads to attenuation bias and underestimated effect sizes (Wooldridge 2002).

Our initial database consists of standardized discharge records from 101 German hospitals, covering all patients discharged from the hospitals during a specific period. The database contains data for 12 months for 72 hospitals, covering January 1 to December 31 of either 2004 or 2005, and 29 hospitals are observed for 24 months, from January 1, 2004, to December 31, 2005, totaling 1,415,754 patient-episode records across 624 hospital departments. Since high occupancy is unlikely to impact the mortality risk of relatively healthy patients, we select a subsample of patients with high mortality risk and focus on patients with six primary diagnoses identified by the U.S. Department of Health as conditions “for which mortality has been shown to vary substantially across institutions and for which evidence suggests that high mortality may be associated with deficiencies in the quality of care” (Agency for Healthcare Research and Quality 2006): acute myocardial infarction (AMI), congestive heart failure (CHF), gastrointestinal hemorrhage (GIH), hip replacement after fracture (HIP), pneumonia (PNE), and stroke (STR). To increase the homogeneity of the sample, we remove all hospitals that do not have emergency admissions, such as rehabilitation clinics, because such hospitals are unlikely to have critically ill patients. For departments with a small volume of these high-risk patients, mortality is rare and department fixed effects together with patient covariates can predict survival perfectly. This leads to numerical instability of the maximum likelihood optimization procedure. We therefore exclude all departments for which the department is a perfect predictor of patient survival.

The fact that the entire patient population for each hospital department is included in the data allows us to calculate daily midnight patient counts for each hospital department from January 1 of the respective observation year. However, at the end of the observation period, we do not have data about patients who are admitted but not discharged during the observation period. As a consequence, calculated occupancy rates begin to drop during the final month of a hospital’s observation period. We therefore restrict our sample to patients admitted between January 1 and November 30 of a hospital’s observation period. The removal of patients who were admitted during the final month of hospital observation is prudent in light of an average

length of stay of 12 days for our chosen subsample. The remaining sample consists of 82,280 patients in 256 departments of 83 hospitals.

#### 4.2. The Need for a Large Sample

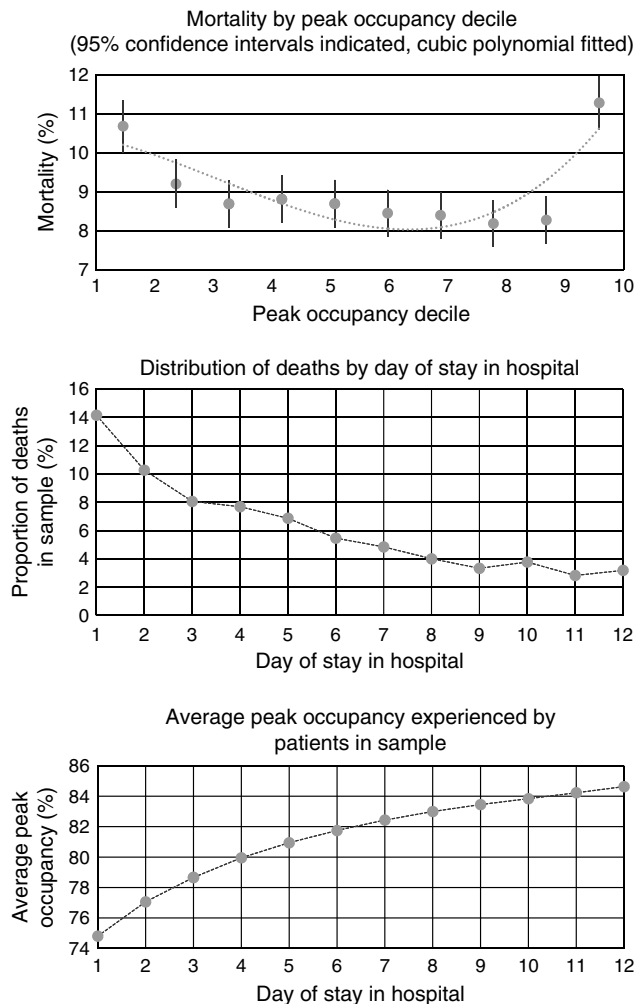
It would be preferable to conduct analyses at the level of single hospital departments and single conditions. However, such subsamples have insufficient size to produce statistically significant results. Although mortality is relatively high among the conditions in our sample, the event of interest—*avoidable* death due to high occupancy—is rare. Estimates of rates of avoidable death range widely in the medical literature, depending on the context; Gruen et al. (2006) study a sample of trauma deaths and estimate that 2.64% were avoidable; Healey et al. (2002) investigate deaths in several surgical departments and find that between 19.0% and 44.1% were avoidable.

A sample size estimation reveals the magnitude of the associated statistical challenge. The simplest specification is a logistic regression model of the form  $\text{logit}(Y_i) = \alpha + \beta X_i + \gamma Z_i$ , where  $Y_i$  is a dichotomous variable indicating the death of patient  $i$ ,  $X_i$  is the occupancy covariate, and  $Z_i$  is a vector of control covariates. For ease of interpretation, let us assume here that  $X_i$  is a dichotomous variable that takes the value 1 if patient  $i$  experiences occupancy levels above a threshold beyond which we believe mortality will be affected. The logistic sample size formula of Hsieh et al. (1998) can then be used for a power analysis for a significant two-tailed Wald test for the null hypothesis  $H_0: \beta = 0$ . The required sample sizes for 80% power at a 5% significance level depends on the unknown effect size, i.e., the excess mortality of those patients who experience occupancy levels above the tipping point. If a patient population mortality of 5% rises to 5.5% for the subpopulation above the tipping point and if 15% of patients experience such high occupancy levels, then the required sample size exceeds 85,000. The required sample size increases further if the occupancy variable  $X_i$  and the controls  $Z_i$  are correlated (Hsieh et al. 1998) or if the population mortality is lower than 5%. The required sample size decreases if the effect size is larger or if more patients are exposed to occupancy levels above the tipping point. In conclusion, mortality studies of the type we conduct in this paper require large samples of high-risk patients. Since only a relatively small proportion of any single hospital’s patients will have a sufficiently high mortality risk, we must combine data from multiple hospitals and multiple patient segments.

#### 4.3. The Need for a Survival Analysis

Figure 1 gives an initial indication of the tipping point on the basis of raw data and illustrates the importance of accounting for time already spent in the hospital in

**Figure 1** Uncontrolled Association Between Day of Stay, Peak Occupancy, and Mortality



the statistical analysis. The figure is based on a patient-day data set, where each observation corresponds to a record of one full in-patient day for a particular patient, including an appropriate measure of occupancy experienced by the patient up to this observation day. Figure 1 is based on peak occupancy, defined as the maximum of all midnight occupancy levels experienced by the patient up to the beginning of the observation day. We will discuss occupancy measures in more detail in §4.4. The top graph in Figure 1 shows how mortality varies across the deciles of peak occupancy, initially decreasing but with a surprisingly marked increase at the 10th decile. The fact that mortality decreases with peak occupancy is to be expected. First, as the middle graph in Figure 1 shows, the mortality risk decreases with the length of stay, because most deaths occur during the first few days of the stay, when patients are most critically ill. Second, as illustrated by the bottom graph, peak occupancy increases over time: The longer a patient stays in the hospital, the more likely it is that

she will be exposed to high occupancy levels at some point during her stay. The combination of decreasing mortality and increasing peak occupancy with time results in a decrease in mortality with peak occupancy, as indicated in the top graph up to the ninth decile of peak occupancy. This expected trend, however, is starkly reversed at the tenth decile, in accordance with the tipping point hypothesis.

