

## **A descriptive framework for new hospital roles in geriatric care**

by John A. Capitman, Jeffrey Prottas, Margaret MacAdam, Walter Leutz, Don Westwater, and Donna L. Yee

*Changes in demographics and in the operating environments of acute care hospitals have resulted in the development of new geriatric service products. Presented in this article is a framework for describing the variety of new services in terms of sponsor goals and core activities. Five broad types of geriatric service developments are described: geriatric medical*

*care, post-acute care, transition management, chronic care, and information services. Assessing the implications of new services for the organizational functioning of hospitals is discussed, followed by an examination of the potential contributions of new geriatric services to the quality and accessibility of geriatric care.*

### **Introduction**

Acute care hospitals have become increasingly concerned with the provision of geriatric medical, post-acute, and long-term care. This concern responds to numerous environmental factors that include changes in consumer markets and treatment technologies, as well as health care financing and organization. The consumer market for hospital services is changing, in part, from the growth of the aged population and from related changes in patterns of morbidity and medical treatment. The aged and, in particular, those over 75 years of age will continue to be a growing share of the population (Soldo and Manton, 1985) and the consumer market for medical care (Rice and Feldman, 1983; Manton and Soldo, 1985), at least until well into the next century. The demand for long-term care service can be expected to grow even more rapidly than implied in the Nation's demographic changes. Better health practices and improved medical technologies may lead to decreased mortality. But increased periods of disability and the resulting increased need for long-term care are also anticipated (Gruenberg, 1977; Riley and Bond, 1983; Verbrugge, 1984).

Hospital interest in products and services geared to the aged also reflects changes in the financing and organization of medical care. Under the prospective payment system (PPS), it is in the financial interest of the provider to discharge patients at the earliest medically acceptable time after admission. Evidence suggests that, nationwide, hospitals have shortened average lengths of stay for most types of cases (Sloan, Morrisey, and Valvona, 1988), though questions remain about the implications of quicker discharges for the status and service needs of patients entering post-acute settings.

Acute care providers have also been affected by other environmental changes that may influence care patterns for all age groups and by a range of business decisions. Most notable among these changes has been the growth of managed-care systems such as health maintenance organizations. Hospital ownership patterns have changed as well, with closure of small

and publicly owned hospitals and with market penetration by investor-owned and not-for-profit chains (Starr, 1982). At the same time, consumers, as well as both public and private third-party payers, have become more active in seeking organizational and financing reforms geared towards increased efficiency, continuity, and responsiveness from health care providers.

One way that hospitals have sought to meet the current challenges of a changing environment and to prepare for the coming challenges of changing patient populations has been the development of new service activities oriented towards elders and other long-term care users. In a 1985 survey of their members, the American Hospital Association found that 24 percent of hospitals owned skilled nursing facilities, 12 percent owned intermediate care facilities, 33 percent provided home health services, 14 percent provided homemaker services, and 2 percent had specialty geriatric inpatient units (Read and O'Brien, 1986). This same survey indicated that 85 percent of hospitals were considering development of new long-term care beds, and 66 percent were considering development of new outpatient services for elders.

There have been few efforts to systematically examine the implications of geriatric service development for the financial viability and organizational functioning of sponsoring hospitals. From the broader perspective of health care policy, there has been little analysis of how new hospital roles may impact on the accessibility and quality of post-acute and long-term care. Such organizational and policy assessments have been hampered by the absence of a conceptual framework for characterizing geriatric service developments.

In this article, we present a framework for describing emergent hospital roles in geriatric care; and we discuss related organizational and policy assessment issues. The discussion is drawn from an assessment of the Robert Wood Johnson Foundation's program for Hospital Initiatives in Long-Term Care (HILTC) and other projects. We propose that geriatric service developments can be described in relation to three dimensions: goals, service approaches, and organizational strategies. Three primary goals for expansion of post-acute and long-term care services are outlined: increased market share, better use of hospital resources, and new

Reprint requests: John A. Capitman, Ph.D., Director of Long-Term Care, Bigel Institute for Health Policy, Heller Graduate School, Brandeis University, Waltham, Massachusetts 02254-9110.

product lines. To achieve these goals, hospitals may develop different service approaches including specialty geriatric medicine, post-acute medical care, transition management, chronic care, and geriatric information. Because of the variations in the personnel and other resources used and consumer markets targeted for new geriatric services, they also appear as components of more general organizational strategies such as vertical integration and diversification.

