Health Care Organizations

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AMBULATORY CARE

Ambulatory (outpatient) care provided to patients in the absence of hospitalization
  – Do not stay overnight or more than 24 hours

Accounts for somewhat more that one-half of all health expenditures
Types of Ambulatory Care Organizations

Medical Group (Physician) Practices
Home Health Care
Urgent Care Centers
Ambulatory Surgery Centers
Diagnostic Imaging
Rehabilitation Centers
Dental Practices
GROWTH FACTORS
Ambulatory Organizations

Technologies
- Less invasive (lasers and scopes)
- Fewer complications & risks (newer anesthesia agents)

Reimbursement
- Do not pay for service as inpatient
- New revenue source (unbundling)

Avoid regulation

Lower cost setting (potential)

Improve patient satisfaction
- Convenience & Service
MEDICAL GROUP

Group (Organization) is *Not* Licensed
  – Instead, each physician is licensed

Medical Group = affiliation of physicians who share:
  – Income and expenses
  – Facilities and equipment
  – Medical records
  – Support personnel
Group Practice Organization

Physician Owners or Physician-Controlled Board
Medical Director

Administrador

Physicians
possibly includes other Clinical Staff, e.g., Nurse Practitioners, Physician Assistants

Strategic Apex = Physicians
Operating Core = Physicians (with some other clinical staff)
Support Services = Administrator
Home Health Care Service Mix

Preventive, supportive, therapeutic or rehabilitative health care in home setting

Services

– Homemaker & home-delivered meals
– Skilled nursing
– Home health aide
– Physical therapy
– Varies - speech therapy, occupational therapy, social worker, dietician, durable medical equipment
Home Health Care
Growth Factors

Decompress inpatient beds

DRGs
  – DRGs pay fixed rate to hospitals for inpatient care
  – On patient discharge, collect DRG rate and begin collecting for home health services

Quality of life - less institutional care

Theory - costs less than inpatient care
Other Ambulatory Organizations

Board of Directors
Or Owners

Administrator

Non-Physician and Physician Clinicians

Administrator = Clinician
LONG-TERM CARE SERVICES

NURSING HOME

ADULT DAY CARE

RESPITE CARE
CANDIDATES FOR LONG TERM CARE

Physically or mentally incapacitated and cannot perform some or all necessary tasks for daily living

Family, friends and hired help are unable or unavailable to provided the level of assistance needed

Emphasis - not on disease or medical problems
Long-Term Care Based on Level of Functioning

Activities of Daily Living (ADL)
- Eating, toileting, dressing, bathing, locomotion

Instrumental Activities of Daily Living
- Cooking, cleaning, laundry, household maintenance, reading, writing, money management, transportation, using telephone, following instructions
LONG-TERM CARE

• Hybrid of health and social services

• Delivered
  – For sustained period of time
  – To persons who lost or never acquired some functional capacity

• Diverse services
  – Assisted Living Facility
  – Nursing Homes
  – Mental Health & Rehab
GROWTH AREA

Increased number of elderly
More women working
Geographic dispersion of families
Increased elder spending power
Emphasis on self-reliance
TYPES OF NURSING HOMES

SKILLED NURSING FACILITY (SNF)
– Highest level of nursing home service
– Organized professional staff & physician supervision
– Have one on-site RN for at least 2 shifts daily
– Provide continuous nursing care

INTERMEDIATE CARE FACILITY (ICF)
– Second highest level of care
– RN on-duty at least one shift daily

CUSTODIAL CARE FACILITY
– Lowest level of care
– Board & Care
Skilled Nursing Facility

Skilled Nursing Facilities provide:

– Licensed

– Short-term, intensive medical care and monitoring for people recovering from acute illness or injury.

– Provide highest levels of medical and nursing care, including 24-hour monitoring and intensive rehabilitative therapies.

– Intended to follow acute hospital care due to serious illness, injury or surgery.