This observation informs our choice of model. Specifically, it rules out the use of the simplest mortality model, which focuses on patient episodes as the unit of observation, survival as a dichotomous episode outcome, and an appropriate aggregate measure of occupancy during the patient episode as the independent variable of interest (e.g., KC and Terwiesch 2009). This model is problematic in our context because it requires the aggregation of occupancy over a patient's episode. The natural aggregate occupancy metric is the average occupancy over the patient's stay. The standard deviation of this metric, however, depends on the length of stay of the patient: the fewer days the patient spends in the hospital, the larger the variation of the average occupancy over these days will be. Therefore, the distribution of the episode-averaged occupancy metric across the patients in the sample will contain an overproportional number of patients with a short length of stay in both tails. At the same time, mortality is higher for patients with a short length of stay for two reasons: first, death curtails length of stay; and second, as shown in Figure 1, patients are most likely to die during the first few days in the hospital. Combining these two facts—the higher frequency of patients with a short length of stay in both tails of the distribution of average occupancy and the higher mortality among patients during the first few days—leads to a nonlinear association between occupancy and mortality. This nonlinear association, however, is a consequence of the aggregation mechanism—the averaging of occupancy—not of occupancy per se and would lead to the identification of a spurious tipping point. Note that one cannot use length of stay as a control variable in a patient-level model of mortality, because mortality curtails length of stay, resulting in reverse causality. It is important to use a model that incorporates the time-varying nature of occupancy and survival analysis is therefore the natural modeling choice. We use a discrete-time survival model based on patient-days as unit of observation, which takes account of the effect of time spent in the hospital and treats occupancy as a time-varying covariate. We explain the survival model in more detail in §5.

The dependent variable of interest in the discrete survival model is a patient's probability of death during a full day in the hospital; the causal variable of interest is peak midnight occupancy experienced by the patient prior to the observation day. It is important

to note that the admission day is not a full day in the hospital. A patient who is admitted to the hospital at 6 P.M. is, *ceteris paribus*, less likely to die on the admission day than on the first day of her hospital stay because she spends only six hours in the hospital on that first day. In fact, the time spent in the hospital on the admission day varies by patient. This makes the inclusion of the admission day problematic because we cannot estimate the probability of death on a full day for these patients. In addition to this methodological concern about the inclusion of the admission day, there is also a contextual concern. Death on the day of admission is less likely to be caused by the conditions in the admitting department and is more likely the result of the conditions in the emergency department or operating theater, if an emergency operation is necessary. We do not have information on these conditions. In view of these methodological and contextual concerns, we discard the patient's admission day, beginning patient observation at midnight following admission, and study the adverse effect of departmental occupancy on the population of patients who survive their admission day.

Occupancy may affect patients differently at different stages of their hospital stay. Specifically, patients are likely to be more critically ill during the early phase, while they recover during the later phase of their stay. Convalescent patients are not as care intensive with regard to monitoring requirements and will be less vulnerable to deviations from optimal care. However, when patients stay considerably longer than expected, this is an indication that they are more severely ill. Since peak occupancy up to the  $t$ th day of the hospital stay is a monotone function of  $t$ , this change in the risk profile of the remaining patients at high values of  $t$  could potentially cause the "bathtub" curve of mortality as a function of peak occupancy, as observed in the top graph in Figure 1. To rule out this cause and increase the homogeneity of the patient-day sample, we restrict our survival analysis to the first week of a patient's hospital stay, which, as shown in the middle graph in Figure 1, is the most critical period of a patient's stay. Such prescribed follow-up periods, known as administrative or type I censoring, are common in clinical and epidemiological studies

(Klein and Moeschberger 1997). The first seven days is a prudent estimate of this critical phase in light of an average length of stay of 12 days. All admitted patients are observed daily at midnight over the first seven days of their stay or up to their day of death or discharge, if this occurs before the end of the seventh day in hospital. After the seventh day, patients are not observed further. Table 1 contains summary statistics of the final sample.

#### 4.4. Occupancy as a Time-Varying Covariate

Because occupancy refers to the percentage of used capacity, we need to first measure capacity for hospital departments. The natural measure is the number of beds in operation; however, this number is rarely available as public documents refer to the number of *certified* hospital beds. Interviews with hospital managers reveal that this number can deviate significantly from the number of beds in operation that are fully resourced and readily available for patients and is therefore not a reliable measure of operational capacity. In addition, certified bed numbers, although available on aggregate for hospitals, are not available at the department level, where we wish to measure occupancy. Moreover, certified bed numbers are only one measure of capacity; others refer to the availability of equipment, operating theaters, and staff. Therefore, instead of bed numbers, we use the maximal daily midnight patient count in the department over the department's observation period as a measure of the department's capacity. For each day of the patient's stay, we then define daily capacity utilization as the ratio of the midnight patient count at the beginning of the day and the department's capacity. Note that our capacity measure is fixed for each department, and therefore variation in the department's occupancy rate is caused only by variation in the department's midnight patient volume; the maximal midnight patient count acts as a normalizing constant to make patient volume variations comparable across departments.

In the survival analysis framework, where we observe patients daily, occupancy is a time-varying covariate. A critical question is how exposure to varying occupancy levels over time should be measured for an individual patient. The midnight patient count at

**Table 1** Descriptive Statistics of Sample

Condition	Patients	Percentage of full sample (%)	Emergency admissions (%)	Age (mean)	Mortality (%)	Length of stay (days)	Seven-day mortality (%)	Seven-day discharges (%)	Seven-day patient-days
AMI	12,811	15.60	53.1	68.1	9.4	10.0	5.9	39.8	69,985
CHF	17,852	21.70	44.5	74.9	9.0	11.4	4.8	29.7	109,089
GIH	9,029	11.00	48.5	64.9	5.2	9.2	2.8	50.9	48,128
HIP	7,974	9.70	66.8	73.5	5.3	17.0	2.4	10.9	52,795
PNE	14,610	17.80	50.5	63.8	11.5	11.7	6.2	27.2	91,179
STR	20,004	24.30	61.9	69.7	10.5	13.5	6.5	20.6	126,404
Full sample	82,280	100.00	53.7	69.4	9.1	12.1	5.2	29.1	497,580



the beginning of day  $t$  would appear to be a natural candidate to affect mortality on day  $t$ . However, with this occupancy metric we would only capture the immediate effect on the observation day; lagged effects, two or three days hence, would be discarded. In view of the rareness of avoidable deaths, it is unlikely that we will have enough power in our data to detect this immediate occupancy effect. A second candidate is the average occupancy experienced up to the beginning of day  $t$ . However, the use of this metric is problematic within a tipping point model and is likely to lead to the spurious detection of a nonlinear effect discussed in §4.3. The time dummies in the survival model do not control for this effect, because they only affect the intercept of the occupancy curve and not its shape. We would therefore estimate a nonlinear effect for time-averaged occupancy, even when occupancy has no effect.

We choose the maximal midnight occupancy level up to the beginning of day  $t$  as the measure of the occupancy experienced to date by a patient in the hospital on day  $t$ . This *peak occupancy* metric has the advantage of being monotonically increasing over the stay in the hospital, which captures an important lag effect: Exposure to high occupancy on day  $t$  can lead to death on a later day and cannot be “undone” by low occupancy after day  $t$ . This monotonicity property of the time-varying exposure also introduces a positive correlation with time, which is itself negatively correlated with mortality. Since the resulting correlation between peak occupancy and mortality is negative, the detection of a positive effect of peak occupancy on mortality beyond a tipping point will only become more difficult, which renders significant estimates conservative.