We also present an application of this framework to the description of the HILTC projects, and we discuss the relative success of different services approaches and organizational strategies. Even though the HILTC experience does not provide definitive answers to sponsor goal-attainment questions, it does provide some insight into the factors that need to be considered in provider assessments of the new services. Similarly, the HILTC projects are useful in clarifying the range of issues and concerns that need to be addressed in policy analyses of hospital vertical integration and diversification efforts.

### Hospital long-term care initiatives

In 1984, the Robert Wood Johnson Foundation awarded 4-year grants to 24 general acute care hospitals to develop systems, services, and educational efforts geared towards encouraging innovation in the role of acute care hospitals in serving long-term care patients. The HILTC program participants developed a broad array of extended care efforts, the diversity of which reflected the range of sponsor and community characteristics included in the demonstration. For example, although 10 of the participants were very large facilities with over 500 staffed beds, 5 had fewer than 250 staffed beds. Similarly, 11 participants served the core of major cities, 7 were in suburban areas, and 6 served rural or primarily rural areas. These hospitals also varied on other measures such as medical school affiliation; ownership type; occupancy rates; and the proportion of discharges covered by Medicare, Medicaid, or other sources.

In 1986, the Foundation awarded a grant to the Bigel Institute for Health Policy at Brandeis University to examine the programs developed under HILTC. Because of the diversity of the sponsoring hospitals and their new programs, the study was not intended as a quantitative comparative assessment of the cost effectiveness or clinical efficacy of the projects. Rather, the evaluation goals included developing a common language for describing these diverse efforts and identifying practical lessons about their implementation that might aid other hospitals. There were two major components to the study. First, data were gathered from all 24 participants by using questionnaires and telephone interviews. Second, detailed case studies were conducted at 19 facilities using inpatient interviews and other techniques to focus on the implementation of geriatric care initiatives. In both components, the hospital, as

opposed to the Foundation-sponsored effort, was the unit of analysis; and attention thus focused on a broad range of new approaches to the aged market. Description of the HILTC experience was also informed by two other Bigel Institute projects. In planning for a demonstration of the Life Care at Home project, detailed information was collected from 14 hospitals with extensive involvements in post-acute and long-term care (Tell and Capitman, 1987). At the same time, data were collected on rural hospitals to explore the range of organizational responses to unused inpatient capacity, including participation in the swing-bed program.

### Descriptive framework

A three-dimensional approach to characterizing geriatric service developments is useful for conceptualizing the new programs because they were initiated by different mixes of participants from administrative, academic, and clinical units within the facilities. These services were labeled in conflicting ways, and they were viewed from diverse perspectives such as problem solving, exploiting new opportunities, and implementation of strategic plans. The rationales and significance of these services were viewed differently by individuals, even within the same hospital. A common language for program comparison and assessment is needed to bridge these perspectives. Our approach characterizes new services and systems relative to the goals for their implementation, the primary activities and resources required for their implementation, and how they relate to more general organizational strategies. The framework is summarized in Table 1, and each component is described below.

**Table 1**  
**Descriptive framework for hospital development of geriatric services**

Goals	Service approaches	Organizational strategies
Market share	Geriatric medicine	Vertical integration
Efficient resource use	Post-acute care	Diversification
New product lines	Transition management Chronic care Geriatric information	

### Geriatric service development goals

Three major goals for new geriatric services have been cited by the HILTC hospitals and others. Most new programs are justified on multiple grounds, but the initiators of geriatric care programs generally identified one as primary.

#### Market share

Hospitals are aware of the Nation's changing demographics and patterns of morbidity; and they are

therefore interested in expanding their roles in the provision of services to the elderly. Concerns with expanded roles in this market may reflect efforts to gain an edge over other providers in a competitive community. But even when other area hospitals are not seeking expanded roles in the aged market, gaining recognition as the preferred provider of care to elders is viewed as desirable from the perspective of winning the loyalty of clients and physicians. Market share concerns may be reflected in the organizational location or design features of geriatric services.

