CHAPTER SUPPLEMENT

1 HEALTH SERVICES SETTINGS

Introduction

Health services are provided in numerous settings, including hospitals, ambulatory care facilities, long-term care facilities, and even at home. Before the 1980s, most health services organizations were independent and not formally linked with other organizations. Those that were linked tended to be part of horizontally integrated systems that controlled a single type of healthcare facility, such as hospitals or nursing homes. In the last 20 years, however, many health services organizations have diversified and become vertically integrated through either direct ownership or contractual arrangements.

Settings

Hospitals

Hospitals provide diagnostic and therapeutic services to individuals who require more than several hours of care, although most hospitals provide ambulatory (walk-in) services as well. To ensure a minimum standard of safety and quality, hospitals must be licensed by the state and undergo inspections for compliance with state regulations. In addition, most hospitals are accredited by *The Joint Commission*. Joint Commission accreditation is a voluntary process that is intended to promote high standards of care. Although the cost to achieve and maintain compliance with Joint Commission standards can be substantial, accreditation provides eligibility for participation in the Medicare program, and hence most hospitals seek accreditation.

Recent environmental and operational changes have created significant challenges for hospital managers. For example, many hospitals are experiencing decreasing admission rates and shorter lengths of stay, resulting in excess capacity. At the same time, hospitals are under pressure to give discounts to private third-party payers, government payments have failed to keep up with the cost of providing services, and indigent care and bad debt losses have increased. Because of the changing payer environment and resultant cost containment pressures, the number of hospitals (and beds) has declined in recent years.

Hospitals differ in function, average length of patient stay, size, and ownership. These factors affect the type and quantity of assets, services offered, and management requirements and often determine the type and level of reimbursement. Hospitals are classified as either general acute care facilities or specialty facilities. *General acute care hospitals*, which provide general medical and surgical services and selected acute specialty services, are short-stay facilities and account for the majority of hospitals. *Specialty hospitals*, such as psychiatric, children's, women's, rehabilitation, and cancer facilities, limit admission of patients to specific ages, sexes, illnesses, or conditions. The number of specialty hospitals has grown significantly in the past few decades because of the increased need for such services.

Hospitals vary in size, from fewer than 25 beds to more than 1,000 beds; general acute care hospitals tend to be larger than specialty hospitals. Small hospitals, those with fewer than 100 beds, usually are located in rural areas. Many rural hospitals have experienced financial difficulties in recent years because they have less ability than larger hospitals to lower costs in response to ever-tighter reimbursement rates. Most of the largest hospitals are academic health centers or teaching hospitals, which offer a wide range of services, including tertiary services. (*Tertiary care* is highly specialized and technical in nature, with services for patients with unusually severe, complex, or uncommon problems.)

Hospitals are classified by ownership as private not-for-profit, investor owned, and government. *Government hospitals*, which make up 19 percent of all hospitals, are broken down into federal and public (nonfederal) entities. *Federal hospitals*, such as those operated by the military services or the US Department of Veterans Affairs (www.va.gov), serve special populations.

Public hospitals are funded wholly or in part by a city, county, tax district, or state. In general, federal and public hospitals provide substantial services to indigent patients. In recent years, many public hospitals have converted to other ownership categories—primarily private not-for-profit—because local governments have found it increasingly difficult to fund healthcare services and still provide other necessary public services. In addition, the inability of politically governed organizations to respond quickly to the changing healthcare environment has contributed to many conversions as managers try to create organizations that are more responsive to external change.

Private not-for-profit hospitals are nongovernmental entities organized for the sole purpose of providing inpatient healthcare services. Because of the charitable origins of US hospitals and a tradition of community service, roughly 69 percent of all private hospitals (48 percent of all hospitals) are not-for-profit entities. In return for serving a charitable purpose, these hospitals receive numerous benefits, including exemption from federal and state

income taxes, exemption from property and sales taxes, eligibility to receive tax-deductible charitable contributions, favorable postal rates, favorable tax-exempt financing, and tax-favored annuities for employees.