#### 4.5. Control Variables

The need for risk-adjustment of patient-level data is discussed comprehensively in the literature (Iezzoni 2003). Our discharge records contain several variables that allow us to control for patient heterogeneity. Beside the primary medical condition and the individual risk factors age, gender, and emergency admission, the presence of secondary diagnoses is an important source of heterogeneity. To account for these comorbidities, we follow Needleman et al. (2011) and use indicator variables for a list of coexisting conditions (Elixhauser et al. 1998), adapted to the German context following Quan et al. (2005). In addition, we control for admission from another hospital with a dichotomous variable and for departmental transfers within the hospital prior to the observation day with a time-varying exposure dummy that takes the value 1 on all days following the first departmental transfer within the hospital.

We include day-of-stay dummy variables to model the baseline mortality hazard over the patient stay. To account for differential baseline risk across the six

conditions, we interact the day-of-stay with the primary condition. Seasonal effects must also be controlled for as there may be times of the year when certain conditions occur more frequently or in a more severe way, e.g., through the winter months, and when occupancy in hospitals is also higher. Time of year can, therefore, confound results. To control for potential temporal correlations, we include dummy variables for the month of the year and for the observation year 2005. We also control for the day of the week of admission to account for the so-called “weekend effect” discussed in the medical literature (e.g., Bell and Redelmeier 2001): patients who are admitted on weekends have a higher mortality risk relative to weekday admissions, even after controlling for their individual risk factors. Finally, we control for the day of the week of the observation day.

We use department dummy variables to control for organizational heterogeneity in an aggregate way as departments will have differences in case mix, size, and staffing. We use department fixed effects rather than hospital fixed effects because departments are fairly autonomous units in our context, as explained in §4.1. To account for potential correlations between the error terms of patients in the same department, we cluster standard errors at the department level. The appendix summarizes the control variables included in the models and shows their correlations with daily mortality and peak occupancy.

## 5. Econometric Specification

We wish to estimate the association between the occupancy levels that patients experience during their hospital stay and the probability of in-hospital survival. Because occupancy levels are most reliably calculated on the basis of midnight counts, a discrete-time survival analysis using patient-day observations is a natural modeling framework for this purpose. The population of interest in this study consists of patients who are admitted to the hospital with one of the six high-risk conditions discussed in §4.1 and who survive until midnight on their day of admission to the hospital. By beginning our observation at midnight following admission we ensure that all observation periods are equal in length. We follow up with patients for seven full days after admission and wish to estimate patient  $i$ 's discrete mortality hazard on day  $t$  after admission:

$$h_{it} = P[T_i = t \mid T_i > t - 1, X_{it}], \quad t = 1, \dots, 7, \quad (1)$$

where  $T_i$  denotes the day of death of patient  $i$ , counted following the day of admission ( $t = 0$ ); and  $X_{it}$  is a covariate vector that is observable at the beginning of day  $t$ . The time-varying covariate vector  $X_{it}$  includes

dummy variables for each period  $t$ , capturing a baseline hazard model as a time-dependent intercept, as well as a component  $X_{jit}$  for peak midnight occupancy experienced by patient  $i$  up to the beginning of day  $t$ . The most common logit, probit, and cloglog specifications for discrete-time hazard models (Singer and Willett 2003) give very similar results. We report results for the probit specification

$$P[Y_{it} = 1 | X_{it}] = \Phi(X_{it}\beta), \quad (2)$$

where  $Y_{it}$  is the observed dichotomous mortality variable, which takes the value 1 if patient  $i$  dies on day  $t$  and 0 otherwise; and  $\Phi$  is the standard normal cumulative distribution function.

### 5.1. The Tipping Point Model

We use a piecewise linear specification to estimate a potential tipping point with respect to occupancy. Specifically, assuming the peak occupancy that patient  $i$  experiences up to day  $t$  of her hospital stay is stored in the  $j$ th component  $X_{jit}$  of the covariate vector  $X_{it}$ , we use the parametric specification

$$\beta_{j1}X_{jit} + \beta_{j2}\max\{X_{jit} - \beta_{j3}, 0\} \quad (3)$$

to model the tipping point  $\beta_{j3}$ . Here,  $\beta_{j1}$  is the slope of the line to the left of the tipping point and  $\beta_{j2}$  captures the change in slope of the line as  $X_{jit}$  exceeds the tipping point  $\beta_{j3}$ . We estimate all three parameters  $\beta_{j1}$ ,  $\beta_{j2}$ , and  $\beta_{j3}$ .

This tipping point model is parsimonious with the minimum number of required parameters—one for the tipping point and one for the behavior of the function on either side of the tipping point—and has several advantages over the more common polynomial specification of a nonlinear effect: First, it treats the tipping point explicitly as a parameter, which will allow us to estimate confidence intervals for the tipping point; second, its estimates have an immediate interpretation; and third, the shape of the piecewise linear function can be asymmetric, with different slopes on either side of the tipping point. The disadvantage of the piecewise linear model is that the term  $\beta_{j2}\max\{X_{jit} - \beta_{j3}, 0\}$  in (3) renders the probit maximum likelihood problem nonconcave. Fortunately, concavity is restored once the tipping point  $\beta_{j3}$  has been fixed in (3). To optimize the likelihood function, we first estimate the remaining parameters repeatedly for a range of tipping points  $\beta_{j3}$  and then use a procedure suggested by Muggeo (2003) to check optimality and estimate the standard error of the tipping point estimate.

### 5.2. Average Partial Effects

In view of the difficulty of interpreting coefficient estimates in generalized linear models, it has become customary to base statistical inference on average

partial effects (APE) (Wooldridge 2002). Given probit estimates  $\hat{\beta}$  based on (2), individual patient-day-level partial effect estimates

$$\nabla_X P[Y_{it} = 1 | X_{it}] = \phi(X'_{it}\hat{\beta})\hat{\beta}$$

are aggregated to average partial effects

$$\text{APE}(\hat{\beta}) = \frac{1}{N} \sum_{(i,t)} \phi(X'_{it}\hat{\beta})\hat{\beta}, \quad (4)$$

where  $\phi(z) = \Phi'(z)$  is the standard normal density and the sum is taken over all  $N$  patient-days  $(i, t)$  in the sample. The APE has a natural population-based interpretation as the proportional effect of a unit increase in a covariate across *all* patient-days (Wooldridge 2002). The asymptotic variance-covariance matrix of the APE can be obtained via the delta method and is of the form  $M\hat{V}M'$ , where  $\hat{V}$  is the variance-covariance matrix of the probit coefficient estimates,

$$M = \frac{1}{N} \sum_{(i,t)} \phi(X'_{it}\hat{\beta})[I - X'_{it}\hat{\beta}\hat{\beta}'X_{it}], \quad (5)$$

and  $I$  is the identity matrix (see Green and Hensher 2010, Chap. 2.6.6). In the context of the tipping point model, we are interested in the average partial effect of peak occupancy below and above the tipping point. To compute these two average partial effects, we average over the appropriate subsample of patient-days with peak occupancy above and below the tipping point, respectively, rather than over the entire sample. Model (3), however, does not provide a direct estimate of the slope above the tipping point  $\beta_{j3}$ ; instead, this slope is the sum of the two correlated estimates  $\beta_{j1}$  and  $\beta_{j2}$ . Furthermore, the slope  $\beta_{j1}$  applies to occupancy below and above the tipping point. We therefore reestimate the model for the already optimized tipping point  $\beta_{j3}$  using the following reparametrization of (3):

$$\tilde{\beta}_{j1}\min\{x_{jit}, \beta_{j3}\} + \tilde{\beta}_{j2}\max\{x_{jit} - \beta_{j3}, 0\}. \quad (6)$$