### **Increased efficiency**

Hospitals are increasingly concerned with how efficiently they use available resources. For many, reduced length of stay for Medicare-covered clients has been sought in the wake of PPS. Some hospitals noted that certain types of patients, particularly those requiring complex patterns of post-acute services, were likely to generate losses under PPS. Others, most often suburban and rural community hospitals, cited unused capacity; and they saw the development of swing-beds or related programs as an alternative to downsizing in response to the problem of staffed but vacant beds. Still others cited concerns with the integration of the hospital with post-acute and long-term care providers or with disorganized networks of specialty outpatient services as major sources of inefficiency in the use of hospital resources. In some cases, the development of new services was viewed as gaining experience relative to consolidated delivery systems. Many shared the belief that public policies would increasingly favor such systems. In each of these cases, concerns with increasing the overall financial viability of the hospital combined with patient-care concerns resulted in a search for measures to assure hospital clientele easy access to post-acute and long-term care services.

### **New product lines**

Hospital missions include responding to unmet needs in their communities through new service offerings. Development of new lines of business may be viewed as beneficial for the overall position of the hospital. Hospital executives were, at times, convinced that new product lines and organizational entities under the hospital's corporate umbrella would improve the financial or humanitarian status of the hospital. For example, development of new geriatric services was viewed as a means to access new revenue streams in response to anticipated restrictions in acute care spending. HILTC projects sponsored by medical school-based providers were also motivated by the desire to initiate or expand opportunities for training of interns, residents, and fellows in geriatrics. In these cases, geriatric service development was not pursued because of specific problems with current practice in acute care delivery or coordination with other providers. Hospitals that cited these goals were more concerned with the viability of the new product than

with its potential impacts on other aspects of the hospital's functioning.

## **Service approaches**

At least five broadly defined groups of geriatric services were undertaken: specialty geriatric medicine services, post-acute care medical services, transition management, chronic care services, and geriatric information services. HILTC participants and other hospitals often pursued several of these approaches at the same time. For example, more than one-half of the HILTC projects included elements drawn from three or more of the five groups. The primary features and examples of specific services within each group are discussed below.

### **Specialty geriatric medicine**

One approach to geriatric service development found at 16 of the 24 HILTC participants is the creation of medical care services that are geared, in particular, to the aged and other long-term care users. For example, hospitals may develop specialized inpatient units for geriatric care. These units reallocate existing personnel and resources to the special needs of frail elderly patients. In some cases, these units take on some of the features of the geriatric evaluation units developed within the Veterans Administration Medical Center system, but other third-party payers have been reluctant to reimburse this model of care.

In some large hospitals, and particularly among providers affiliated with medical schools, geriatric consultation teams have been developed. In these programs, a physician-led team that may also include geriatric nurses and other health professionals is available upon the referral of an inpatient's attending physician to review medical and nursing needs. The team may make recommendations for altering treatment regimens or for post-acute care.

Some hospitals are developing geriatric outpatient programs that coordinate medical and related services on an ongoing basis. These programs focus on providing outpatient care in a setting tailored to the particular needs of the elderly. A broad variety of medical and allied health professional specialties are assembled, and comprehensive medical assessment and treatment plans are developed for patients. In some cases, these clinics may offer transition management services, as discussed later, for clinic patients.

### **Post-acute medical care services**

Probably the most popular group of geriatric services developed, pursued by 20 of the 24 HILTC participants, has been post-acute medical services. These programs offer extended medical, nursing, or rehabilitative services to individuals who no longer require the intensity of care provided in an acute care unit. For example, hospitals have developed, purchased, or gained management of freestanding

skilled nursing facilities (SNF's), or developed hospital-based swing-bed or distinct-part SNF's.

Transitional care units, sometimes referred to as "stepdown" or "super-SNF" units, are another example of this approach. These services focus on patients whose medical needs or rehabilitative service requirements exceed the capacities of a traditional SNF but who are nonetheless sufficiently medically stable to be discharged from the acute care setting. Clinical practice in transitional care units often combines some elements of acute care provision with the special skills required for chronic and rehabilitative service delivery.

The development or purchase of a Medicare-certified home health agency represents a third example of this approach. Hospital providers of post-acute skilled home health care often note the differences between their services and client populations and those associated with community-based home health agencies. In general, hospital-based home health care has focused more attention on patients requiring technologically complex home care such as respirator-dependent cases. When hospital-sponsored home care is, in fact, high technology care aimed at exceptionally ill patients, it can be seen as an extension of the hospital's services outside its physical confines. In contrast, to the extent that hospital-based home health agencies differ little from existing community-based providers, they are really attempts at penetration into an allied but distinct industry and are better classified as examples of the chronic care strategy described later.