– Medicare, Medicaid and private insurance will pay, but only up to specific coverage limits.
Licensed Practical Nurse Education

• Prerequisites
  – High school diploma required for entry in program

• Training
  – 9 to 12 month program
  – Classroom (patient care related subjects)
  – Clinical (hospital experience)

• 750,000 LPNs in 2010 (U.S)
  – Projected need in 2020 = 921,000
LPN Job Duties

– Monitor patient’s health – take vital signs
– Administer nursing care – change bandages and insert catheters
– Provide for personal hygiene – help patients dress and bathe
– Keep records of patient’s health – including charting food and liquid intake
– Report patient’s status to physician or registered nurses (RN)
Nursing Homes

Board of Directors or Owners
Nursing Home Administrator

Director of Nursing

Medical Staff

Registered Nurses (limited number)
Licensed Practical Nurses (LPNs)
Certified Nursing Assistants (CNAs)

As required by law

Therapists
Social workers
Other
LTC WAGES, BENEFITS & TURNOVER

15% Lower Wages Than Hospital Nurses

Many Have No Health Benefits

RN Turnover Rate – 48.9%

CNA Turnover Rate – 71.1%

Need to Stabilize the Workforce

Source: AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes
Intermediate Care Facilities (ICFs)

1. Provide less nursing and other medical care than SNFs.

2. For people needing long recovery period from serious illness, injury or surgery, but who no longer need SNF level of nursing care or high-tech monitoring
   - Residents in an ICF are usually ambulatory, for example.

3. Staff geared toward personal care and assistance and medical care

4. Have a licensed vocational or practical nurse on duty.

5. Medicare does not cover ICFs and private insurance coverage is rare. Medicaid, however, may cover much of ICF care.
Profile of SNF and ICF Residents

- Senility 63%
- Cannot see to read newspaper 49%
- Cannot hear on telephone 35%
- Incontinent 35%
- Bed-bound or chair-bound 31%
- Impaired speech 24%
Custodial Care Facilities

1. CCFs provide services that are often lumped together under the heading of custodial care:
   • personal assistance and low-level nursing care, but not intensive medical care.

2. Sometimes referred to as Rest Homes or Nursing Homes

3. Custodial care facilities are considerably less expensive than SNFs or ICFs

4. In addition to monitoring residents' physical conditions, they provide social, educational and recreational activities and organized exercise.
Nursing Home Ownership (2010)

Private Non-Profit 26.00%
Public 6.00%
For-Profit 68.00%

Source: CMS OSCAR Data Current Surveys and featured in Statehealthfacts.org
Point-in-Time LOS of a Nursing Facility Female Patients

- <1 Month: 37%
- 1-3 Months: 19%
- 3-6 Months: 9%
- 6-12 Months: 9%
- 1-2 Years: 8%
- 2-3 Years: 5%
- 3-5 Years: 6%
- 5-10 Years: 5%
- 10 Years+: 2%
- 10 Years+: 2%
Point-in-Time LOS of a Nursing Facility Male Patients

- <1 Month: 40%
- 1-3 Months: 20%
- 3-6 Months: 10%
- 1-2 Years: 9%
- 2-3 Years: 4%
- 3-5 Years: 4%
- 6-12 Months: 9%
- 5-10 Years: 3%
- 10 Years+: 1%
- 10 Years+: 1%
End of Life Care Organizations

HOSPICE
- Palliative & support services for terminally ill
- Unit of care = family
- Goals
  - Pain & symptom management
  - Psychological well-being
  - Curative interventions irrelevant
Health Care Social Service or Commodity?

Other Developed Nations
- Health care is a social service
- Distributed according to medical need

U.S.
- Health care is a commodity
- Distributed based on ability to pay
- Market-driven system with competition among providers and insurers
- Byproduct – high costs, including large administrative costs
Part 2 Questions

1. What differences exist in the composition of the strategic apex, middle line and operating core among hospitals, medical practices, and nursing homes?
2. What factors have influenced growth in ambulatory care, home care, and long term care?
3. What are the differences in the three types of nursing homes?
4. What are ADLs and why are they important in long term care?
5. How does the purpose of a hospice differ from that of a nursing home?