In this model,  $\tilde{\beta}_{j1} = \beta_{j1}$  estimates the slope below the tipping point  $\beta_{j3}$ , and  $\tilde{\beta}_{j2} = \beta_{j2} + \beta_{j1}$  estimates the slope above the tipping point. Because the Muggeo (2003) estimation procedure for the tipping point does not apply directly to the parametrization (6), we first estimate the tipping point on the basis of the parametrization (3), then we fix the tipping point  $\beta_{j3}$  and reestimate the model with the alternative parametrization (6). We then calculate average partial effects associated with  $\tilde{\beta}_{j1}$  and  $\tilde{\beta}_{j2}$  via (4) and (5) by averaging over the relevant subsamples of patient-days with peak occupancy below or above the estimated tipping point  $\beta_{j3}$ .

### 5.3. Discharge as a Competing Risk

Patient observations are censored in two ways in our model: First, we follow patients only during the first week of their stay in the hospital and discard observations beyond the first week. This so-called type I censoring is noninformative; i.e., censoring of a patient provides no information about the survival probability of this patient beyond the censoring time. Standard survival analysis methods allow for such uninformative right censoring (Klein and Moeschberger 1997). Second, patients are lost to follow up when they are discharged from the hospital. This censoring is informative; knowing that a patient has been discharged provides information about her health status and thus her survival prospects. To treat discharge properly as informative censoring, we use a competing risk model, with discharge as the competing risk, and estimate the subdistribution hazard, a concept introduced by Fine and Gray (1999) that is applied increasingly in biostatistics and epidemiology (Lau et al. 2009). Rather than censoring discharged patients on the day of discharge, the Fine–Gray approach maintains the records of the discharged patients in the data beyond the time of discharge. This is operationalized by duplicating a patient’s record on the day of discharge and censoring the patient at the end of the seven-day follow-up period. Estimation is achieved by applying model (2) to the expanded data set.

The expansion of the risk set on day  $t$  by all patients who were discharged prior to day  $t$  changes the hazard definition. The standard mortality hazard—the probability that a patient survives day  $t$  in the hospital, conditional on having survived up to the end of day  $(t - 1)$ —is estimated by  $h(t) = N_t/R_t$ , where  $N_t$  is the number of patients in the sample who die on day  $t$  of their hospital stay and  $R_t$  is the number of patients in the sample who are still in the hospital at the beginning of day  $t$  of their stay. If we keep the records of discharged patients in the data set after their discharge date, as proposed, we enlarge this risk set on day  $t$  and estimate  $h_s(t) = N_t/(R_t + D_t)$  instead, where  $D_t$  is the number of patients who were discharged prior to the  $t$ th day of their stay. This quantity estimates the Fine–Gray subdistribution hazard, which is the probability of dying on day  $t$  given that either the patient is still in the hospital at the beginning of day  $t$  or the patient has been discharged prior to day  $t$  (Lau et al. 2009). The fact that the discharged patients are maintained in the risk set is equivalent to assuming that all patients discharged before day seven of their hospital stay would have survived in the hospital up to the end of the follow-up period of seven days had they not been discharged and would not have been exposed to further variation in occupancy levels. Using the subdistribution hazard in our context, therefore, leads to a conservative estimate of the mortality risk, accounting

for the unknown correlation between discharge risk and mortality risk. We refer the reader to the original paper by Fine and Gray (1999) and the survey article by Lau et al. (2009) for more details on this method. In §7.1, we explain and analyze an alternative to the Fine–Gray approach as part of our robustness checks.

## 6. Results

We estimated the discrete subdistribution model (2) using the *probit* command in STATA, Version 13. Table 2 shows the estimation results for the variables of interest. The linear model includes peak occupancy up to the observation day as a linear covariate. The estimated coefficient ( $\beta = 0.127$ ,  $p = 0.024$ ) is statistically significant at the 5% level. The slope estimates in the tipping point model refer to the parametrization (6). The tipping point and its standard error are estimated using the alternative parametrization (3), as proposed in Muggeo (2003). The tipping point is estimated at 92.5% with a 95% confidence interval of [88.9%, 96.0%]. In contrast to the linear model, the tipping point model renders peak occupancy below the tipping point statistically insignificant ( $\beta = 0.0374$ ,  $p = 0.56$ ). The effect of peak occupancy above the tipping point, however, is statistically highly significant ( $\beta = 1.772$ ,  $p < 0.001$ ). The overall model fit is significantly improved relative to the linear model (deviance = 12.4,  $p = 0.002$ ). These estimations support the tipping point hypothesis.

### 6.1. Effect Size Estimations

Of the 557,828 patient-days in our expanded sample, 71,510 (12.8%) were associated with historical peak occupancy above the estimated tipping point. The average historical peak occupancy on these days was 95.8%, and the average daily mortality rate on these days was 0.00757; i.e., on average, 757 of 100,000 patients who had experienced occupancy above the tipping point in the past died each day. The final column

**Table 2** Coefficient Estimates of Discrete (Daily) Subdistribution Hazard of In-Hospital Mortality

	Linear model	Tipping point model
Peak occupancy	0.127* (0.0561)	
Tipping point		0.925 (0.0184)
Peak occupancy below tipping point		0.0374 (0.0647)
Peak occupancy above tipping point		1.772*** (0.442)
Patient-days	557,828	557,828
Number of parameters	366	368
Log-likelihood	−22,143.46	−22,137.26
p-value of likelihood-ratio test		0.002

*Notes.* Robust standard errors in parentheses. Errors clustered by hospital department.

\* $p < 0.05$ ; \*\*\* $p < 0.001$ .

**Table 3** Average Partial Effect Estimates of Discrete (Daily) Subdistribution Hazard of In-Hospital Mortality

	Linear model	Tipping point model
Peak occupancy	0.0024* (0.0011)	
Peak occupancy below tipping point		0.0007 (0.0012)
Peak occupancy above tipping point		0.0337*** (0.0091)

Note. Standard errors in parentheses.

\* $p < 0.05$ ; \*\*\* $p < 0.001$ .