### **Transition management**

Four of the 24 HILTC participants developed programs that enhanced the discharge planning function of the hospital. These programs were designed to increase the efficiency and responsiveness of hospital services that assist patients in managing the transition from acute to post-acute or long-term care. Transition management programs, however, can represent a radical change in the discharge planning functions and the relationships between the hospital and community agencies. Components of transition management programs include comprehensive assessment of the functional capacities and social supports of patients on admission; identification of patients requiring post-acute or long-term care services as soon as possible during the stay; development of post-acute plans, including a broad array of formal and informal providers; and monitoring of care, either until the patient is stable or established with a community care management agency. These programs are often difficult to implement because they entail not only developing systematic arrangements with community providers but changing standard practices in several inpatient departments. Discharge planning is the most affected, but a serious attempt at transition management also has implications for clinical-care practices on the wards as well.

### **Chronic-care services**

Hospitals may develop geriatric services that represent a departure from current roles in the care of the chronically physically and mentally disabled by offering chronic care services. Developed at one-half of the HILTC sites, these services include not only intermediate care, personal care, and supportive residential facilities but an array of outpatient long-term care services such as adult day care, homemaker or chore, and community care management programs. All of the services in this category require the development of new staff skills and resources. Residential programs most often involve significant new capital investments. Unlike other geriatric service developments, however, developing these programs may occur with only tangential linkage to other hospital activities. Among the HILTC participants, for example, most referrals to these new services came from outside of the hospital, and program participants often were clients of competing acute care providers.

HILTC hospitals included case management among the chronic-care services they offered. Case management, as a chronic-care service approach, must be clearly distinguished from care management as part of a geriatric medical care approach on the one hand and from transition management on the other. Medical care management programs focus on the coordination of services provided by physicians and allied health professionals for clients with ongoing need for such assistance. Transition management programs address a broader array of professional, paraprofessional, and informal care providers; but the service is time limited and targeted to inpatients requiring post-acute care. In contrast, case management, like the models explored in the National Long-Term Care Channeling Demonstration and related studies (Kemper, Applebaum, and Harrigan, 1987), coordinates a broad and complex array of caregivers; but it is open-ended with respect to length of stay and targeted primarily to patients whose service needs outlast traditional post-acute third-party payer benefits. At least three HILTC hospitals became providers of long-term case management services to low-income elders whose needs were comparable to those of nursing home users under the auspices of Medicaid 2176 home- and community-based waiver programs. The remaining HILTC case management programs were targeted to those whose needs were less severe than those of nursing home eligibles and those with greater financial resources (Capitman et al., 1986; Capitman, MacAdam, and Yee, forthcoming).

### **Geriatric information programs**

Informational programs include public lecture series on aging health issues, training and counseling programs for patients and caregivers, and membership programs. Access to both lecture series and patient and caregiver programs are sometimes offered as

benefits of joining a hospital's membership program. Other membership programs offered benefits such as newsletters, assistance with billing and third-party payments, and waiver of some portion of Medicare copayments or deductions. This approach requires the smallest investment of hospital resources of all those mentioned.

## **Organizational strategy**

One way of understanding the nature of alternative goals and service approaches being pursued by hospitals that develop new extended care programs is to categorize them in terms of a more general organizational strategy. Clement (1988) suggests that hospital development of new services can be conceptualized in much the same way as the initiation of new services or product lines by any large organization. In particular, the implicit strategy in the development of a new service depends on its linkage to the core activities of the hospital—the production of medical and allied health professional diagnostic and treatment services to inpatients with relatively short-term though intensive needs defined by emergent illness. Two broad strategies may be identified: vertical integration and diversification.