The remaining 31 percent of private hospitals (21 percent of all hospitals) are investor owned. This means that they have owners (typically shareholders) that benefit directly from the profits generated by the business. Historically, most investor-owned hospitals were owned by physicians, but now most are owned by large corporations such as HCA Healthcare (https://hcahealthcare.com), which owned 185 hospitals in 2020; Community Health Systems (www.chs.net), which owned, operated, or leased 99 hospitals in 2020; and Tenet Healthcare (www.tenethealth.com), which operated 65 acute care and specialty hospitals in 2020.

Unlike not-for-profit hospitals, investor-owned hospitals pay taxes and forgo the other benefits of not-for-profit status. However, investor-owned hospitals typically do not embrace the charitable mission of not-for-profit hospitals. Despite the expressed differences in mission between investor-owned and not-for-profit hospitals, not-for-profit hospitals are being forced to place greater emphasis on the financial implications of operating decisions than in the past. This trend has raised concerns in some quarters that many not-for-profit hospitals are now failing to meet their charitable mission. As this perception grows, some people argue that these hospitals should lose some, if not all, of the benefits associated with their not-for-profit status.

Hospitals are labor-intensive because of their need to provide continuous nursing supervision to patients, in addition to the other services they provide through professional and semiprofessional staffs. Physicians petition for privileges to practice in hospitals. While they admit and provide care to hospitalized patients, many physicians are not hospital employees and hence are not directly accountable to hospital management. However, physicians retain a major responsibility for determining which hospital services are provided to patients and how long patients are hospitalized, so physicians play a critical role in determining a hospital's costs and revenues and hence its financial condition.

Ambulatory (Outpatient) Care

Ambulatory care, also known as *outpatient care*, encompasses services provided to noninstitutionalized patients. Traditional outpatient settings include medical practices, hospital outpatient departments, and emergency departments. In addition, there has been substantial growth in nontraditional ambulatory care settings such as home health care, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation and sports medicine centers, and clinical laboratories. In general, the new settings offer patients increased amenities and convenience compared with hospital-based

services and, in many situations, provide services at a lower cost than hospitals do. For example, urgent care and ambulatory surgery centers are typically less expensive than their hospital counterparts because hospitals have higher overhead costs.

Many factors have contributed to the expansion of ambulatory services, but technology has been a leading factor. Patients who once required hospitalization because of the complexity, intensity, invasiveness, or risk associated with certain procedures can now be treated in outpatient settings. In addition, third-party payers have encouraged providers to expand their outpatient services through mandatory authorization for inpatient services and by payment mechanisms that provide incentives to perform services on an outpatient basis. Finally, fewer entry barriers to developing outpatient services relative to institutional care exist.

As outpatient care consumes an increasing portion of the healthcare dollar and as efforts to control outpatient spending are enhanced, the traditional role of the ambulatory care manager is changing. Ambulatory care managers historically have focused on such routine management tasks as billing, collections, staffing, scheduling, and patient relations. However, reimbursement changes and increased affiliations with insurers and other providers are requiring a higher level of management expertise. This increasing environmental complexity, along with increasing competition, is forcing managers of ambulatory care facilities to become more sophisticated in making business decisions, including finance decisions.

Long-Term Care

Long-term care entails the provision of healthcare services, as well as some personal services, to individuals who lack some degree of functional ability. It usually covers an extended period of time and includes both inpatient and outpatient services, which often focus on mental health, rehabilitation, and nursing home care. Although the greatest use is among the elderly, long-term care services are used by individuals of all ages.

Long-term care is concerned with levels of independent functioning, specifically activities of daily living such as eating, bathing, and locomotion. Individuals become candidates for long-term care when they are too mentally or physically incapacitated to perform necessary tasks and when their family members are unable to provide needed services. Long-term care is a hybrid of healthcare services and social services; *nursing homes* are a major source of such care.

Three levels of nursing home care exist: (1) skilled nursing facilities, (2) intermediate care facilities, and (3) residential care facilities. *Skilled nursing facilities* provide the level of care closest to hospital care. Services must be

provided under the supervision of a physician and must include 24-hour daily nursing care. *Intermediate care facilities* are intended for individuals who do not require hospital or skilled nursing care but whose mental or physical conditions require daily continuity of one or more medical services. *Residential care facilities* are sheltered environments that do not provide professional healthcare services and thus for which most health insurance programs do not provide coverage.