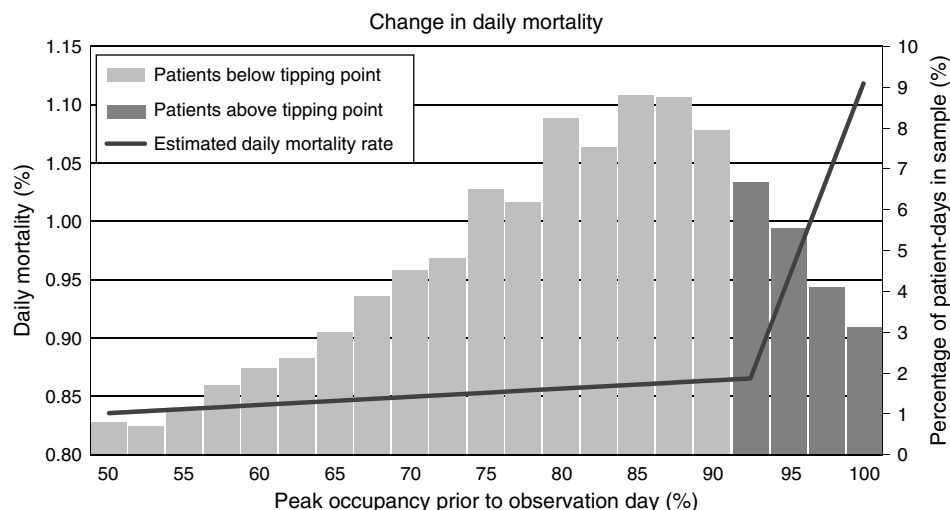
in Table 3 reports the average partial effects for the tipping point model, as explained in §5.2. The average partial effect estimate of peak occupancy above the tipping point is 0.0337 with a 95% confidence interval of [0.016, 0.052]. This suggests that a reduction of peak occupancy *above* the tipping point by one percentage point, reducing average occupancy from 95.8% to 94.8%, would reduce the daily mortality rate on these days by 0.000337 (95% CI = [0.00016, 0.00052]). On aggregate, the daily loss of 757 patients per 100,000 patients would be reduced by 39 patients (95% CI = [16, 52]), which equates to a reduction of the death rate by 6.2% (95% CI = [2.9%, 9.5%]). This is a clinically significant effect associated with a modest one percentage point reduction in peak occupancy above the tipping point. Figure 2 gives an indication of the effect of peak occupancy on daily mortality. The slopes of the mortality line correspond to the respective average partial effect estimates, and the vertical axis intercept is calculated such that average mortality on patient days below the tipping point is achieved at average peak occupancy levels on patient-days below the tipping point. The histogram indicates the distribution of patient-days in the sample. A comparison of the average partial effects in Table 3 shows that the linear model overestimates the

effect of a reduction of occupancy below the tipping point and severely underestimates the effect above the tipping point.

The tipping point model suggests a straightforward estimation of the total number of avoidable deaths due to high system load in the sample: Our model allows us to predict the mortality hazard on each observed patient-day for varying levels of peak occupancy. For each patient-day with a peak occupancy value above the estimated tipping point level of 92.5%, we can compare the predicted mortality hazard  $h_{it}$  (1) with the counterfactual predicted hazard  $h'_{it}$  if peak occupancy were reduced to the tipping point level. Summing up the differences between these two hazards over all patient-days in the sample provides an estimate of lives saved if no patient in the sample had experienced peak occupancy above the tipping point. For our sample this results in 78 lives saved out of 4,247 deaths: an overall reduction in mortality by 1.8%. One in 55 deaths in the sample is accounted for by occupancy above the tipping point.

Since peak occupancy can only have an effect on *avoidable* deaths, it is useful to relate this estimate to avoidable death estimates in the medical literature. Such estimates vary significantly depending on the context (Lessing et al. 2010). Combining an extreme estimate of a 44.1% avoidable death rate (Healey et al. 2002) with the estimated one in 55 deaths due to high occupancy in our study results in a combined estimate of 4.2% avoidable deaths due to high occupancy. Combining our estimate with a more realistic assumption that one in 10 deaths are avoidable in our high-risk sample would suggest that 18% of these avoidable deaths can be explained by peak occupancy above the safety tipping point.

So far, we have only discussed the size of the effect of high occupancy on *all* patients. However, 82.6%

**Figure 2** The Tipping Point Phenomenon

of patients in our sample did not experience occupancy above the tipping point. If we relate the estimated 78 saved lives to the 541 deaths among the 14,321 patients who experienced occupancy levels above the tipping point, the size of the effect becomes substantially larger. The counterfactual analysis suggests that 14.4% of deaths among these patients could have been avoided if no patient had been exposed to occupancy above the tipping point.

## 7. Robustness Checks

### 7.1. Discharge as a Selection Problem

Patients are discharged as their health status improves, and this discharge trigger may well be affected by occupancy levels. When occupancy is high, doctors make space for new patients by discharging some patients prematurely (KC and Terwiesch 2012). If this is so, they are likely to choose patients who are less ill for early discharge (Long and Mathews 2013). We have dealt with discharge as a competing risk, based on the subdistribution approach of Fine and Gray (1999). In this section, we analyze an alternative way of dealing with discharge by extending the probit model (2) to account for endogenous discharge decisions in a bivariate probit model with selection (Green 2003). As in the standard probit model, we assume that death occurs on day  $t$  when a latent sickness status  $Y_{it}^*$  becomes positive. Analogously, discharge on day  $t$  is triggered by a second latent variable  $S_{it}^*$ , which is interpreted as the difference between the utility for a clinician of keeping patient  $i$  in hospital beyond day  $t$  and the utility of discharging her on day  $t$ . If  $S_{it}^* > 0$ , then the patient is kept in hospital beyond day  $t$ ; otherwise, she is discharged on day  $t$ . Both latent variables are assumed to depend on individual covariates and random errors

$$\begin{aligned} Y_{it}^* &= X_{it}\beta + \epsilon_{it}, \\ S_{it}^* &= Z_{it}\gamma + \nu_{it}. \end{aligned} \quad (7)$$

As in the probit model (2), both error terms are assumed to follow standard normal distributions. However, some of the unobserved factors that explain the latent sickness status may also affect the discharge decision. We therefore allow for correlated errors and assume them to be sampled from a bivariate normal distribution with a correlation coefficient  $\rho$  that needs to be estimated. By allowing for correlated errors in the simultaneous equations, we lift relevant unobserved information from the discharge equation to the mortality equation.

In a standard bivariate probit model, one observes each of the four combinations of the two events, discharge and death. In our context, however, we do not

observe the combined outcome—death and discharge— but just one of three event combinations:

1. patient  $i$  was discharged on day  $t$ ;
2. patient  $i$  was not discharged on day  $t$  and died on day  $t$ ;
3. patient  $i$  was not discharged on day  $t$  and survived day  $t$ .

This leads to a bivariate probit model with selection (Green 2003, Chap. 21.6.4). This model allows us to test for confounding by discharge in our sample by testing whether  $\rho$  is significantly different from zero.

Although the bivariate model is, in principle, identified by its bivariate normality assumption, robust identification benefits greatly from covariates that satisfy an exclusion restriction (Wooldridge 2002). Such variables are significant predictors in the discharge equation but are excluded from the mortality equation in the sense that they have vanishing coefficients in the population model of this equation. The former condition is testable, while the latter is an untestable assumption. We make use of two covariates for which we believe an exclusion restriction is plausible. The first covariate is a dichotomous variable that takes the value 1 if the observation day is a Sunday. Patients are unlikely to be discharged on Sundays because administrative staff is unavailable and staffing is generally lower and focused on clinical care. It is plausible to assume that, after controlling for the control variables, patients are not more or less likely to die on a Sunday than on a weekday.

The second variable with an exclusion restriction is the discharge rate of the other patients (i.e., excluding the observed patient) on the day of observation. This variable captures the general discharge behavior of clinicians and should be related to the observed patient's discharge probability. We believe it is plausible to assume that this variable satisfies an exclusion restriction for the outcome equation, i.e., that an individual patient's probability of dying on day  $t$  does not depend on the rate at which other patients in the department are discharged, after controlling for the other variables in the mortality equation. To make discharge comparable between departments, we calculate the z-score of the number of discharges for each day in each department by normalizing daily discharge numbers with respect to the average number of discharged patients and the associated standard deviation in the department during the observation period for the department. Formally, we calculate the following variable for patient  $i$  in department  $j$  on day  $t$  of her stay:

$$z_{ijt} = \frac{d_{ijt} - (\bar{d}_j - 1)}{\sigma_j}, \quad (8)$$

where  $d_{ijt}$  is the number of other patients (excluding patient  $i$ ) discharged on day  $t$  of patient  $i$ 's stay

in department  $j$  and  $\bar{d}_j$  and  $\sigma_j$  are the average and standard deviation of the daily discharge numbers in department  $j$  during the observation period. We use  $\bar{d}_j - 1$  instead of  $\bar{d}_j$  in the numerator because the variable relates to all patients except patient  $i$ .