### **Vertical integration**

Traditionally, hospital vertical integration has been viewed from the perspective of stages of production—owning or managing more than one link in a linear chain from insurance coverage to ambulatory care, secondary inpatient care, and tertiary care in a nursing home. However, this conception of vertical integration ignores the fact that similar allied health and paraprofessional services may be delivered outside this sequential chain or to consumers seeking services for different reasons. Clement (1988) points out that a more helpful definition focuses on the extent that new activities involve the same or similar physical and staffing resources, management approaches, consumer groups, functions for consumers, and sources of payments. From this perspective, hospitals seeking vertical integration attempt to control, through ownership or management, all production and distribution processes directly related to their core activities. Manufacturing components (supplies, machines, drugs), management of ancillary services (radiology, laboratory, dietary), education of medical and allied professional staff, and offering insurance plans are all examples of activities directly linked to the production of inpatient treatment of emergent illness. To the extent that development of new activities in these areas requires similar staffing and management approaches, they may be viewed as examples of vertical integration.

### **Diversification**

By contrast, hospitals seeking diversification develop services and products peripherally related to

their core activities. As such, the new products require new types of management expertise, personnel and physical resources, consumer groups, functions for consumers, and payment sources. A new activity may represent a more related diversification, depending on how much it requires new production technology, new types of consumers, or new functions of the product for the consumer. Development of burn centers, birthing centers, sports medicine or wellness programs, and cardiac care units are all new activities for a hospital that do not, in general, represent diversification because the elements of production and their relationships remain similar to the core activities. By contrast, development of housing or health clubs by hospitals represent unrelated diversification because they require new technologies, personnel, and a potentially broader group of consumers seeking services for reasons other than those used when seeking the services of a hospital. More related diversifications (such as those associated with some geriatric services or with selling hospital laundry, dietary, management, or data processing services to other businesses) may use related technologies and resources or serve related functions for consumer groups.

## **Applying the framework**

In this section, we apply the framework based on our interpretations of the case studies and the survey of HILTC participants. Each type of activity developed by the hospitals is classified in terms of the service approaches. Each major example of the service approaches is then classified in terms of an organizational approach based on the personnel resources required, the production technology, consumer types, functions for consumers, and payment sources. When most respondents at hospitals adopting each service approach noted major changes in any of these factors, then the service approach was classified as having diversification as the implicit organizational strategy. When major changes in these components of production were not noted by the majority of hospitals that developed a service type, it was classified as having vertical integration as the implicit organizational strategy. Finally, based on the most frequently cited reasons for developing a service or continuing it after the grant period, each example of the service approaches was classified in terms of a goal. The findings that are discussed in the next sections are summarized in Table 2.

### **Geriatric medical-care approach**

New geriatric medicine services usually used existing personnel and resources in the hospital, and they were targeted to elders who already sought acute medical and ambulatory medicine services from the sponsor. These services attempted to tailor existing product lines to the special needs of elders or to other patients with chronic medical problems. Inpatient geriatric specialty units and geriatric consulting teams were not

**Table 2**  
**Categorization of hospital geriatric services**

Service approach	Implicit organizational strategy	Primary goal
<b>Geriatric medicine</b>		
Inpatient unit	Vertical integration	New product line
Consult team	Vertical integration	New product line
Outpatient unit	Vertical integration	Market share
<b>Post-acute care</b>		
Transition unit	Vertical integration	Resource efficiency
SNF swing beds	Vertical integration	Resource efficiency
High technology home health agency	Vertical integration	Resource efficiency
Other home health	Diversification	New product line
<b>Transition management</b>	Vertical integration	Resource efficiency
<b>Chronic care</b>		
ICF personal care unit	Diversification	New product line
Adult day care	Diversification	New product line
Personal care or homemaker	Diversification	New product line
Case management	Diversification	Market share
2176 case management	Diversification	New product line
<b>Geriatric information</b>		
Lecture series	Diversification	Market share
Membership program	Vertical integration	Market share

NOTES: SNF is skilled nursing facility. ICF is intermediate care facility.

expected to affect the market role concern or to result in less intensive or shorter acute care stays. They were intended as new products that accessed existing payer streams or new opportunities for medical training. Outpatient geriatric specialty units, by contrast, were often developed or maintained because they brought new outpatients and prospective inpatients to the hospital who might otherwise have used other facilities. In addition, some of these units were self-sustaining because of third-party reimbursement.