Nursing homes are more abundant than hospitals and are smaller, with an average bed size of about 109 beds, compared with about 150 beds for hospitals.[1,2] Nursing homes are licensed by states, and nursing home administrators are licensed as well. Although The Joint Commission accredits nursing homes, only a small percentage participate because accreditation is not required for reimbursement and the standards to achieve accreditation are much higher than they are for licensure requirements.

The long-term care sector has experienced tremendous growth in the past 50 years. Long-term care accounted for about 4.8 percent of healthcare expenditures in 2016.[3] Further demand increases are anticipated, as the number of Americans aged 65 or older is projected to increase from 40.2 million in 2010 to 88.5 million in 2050.[4] The elderly are disproportionately high users of healthcare services and are major users of long-term care.

Although long-term care is often perceived as nursing home care, many new services are being developed to meet society's needs in less institutional surroundings, such as adult day care, life care centers, and hospice programs. These services tend to offer a higher quality of life, although they are not necessarily less expensive than institutional care. Home health care, provided for an extended time period, can be an alternative to nursing home care for many patients, but it is not as readily available as nursing home care in many rural areas. Furthermore, third-party payers, especially Medicare, have sent mixed signals about their willingness to adequately pay for home health care. In fact, many home health care businesses have been forced to close in recent years as a result of a new, less generous Medicare payment system.

Integrated Delivery Systems

Many healthcare experts have extolled the benefits of providing hospital care, ambulatory care, long-term care, and business support services through a single entity called an *integrated delivery system*. The hypothesized benefits of such systems include the following:

- Patients are kept in the corporate network of services (*patient capture*).
- Providers have access to managerial and functional specialists (e.g., reimbursement and marketing professionals).

- Information systems that track all aspects of patient care, as well as insurance and other data, can be developed more easily, and the costs to develop them are shared.
- Linked organizations have better access to capital.
- The ability to recruit and retain management and professional staff is enhanced.
- Integrated delivery systems are able to offer payers a complete package of services ("one-stop shopping").
- Integrated delivery systems are better able to plan for and deliver a full range of healthcare services to meet the needs of a defined population, including chronic disease management and health improvement programs.
- Incentives can be created that encourage all providers in the system to work together for the common good of the system, which has the potential to improve quality and control costs.

Although integrated delivery systems can be structured in many different ways, the defining characteristic of such systems is that the organization has the ability to assume full clinical responsibility for the healthcare needs of a defined population. Because of current state laws, which typically mandate that the insurance function be assumed only by licensed insurers, integrated delivery systems typically contract with insurers rather than directly with employers. Sometimes, the insurer, often a managed care plan, is owned by the integrated delivery system itself, but generally it is separately owned. In contracts with managed care plans, the integrated delivery system often receives a fixed payment per plan member and hence assumes both the financial and clinical risks associated with providing healthcare services.

To be an effective competitor, integrated delivery systems must minimize the provision of unnecessary services because additional services create added costs but do not necessarily result in additional revenues. Thus, the objective of integrated delivery systems is to provide all needed services to its member population in the lowest-cost setting. To achieve this goal, integrated delivery systems invest heavily in primary care services, especially prevention, early intervention, and wellness programs. The primary care gatekeeper concept is frequently used to control utilization and hence costs. While hospitals continue to be centers of technology, integrated delivery systems have the incentive to shift patients toward lower-cost settings. Thus, clinical integration among providers and components of care is essential to achieving quality, cost efficiency, and patient satisfaction.

SELF-TEST QUESTIONS

1. What are some different types of hospitals, and what trends are occurring in the hospital sector?
2. What trends are occurring in outpatient and long-term care?
3. What is an integrated delivery system?
4. Do you think that integrated delivery systems will be more or less prevalent in the future? Explain your answer.

Notes

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2. American Hospital Association. 2020. "Fast Facts on US Hospitals, 2020." Accessed January 13. www.aha.org/statistics/fast-facts-us-hospitals.
3. Hartman, M., A. B. Martin, N. Espinosa, A. Catlin, and the National Health Expenditure Accounts Team. 2018. "National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions." *Health Affairs* 37 (1): 150–60.
4. Vincent, G. K., and V. A. Velkoff. 2010. "The Next Four Decades: The Older Population in the United States: 2010 to 2050." US Census Bureau, Current Population Reports. Published May. www.census.gov/prod/2010pubs/p25-1138.pdf.