We estimate the bivariate model using the *heckprob* command in STATA, Version 13. The occupancy tipping point estimate of 92.4% and the slope estimates for peak occupancy in the mortality equation are similar to the estimations in Table 2, with an insignificant left slope ( $\beta = -0.0518$ ,  $p = 0.45$ ) and a highly significant right slope ( $\beta = 1.568$ ,  $p < 0.001$ ). The selection effect, as identified by the correlation coefficient between the error terms in the two equations, is significant ( $\rho = 0.272$ ,  $p < 0.01$ ), as are the two variables with exclusion restrictions in the selection equation, the Sunday indicator variable ( $\beta = 0.256$ ,  $p < 0.001$ ), and the discharge rate of the other patients ( $\beta = -0.213$ ,  $p < 0.001$ ). In summary, the selection model provides very similar results to the subdistribution hazard model.

### 7.2. Proportional Hazards

The survival model assumes that the effect of peak occupancy before the observation day is the same for all observation days during a patient's stay in the hospital. To test this proportionality assumption, we divide the seven-day observation window into an early phase, from the first to the third day of stay, and a late phase, from the fourth to the seventh day, and code phase-dependent slopes on either side of the tipping point using a phase dummy variable (Singer and Willett 2003). The tipping point estimate remains at an occupancy level of 92.5% and the estimated coefficients for peak occupancy below the tipping point are 0.032 (standard deviation = 0.074,  $p > 0.1$ ) for the early phase and 0.0436 (standard deviation = 0.089,  $p > 0.1$ ) for the late phase, whereas the coefficient estimates for peak occupancy above the tipping point are 1.957 (standard deviation = 0.623,  $p < 0.01$ ) for the early phase and 1.662 (standard deviation = 0.636,  $p < 0.01$ ) for the late phase. A Wald test does not reject the equal coefficient hypothesis for the two phases ( $p = 0.95$ ). We are therefore satisfied that the proportionality assumption is tenable in our case.

### 7.3. Expanded Follow-Up Period

Recall that we chose the seven-day follow-up period because we expect unobserved heterogeneity among patients to increase with time spent in the hospital. Although most patients with the considered conditions are severely ill during the early phase of their stay, they separate into two groups during the later phase: those whose health is improving and who are soon to be discharged and those who were particularly ill at the outset and remain at risk of dying. As the hospital stay progresses, the latter, sicker group of patients may in fact dominate the patient pool and, in conjunction with

the monotonically increasing peak occupancy, cause a spurious tipping point estimate. As a robustness check, we estimate a model over a 14-day follow-up period. The model estimates a significant tipping point at 92.1% with left slope 0.126 (sd = 0.0579,  $p = 0.03$ ) and right slope 1.36 (standard deviation = 0.326,  $p < 0.001$ ). To test the proportionality assumption, we then allowed for different slopes in the first and second weeks of the patient's stay, as in §7.2. The tipping point changed to 93.0%. A Wald test failed to reject the hypothesis of equal slopes only marginally ( $p = 0.07$ ), indicating that the proportional hazards assumption will become violated as we expand the follow-up period. This provides additional justification for our choice of a seven-day follow-up period.

### 7.4. Multiple Tipping Points and Smooth Splines

To test whether models with multiple tipping points or smooth curves would fit the data better, we use a model selection procedure suggested by Royston and Sauerbrei (2007), implemented in the STATA command *uvrs*, which chooses among alternative spline models with multiple breakpoints. We allow for a maximum of 10 spline pieces with nine breakpoints located at the 10th, 20th, ..., and 90th percentiles of peak occupancy. The algorithm chooses the best-fitting model by comparing successively increasingly complex spline models, i.e., models with an increasing number of breakpoints across the possible locations, with the most complex model, i.e., the model with nine breakpoints. The algorithm stops when this most complex model does not provide a significantly better fit at the 5% significance level, based on the chi-square statistic of log-likelihood differences. If all goodness-of-fit tests are significant, the most complex model is chosen. We first estimate linear spline models, i.e., continuous models with linear pieces between the breakpoints. This method identifies the piecewise linear model with a single tipping point at the 90th percentile of peak occupancy as the best fit. Repeating this procedure with cubic instead of linear splines allows for nonlinearity between breakpoints but forces smoothness at breakpoints. The resulting best-fitting cubic spline also has a single tipping point at the 90th percentile of peak occupancy, but has lower likelihood than the piecewise linear model. The advantage of nonlinearity between breakpoints is insufficient to compensate for the forced smoothness at the breakpoints. We are therefore satisfied that the piecewise linear model with a single tipping point is appropriate.

## 8. Managerial Implications of the Tipping Point

Our empirical study provides evidence that occupancy levels above a tipping point are associated with a substantial increase in in-hospital mortality. If the tipping point is reached frequently, the hospital will experience

a sustained quality problem, which may threaten its survival (Ruef and Scott 1998). In this section, we discuss two natural managerial responses: increasing capacity and pooling capacity with nearby hospitals; the first will reduce occupancy levels on all patient-days, and the second will reduce the variability of occupancy levels. From both actions we may infer that fewer patients will exceed the occupancy tipping point. We estimate the safety effects of these interventions via a counterfactual analysis on the basis of our data and model estimates and discuss the value of flexibility in the context of capacity increase.

### 8.1. Rigid vs. Flexible Capacity

We begin by estimating the effect of a 1% increase in hospital system capacity on mortality and the associated costs. To this end, we consider two options: a rigid capacity expansion with fully resourced *and* fully staffed beds, and a semiflexible capacity expansion, where beds are fully resourced but staffing is flexibly deployed in response to occupancy surges, so that the additional capacity is only fully functional when needed. Increasing system capacity by 1% reduces peak occupancy for all patient-days by a factor of 1/1.01. Our model allows us to predict the corresponding changes in daily mortality hazards, which we total across the sample to obtain the number of lives saved. Increasing capacity across the sample by 1% reduces the number of patients who are exposed to occupancy above the tipping point from 14,321 to 12,039: a reduction of 15.9%. The model predicts that 21 lives could have been saved with a 1% increase in capacity, amounting to 3.9% of the 541 patients who died after having experienced occupancy above the tipping point. Note that these 21 saved patients account for 26.9% of the 78 patients that could have been saved if *no* patient had been exposed to occupancy levels above the tipping point (see §6.1). For the cost benefit analysis we annualize the number of saved deaths, accounting for the fact that observation periods differ by department in the sample. This results in 22.13 lives saved per annum across all of the hospitals in our sample.

We estimate the annual costs of a 1% increase in capacity using national average costs (German Bureau of Statistics 2013) and department-specific staffing information from published hospital reports. We differentiate between clinical staff costs, which relate to doctors and nurses, and other infrastructure and overhead costs of capacity, such as beds, space, and support services. We consider two options: fixed staffing and flexible staffing. The fixed staffing option assumes that both clinical staff and other infrastructure costs in the department are increased by 1%. For the flexible staffing option infrastructure costs are increased by 1% and clinical staff costs are only increased by 1% on days when occupancy is above the tipping point.