### Post-acute and transition approaches

With the exception of home-health agencies that did not target patients requiring especially intensive or high technology services, the post-acute care and transition-management programs continued the treatment of current patients through treatment stages following sequentially from care in the inpatient units. These services did not require the development of relationships with new third-party payers or marketing to new consumer groups and referral sources. The primary goal for developing post-acute services seems to be resource efficiency. Even when these services were not financially self-sustaining because of absent or inadequate third-party reimbursement, they were retained by hospitals because of the resulting ability to more readily transfer acute care patients to a lower level of care or to receive some reimbursement on unused acute care capacity.

Development of home health agencies without a special focus on high technology cases appeared to be motivated by somewhat different factors and involved a different organizational strategy. Hospitals that developed these home health agencies tended to serve

patients from other referral sources as well as from their own acute care wards, and they needed to learn community care techniques that required new paraprofessional personnel and their management. Because of the broadened referral network, these home health agencies were more like the chronic-care services because they provided care that was not always sequentially linked to acute inpatient stays. The decision to diversify service provision in this way also tended to be based on whether or not reimbursement was adequate to cover costs for the new service, rather than on its impacts on the core activities of the sponsor.

### Chronic-care approaches

New chronic-care services required reaching out to patients seeking maintenance, as opposed to rehabilitative or treatment-oriented care. These services required development of linkages with new sources of referral, competition for social service funding, and use of service production technologies and resources that were formerly unfamiliar to hospitals. In most cases, the decision to develop these services or maintain them after grant funding terminated was based on meeting an observed community need or offering access to a new source of revenue, such as Medicaid 2176 reimbursement or Social Service Block Grant funding. The long-term case management programs not linked to 2176 Medicaid home- and community-based care systems were an exception. These services were not expected to facilitate transitions to the community because they usually targeted community residents rather than inpatients being discharged. Third-party and private

out-of-pocket reimbursement was often not available, and case management programs needed to compete with community providers. The value of these services was most often judged on the extent to which they introduced new patients to the hospital or improved its market position or image as a geriatric care providers.

### **Geriatric information approaches**

Although offering a geriatric lecture series did not require new personnel or other resources, elders did not seek these services in response to acute or chronic medical needs but rather for education or entertainment. By contrast, membership programs involved the hospital in patients' decisions about insurance for medical care and choice of acute care and ambulatory care providers. These programs were designed to increase the market share of the hospital by familiarizing prospective patients with the facility and increasing the likelihood of choosing to use its services or those of affiliated physicians. Lecture series and membership programs were most often free and, therefore, could not bring new revenue to the hospital. Providers who developed these services often believed they were also meeting a community need.

### **Organizational evaluation issues**

The foregoing framework suggests considerations for hospitals seeking to evaluate the organizational impacts of developing new geriatric services. Although, with few exceptions, the HILTC participants and other hospitals have not systematically examined the success of different approaches in attaining these goals, the experiences of the projects indicate some of the factors that need to be considered in each case. From this perspective, assessment focuses on the potential to improve the organizational functioning and financial viability of the hospital through efforts designed to improve geriatric market share, increase efficiency in use of resources, and to develop new product lines.

### **Improved market share**

Several of the service development approaches seemed primarily intended to increase the sponsor's share of the geriatric market. Several participating hospitals conducted market surveys and analyses of referrals by new programs to existing services to assess market share impacts of specialty geriatric outpatient clinics, case management services, and geriatric information programs. Results suggested that these services could bring new patients to the core services or increase community awareness of the hospital's dedication to serving the elderly. However, development of outpatient clinic and case management services may be costly, particularly when out-of-pocket or third-party reimbursement is inadequate or unavailable. As a result, assessment

efforts have to focus on the overall financial impact of the program as well as on whether or not it attracts new users. Case management programs and offsite geriatric outpatient clinics (such as clinics located at community housing or senior center sites) involved relatively small patient groups; thus, the major issues in their assessment focus on image impacts and the utilization patterns of clinic users. For larger outpatient clinic programs and geriatric information services, the evaluative focus needs to be directed to hospital utilization by program participants. To the extent that these services bring new Medicare clients to the hospital, sponsors need to consider the patient groups attracted to the hospital, how they will use services, and how this care will be reimbursed. It is possible that the overall financial viability of the hospital can be decreased rather than improved if these programs attract new patients in PPS diagnostic categories on which the facility is likely to lose money.

### **Efficient use of resources**

Some strategies for geriatric service development are intended to improve the efficiency with which hospital resources are used. Examining post-acute services and transition management requires careful study of their impacts on the utilization of core services and the resources used in their production. As with market share oriented services, if reimbursement for post-acute or transition management services is inadequate or unavailable, any savings attributed to the new programs must be compared with implementation costs. HILTC participants and others who developed post-acute and transition management programs could provide anecdotal evidence that discharge of complex patients from acute wards was facilitated. Only one HILTC site, however, conducted a clinical trial to assess impacts of transition management on acute care length of stay, but the results were inconclusive because of small highly heterogeneous samples. Overall, the small size of these programs made it difficult to assess them through time-series analyses of aggregate utilization trends. Because of these difficulties in gathering utilization data to demonstrate more efficient use of the core services, a focus on organizational change is, perhaps, more realistic for assessing program outcomes. In this context, evaluation focuses on the success of the post-acute and transition management programs in attracting appropriate referrals from other units in the hospital and in developing linkages to other community providers to facilitate more timely discharges.

### **New product lines**

Geriatric services may be developed as new lines of business, to meet observed community needs, or to enhance training programs. HILTC hospitals were able, in most cases, to access Medicare reimbursement for specialty inpatient units and Medicaid reimbursement for ICF care. Medicaid 2176 waiver

reimbursement or social service funding was accessed for other chronic-care services. Evaluation should focus, in these cases, on the ability of the hospital to negotiate favorable rates for these services. Alternatively, hospitals that consider offering home health services and chronic-care services, in competition with existing community providers or because of their absence, should focus evaluation efforts on the adequacy of new revenue to cover the costs of these services. With adequate rate negotiation and good fiscal management, these services can be self-supporting or profit-generating affiliates for an acute care hospital. The major challenge with these services revolves around managing their similarities and differences with core activities. For example, in swing-bed programs and distinct-part SNF providers, a common complaint by nursing staff is how difficult it is to vary clinical practice when the patient stays in the same bed or is transferred within the facility. Hospitals must be clear as to what extent geriatric service development will require new staff or new skills for current staff.

Third-party payment is rarely available for chronic-care services, and the hospital must fund the services for other reasons (e.g., as a loss leader). Some hospitals have explored the private-pay markets for these services with relatively little success. In many States, however, hospitals can become providers of Medicaid 2176 care-management and community services. It may still be difficult to show that these services improve the overall financial status of the hospital because of both small scale and low reimbursement rates. At times, hospitals are competing for these roles against community organizations with less costly overhead, staffing, and salary structures. Medicaid agencies may be unwilling to pay higher reimbursements, and so providers are faced with the choice of continuing to offer the services at a loss for other reasons or terminating them.

## **Implications for quality and accessibility**

There have been few attempts to assess the impacts of geriatric service developments in acute care hospitals on the quality and accessibility of care. To some extent this reflects the potentially conflicting goals and diversity of strategies in this area. Programs geared towards market share improvements, for example, may focus on increasing prospective patients' and physicians' awareness of the sponsoring hospital's position as a provider of geriatric care. But the impacts of such activities on patient access to an appropriate range of high-quality and affordable services are determined by the sponsor's geriatric services and linkages to community providers. Similarly, programs aimed at increased efficiency in the use of hospital resources through control of post-acute services focus on reducing the length and complexity of inpatient stays. But a successful post-acute program without transition management services

or other strong linkages to the acute care wards may not affect the quality of inpatient care or on the accessibility of post-acute care. Experiences of the hospitals being studied, nonetheless, suggest some of the ways that vertical integration and diversification strategies can impact on care quality.

## **Vertical integration**

Some of the geriatric medical enhancements, post-acute services, and transition management approaches that appear most consistent with Clement's concept of vertical integration also seem to hold the greatest promise for positive impacts on quality of care and accessibility. Outpatient geriatric specialty clinics can allow patients to access a full complement of appropriate services during one visit. When the clinic is linked through an information system or the primary care physician to patient treatment during an inpatient stay, it may be possible to improve both the responsiveness and the efficiency with which care is provided inhouse and during recovery. Similarly, transition management programs and stepdown or rehabilitative units can assure that patients are not lost to the caregiving system during such critical times. It would appear in each of these instances that access and quality improvements are dependent on improving information exchange and removing barriers to collaboration between hospital and nonhospital care providers.