For the fixed capacity option, we first increase medical staffing in all departments by 1%. For 14 departments where we do not have staffing information, we calculate staffing based on mean staffing per unit of capacity of the other departments of the same type in our sample. On aggregate, a 1% increase in clinical staffing in all departments in our sample would require an additional 52 doctors and 164 nurses. Based on national average costs this results in total costs of 13.8 M euros. Taking into account departmental capacities and department-specific national cost averages, we estimate costs for support services (radiology, pathology, anesthesia) of 4.6 M euros, administrative overheads and logistics (e.g., kitchen services, energy, maintenance) of 10.0 M euros, and capital costs of 2.0 M euros. Capital costs are based on investment costs of 0.2 M euros per bed and a depreciation period of 25 years (Bavarian Ministry of Finance 2013). All other costs were calculated on the basis of national average costs of the three most frequent conditions (diagnosis-related groups) in the department (InEK GmbH 2013). In summary, the estimated total annual cost of a 1% capacity expansion in the sample departments amounts to 30.4 M euros, of which 13.8 M euros is the cost of additional departmental medical staff. In relation to the 22.13 saved lives associated with a 1% capacity increase, this amounts to a cost of 1.37 M euros per life saved. This is a very conservative estimate of the benefits of a 1% capacity increase as it is likely that for each avoidable death there are many more adverse events that result not in death but in harm and its associated medical, legal, and reputational costs. Importantly, the capacity expansion will benefit not only the patients with one of our six conditions during the first seven days of their stay, as considered in this paper, but all patients in the department.

The tipping point phenomenon suggests installing semiflexible capacity and employing this capacity only when occupancy reaches the safety tipping point. We can estimate the associated costs by assuming that the required infrastructure is installed but its departmental clinical staffing remains flexible. The total cost of capacity without clinical staffing is 16.6 M euros. Since only 4.0% of departmental days in the sample had occupancy above the tipping point, this reduces staffing costs to 0.8 M euros, giving a total cost of 17.4 M euros, or 0.79 M euros per life saved; semiflexible capacity is 42.7% cheaper than fixed capacity and achieves, because of the tipping point phenomenon, the same mortality reduction.

### 8.2. Capacity Pooling

Because capacity expansion is associated with high costs, we study the effect of capacity pooling as a potentially less costly alternative. Pooling reduces the variability of demand and therefore of occupancy levels, which in

turn reduces the chance of a patient experiencing occupancy levels above the tipping point. Pooling is often implemented at the hospital level through cooperation agreements. Such agreements can include transfers of patients before or following admission, as well as transfers of staff to cover shortages at a partnering hospital. To date, the main rationale for such cooperation has been cost reduction; the safety aspect, due to reducing the proportion of days with occupancy levels above the tipping point, is less appreciated. We can estimate this effect within our sample.

To achieve synergies from pooling, especially for emergency patients, pooled hospitals should be in close proximity so that ambulance diversions in response to high occupancy levels do not cause inappropriate delays. We use German postcodes to estimate the distances between the hospitals in our sample. This allows us to group the 83 hospitals into clusters. We do this stepwise, starting from single hospital clusters by merging two clusters if they contain two hospitals that are less than 30 km apart. This results in 43 hospital clusters for our sample, of which the largest consists of 18 hospitals. The maximum distance between any two hospitals within any of the clusters is 53 km. We then recalculate daily occupancy levels for each department type across the hospitals in the clusters by pooling departmental capacities: For each day of the year, we combine midnight patient counts across departments of the same type in the cluster and divide these by the sum of the capacities of these departments to obtain cluster occupancy levels. Pooling reduces the 71,510 patient-days with peak occupancy above the estimated tipping point to 50,302, a reduction of 30%. At the patient level, 14,321 patients were exposed to occupancy above the tipping point on any of their first seven days in the hospital. After pooling, this number is reduced to 10,114. We can estimate the number of lives saved by calculating for each patient-day the difference between the model-predicted mortality hazard for the realized peak occupancy level and the counterfactual pooled peak occupancy level and summing up the differentials over all patient-days. This results in an estimated 27 lives saved by pooling. As we had estimated previously that 78 patients could have been saved if *no* patients had been exposed to occupancy above the tipping point, this suggests that the adverse mortality effect of high occupancy can be reduced by 34.4% by pooling alone.

These estimated benefits of pooling are purely indicative and discard important costs, such as the additional cost of patient transport. Also, even if the pooling of hospital capacity is desirable, it may not be easy to implement. Hospitals that compete fiercely, as is often the case in large cities, are less likely to cooperate; insurance companies may have different agreements with different hospitals, which can lead to reimbursement problems; patients will often be involved in the choice

of hospital and may wish to go to a specific hospital, even if it is running at high capacity. Despite these limitations, the above analysis suggests that safety can be a powerful rationale for hospital cooperation in addition to the prevalent cost argument.

## 9. Conclusion

Acute hospitals cannot turn away patients with acute conditions and therefore have to deal with surges in demand and spikes in occupancy levels. When occupancy is very high, the managerial ability to respond by exploiting variability buffers becomes constrained as these buffers become depleted. The strain is passed on to employees, who are forced to ration limited resources to cope with excessive demand, while stress impairs their cognitive abilities. In combination, these factors lead to safety tipping points in hospitals. Neither the organization nor its clinical staff are able to absorb a further increase in occupancy beyond the safety tipping point without significant deterioration in the quality of care. Our empirical analysis demonstrates that such tipping points exist. In our sample, a patient's mortality risk begins to increase significantly with occupancy when occupancy levels exceed a tipping point of 92.5%. Our results provide ammunition for operations managers when their finance colleagues argue that capacity can be reduced while activity levels are maintained. When capacity is cut, more patients will experience an unsafe day in the hospital, i.e., a day when occupancy levels exceed the safety tipping point. In our sample, 17.4% of patients experienced days with occupancy above the estimated tipping point, and one in seven deaths among these patients can be attributed to high departmental occupancy.

The existence of safety tipping points is important. Earlier studies neglect this phenomenon and either do not find a relationship between occupancy and mortality or exaggerate the effect at low occupancy levels and underestimate the effect at high levels. This is particularly relevant in the debate about capacity pooling as the associated reduction in occupancy variability reduces the chance of a patient experiencing occupancy above the tipping point. In a simulation of capacity pooling, we have estimated that in our sample more than a third of the deaths that are attributable to high occupancy could have been avoided if capacity had been pooled with nearby hospitals. This significant safety effect of capacity pooling is not apparent in a linear occupancy model, where safety gains from avoiding high occupancy in one hospital are offset by deterioration in the receiving hospital. This consideration adds an important safety dimension to the cost-reduction benefits of hospital cooperation.

A further important implication of the safety tipping point is its marked impact on the value of semiflexible capacity and, specifically, capacity with flexible clinical



staffing. Within the context of our data, we estimate that an increase in capacity with flexible staffing, utilized only at high occupancy levels, may be more than 40% cheaper than rigid capacity, while achieving the same safety outcomes in terms of mortality reduction.