## **Diversification**

Hospitals establishing new and essentially unrelated product lines such as provision and management of long-term social services may improve the delivery systems in their communities. New services may fill critical gaps and thus improve patient access to high-quality care. But acute care providers have yet to demonstrate that they are uniquely positioned to offer these services. Hospitals may find it difficult to compete with existing community providers on either price or quality: More intensive staffing and more highly trained professionals add to the cost, but they may not improve the responsiveness or appropriateness of community-based, chronic-care services. Hospital-based provision of chronic-care services may offer patients' and physicians' clear advantages when transition management and other integrative services are used to create stronger links between components of the delivery system and, thereby, increase the continuity of care. Further, for individuals with particularly medically complex problems, more direct organizational relations between acute and long-term care providers may increase the responsiveness of care.

## **Summary**

The preliminary and incomplete data currently available on emerging hospital roles in post-acute and

geriatric care make it difficult to assess the potential contributions of these developments for providers or consumers. It appears that it is easier for hospitals to offer new services designed to increase the vertical integration of the acute care delivery system than it is to diversify into chronic care and social services. New proposals for greater hospital control over post-acute care, for example, create strong incentives for integrative approaches. As hospitals develop the clinical and organizational management skills to support these new services, they hold the potential for increasing the continuity and medical responsiveness of care.

Diversification appears to hold less certain advantages: There is still no evidence to suggest that hospitals are uniquely positioned to expand their product lines. However, preliminary data suggest that, just as for vertical integration efforts, the success of diversification efforts will depend on the development of systems for sharing information and maximizing the continuity of care as patients move between inpatient and clinic medicine settings and the new community-based and long-term care services.

## References

- Capitman, J. A.: Community based long-term care models, target groups, and impacts on service use. *The Gerontologist* 26(4):389-397, Aug. 1986.
- Capitman, J. A., MacAdam, M., and Yee, D.: Hospital-based care management. *Generations*. Forthcoming.
- Clement, J. P.: Vertical integration and diversification of acute care hospitals: Conceptual definitions. *Hospital and Health Services Administration* 33(1):99-110, Spring 1988.
- Gruenberg, E. M.: The failures of success. *Milbank Memorial Fund Quarterly/Health and Society* 55(1):3-24, 1977.
- Kemper, P., Applebaum, R., and Harrigan, M.: Community care demonstrations: What have we learned. *Health Care Financing Review*, Vol. 8, No. 4. HCFA Pub. No. 03239. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Summer 1987.
- Manton, K. G., and Soldo, B. J.: Dynamics of health changes in the oldest old: New perspectives and evidence. *Milbank Memorial Fund Quarterly/Health and Society* 63(2):206-285, Spring 1985.
- Read, W. A., and O'Brien, J. L.: *Emerging Trends in Aging and Long Term Care Services*. Chicago. The Hospital Research and Educational Trust, 1986.
- Rice, D. P., and Feldman, J. J.: Living longer in the United States: Demographic changes and health needs of the elderly. *Milbank Memorial Fund Quarterly/Health and Society* 61(3):362-396, Summer 1983.
- Riley, M. W., and Bond, K.: Beyond ageism: Postponing the onset of disability. In Riley, M. W., Hess, B. B., and Hess, K., eds., *Aging in Society: Selected Reviews of Recent Research*. Hillsdale, N. J. Lawrence Earlbum Associates, 1983.
- Sloan, F. A., Morrissey, M. A., and Valvona, J.: Case shifting and the Medicare prospective payment system. *American Journal of Public Health* 78(5):553-561, May 1988.
- Soldo, B. J., and Manton, K. G.: Changes in the health status and service needs of the oldest old: Current patterns and future trends. *Milbank Memorial Fund Quarterly/Health and Society* 63(3):286-319, Summer 1985.
- Starr, P.: *The Social Transformation of American Medicine*. New York. Basic Books, 1982.
- Tell, E. J., and Capitman, J. A.: Life Care At Home Site Selection Project. Final Report. Waltham, Mass. Bigel Institute for Health Policy, Heller Graduate School, Brandeis University, 1987.
- Verbrugge, L. M.: Longer life but worsening health: Trends in health and mortality of middle-aged and older persons. *Milbank Memorial Fund Quarterly/Health and Society* 62(3):475-519, Summer 1984.