We point out the statistical challenges of estimating occupancy tipping points with respect to mortality and, specifically, the fact that avoidable mortality is a rare event that requires large samples. It was necessary to assemble a multihospital department-based data set for our analysis. There are, however, other less severe but more frequent indicators of quality deterioration, such as readmission to the hospital, operating theater or intensive care, patient falls, medication errors, and patient complaints, which are routinely collected by hospitals (KC and Terwiesch 2012, Kim et al. 2013, Long and Mathews 2013). Although they are rarely associated with patient deaths, these events are indicative of poor clinical quality and are likely to be affected by occupancy levels. These events are sufficiently frequent to allow for department-level tipping point analyses, similar to the analysis conducted in this paper.

The strength of a department-level analysis would be further enhanced by including data on day-to-day variations in staffing levels, which is currently not available in a sufficiently standardized form for multihospital studies. In fact, the present paper considers departmental capacity as an aggregate figure, measured by the maximal midnight patient count in a department during its observation period, and studies the effect of changes in the percentage utilization of this aggregate capacity. In reality, capacity is determined by many factors, including facilities, such as beds and operating theaters, required equipment, and, crucially, staff. If we break down capacity into its constituent factors, we obtain separate factor utilization metrics; for example, patients per bed and patients per nurse. Some of the capacity factors will vary over time, and these factor utilization metrics will therefore not be totally correlated. Our study does not allow us to infer which of these factors have safety tipping points. With more granular data, however, it may be possible to decompose the aggregate effect of capacity utilization and estimate the individual contributions of staff utilization, measured by patients per nurse, and facility utilization, measured by patients per bed. The results of such analyses would provide much-needed evidence to guide the design of departmental escalation policies and process reengineering efforts. The call for more research on safety tipping points is summarized by feedback we received from the clinical director of a large medical department: “The tipping point is the point at which further reductions in staff are associated with worse outcomes. If we could identify what factors altered the tipping point, we might begin to understand how to improve outcomes with less staff—to

increase efficiency. What are those factors: cultural, technological, skill mix, experience?” More research is required to answer this question.

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### Appendix. Control Variables

	Mean (SD)	Correlation coefficients	
		Died	Peak occupancy
Peak occupancy	0.791 (0.125)	−0.0053***	
Conditions			
AMI (reference)	0.153	0.0058***	0.0194***
CHF	0.218	−0.0032***	−0.0330***
GIH	0.111	−0.0145***	−0.0509***
HIP	0.099	−0.0159*	−0.0498***
PNE	0.177	0.0081***	−0.0066***
STR	0.242	0.0126***	0.0934***
Age categories			
< 10	0.029	−0.0082***	−0.0613***
≥ 10 and < 20	0.007	−0.0056***	−0.0141***
≥ 20 and < 30	0.010	−0.0065***	−0.0084***
≥ 30 and < 40	0.020	−0.0096***	−0.0087***
≥ 40 and < 50	0.052	−0.0124***	0.0154***
≥ 50 and < 60	0.088	−0.0138***	0.0165***
≥ 60 and < 70	0.194	−0.0163***	0.0360***
≥ 70 and < 80 (reference)	0.289	−0.0049***	0.0104***
≥ 80 and < 90	0.244	0.0260***	−0.0175***
≥ 90	0.068	0.0313***	−0.0241***
Elixhauser comorbidities			
Congestive heart failure	0.239	0.0114***	−0.0033*
Cardiac arrhythmias	0.282	0.0100***	0.0210***
Valvular disease	0.107	−0.0105***	0.0103***
Pulmonary circulation disorders	0.029	0.0009	0.0223***
Peripheral vascular disorders	0.067	0.0034*	0.0229***
Hypertension, uncomplicated	0.432	−0.0204***	0.0572***
Hypertension, complicated	0.082	−0.0090***	0.0175***
Paralysis	0.150	0.0085***	0.0556***
Other neurological disorders	0.116	0.0074***	0.0173***
Chronic pulmonary disease	0.118	−0.0027*	0.0100***
Diabetes, uncomplicated	0.157	−0.0024	0.0184***
Diabetes, complicated	0.110	0.0000	−0.0120***
Hypothyroidism	0.033	−0.0074***	0.0082***
Renal failure	0.143	0.0072***	0.0194***
Liver disease	0.032	0.0031*	0.0038**
Peptic ulcer disease excluding bleeding	0.007	−0.0038**	−0.0048***
AIDS/HIV	0.001	−0.0010	0.0045***
Lymphoma	0.006	0.0005	0.0149***
Metastatic cancer	0.013	0.0167***	0.0025
Solid tumor without metastasis	0.025	0.0121***	0.0059***
Rheumatoid arthritis/collagen, vascular diseases	0.013	−0.0051***	0.0109***
Coagulopathy	0.030	0.0123***	0.0258***
Obesity	0.100	−0.0160***	0.0198***
Weight loss	0.023	0.0188***	−0.0148***

## Appendix. (Continued)

		Correlation coefficients	
	Mean (SD)	Died	Peak occupancy
Elixhauser comorbidities (continued)			
Fluid and electrolyte disorders	0.166	0.0192***	−0.0094***
Blood loss anemia	0.011	−0.0029*	−0.0025
Deficiency anemias	0.019	−0.0039**	−0.0035**
Alcohol abuse	0.038	−0.0041**	0.0051***
Drug abuse	0.005	−0.0037**	0.0056***
Psychoses	0.006	−0.0027*	−0.0017
Depression	0.036	−0.0111***	0.0033*
Day of stay			
Day 1 (reference)	0.148	0.0246***	−0.0143***
Day 2	0.145	0.0083*	−0.0680***
Day 3	0.144	−0.0008	−0.0174***
Day 4	0.142	−0.0020	0.0219***
Day 5	0.141	−0.0054***	0.0500***
Day 6	0.140	−0.0112***	0.0711***
Day 7	0.139	−0.0141***	0.0877***
Admission period			
January (reference)	0.096	−0.0004	−0.0059***
February	0.093	0.0019	0.1021***
March	0.103	0.0049***	0.1094***
April	0.089	−0.0004	−0.0147***
May	0.090	−0.0008	−0.0275***
June	0.085	−0.0014	−0.0127***
July	0.083	−0.0008	−0.0444***
August	0.082	−0.0003	−0.0765***
September	0.082	−0.0001	−0.0241***
October	0.088	−0.0007	0.0065***
November	0.088	−0.0013	0.0226***
December	0.021	−0.0020	−0.0966***
Year 2005	0.556	−0.0007	0.1069***
Admission day of the week			
Monday	0.178	−0.0036**	0.0580***
Tuesday	0.161	−0.0047***	0.0400***
Wednesday	0.152	−0.0001	0.0149***
Thursday	0.156	−0.0018	−0.0077***
Friday	0.147	−0.0007	−0.0756***
Saturday	0.103	0.0063***	−0.0547***
Sunday (reference)	0.104	0.0070***	0.0130***
Observation day of the week			
Monday	0.139	0.0003	−0.0553***
Tuesday	0.147	0.0001	0.0124***
Wednesday	0.148	−0.0017	0.0391***
Thursday	0.148	0.0002	0.0468***
Friday	0.154	−0.0031*	0.0337***
Saturday	0.136	0.0026	−0.0237***
Sunday (reference)	0.128	0.0018	−0.0592***
Other controls			
Gender (male = 1)	0.498	−0.0113***	0.0284***
Emergency admission	0.534	0.0178***	0.0280***
Admission from another hospital	0.064	−0.0080***	0.0276***
Departmental transfer within hospital	0.057	0.0086***	0.0549***
255 department dummies		Not reported	
30 interactions of day-of-stay and conditions		Not reported	
Patient-days	557,828	557,828	557,828

\* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ .

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