An Analysis of the Organizational Structures and Administrative Processes in Nonprofit and US Military Healthcare Organizations

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Abstract

This paper presents an analysis of the organizational structures and administrative processes found in nonprofit and military healthcare organizations. It provides the unique characteristics of these two types of healthcare organizations. The focus of the paper is to utilize the authors' experiences with and perspectives about these two types of health care nonprofits, in order to ascertain similarities and differences in organizational structures and administrative processes of these two health care systems.

Key Words: Nonprofit healthcare, Military Health System, organizational structures, administrative processes, comparative analysis, experiential perspectives.

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Introduction

There are many similarities and differences between public, for-profit and nonprofit organizational structures of health care facilities across the US. The focus of this paper is to identify some of those similarities and differences between manor nonprofit healthcare facilities and major US Military health care centers. In order to establish a comparative framework, background information on the two health care systems including their history need to be developed. Analysis of such information, and survey of people knowledgeable about the two systems can highlight advantages and disadvantages of both organizational systems for effective and efficient health care service delivery.

This paper was written primarily based on the experiences and knowledge of the author(s) about the two health care systems compared. To augment the authors' knowledge and initial findings, a survey was conducted with a select group of individuals who have work experience or familiarity with either of the two health care systems. Survey respondents covered six states across the US. Individual levels of exposure to the two inclusive types of health care facilities varied. Additionally, not all answered with the same number of responses by types and categories. The results of this exploratory inquiry provided various information on perceptions of the management aspects of these two systems. There are similarities in responses as well as contradictions in opinions for many of the items in the survey. This paper presents some preliminary findings of the research.

Background

Health Care Facilities in the USA

In his 1991 report on international comparative health care systems, Iglehart identified four main models of health care delivery and their respective countries of participation: Provincial Government Health Insurance Model (Canada), National Health Service Model (United Kingdom), Social Insurance Model (Germany, France, and Netherlands), and :Private Sector Model (United States, Switzerland). In the US model, patients primarily receive their health care through private providers. The current role of the government is through health care facilities for specific employees (such as veterans, military personnel and their dependents, etc.) and through provisions of Medicare and Medicaid programs. Majorities of hospitals are managed and operated through revenues generated from a combination of health care charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programs, and direct patient fees (McDougall et al., 2003). Hospitals are also paid through the multiple forms of per diem and length of stay payments.

Inpatient health care services are provided in a myriad of hospital types based on their missions and/or revenue alignments. They include: for profit (private), nonprofit, and public hospitals and health care systems. All these health care facilities differ in their administrative structures and operating procedures based on organizational goals, capacities, and revenue bases. Even among public hospitals, the organizational structure and administrative process differ between civil hospitals and military hospitals. The focus of this paper is to highlight some similarities and differences between

nonprofit hospitals and military hospitals within a comparative framework developed by the authors.

Nonprofit Health Organizations

There are currently over 1.5 million registered nonprofit organizations the United States. Of that 1.5 million, health care nonprofit organizations account for roughly one eighth of them. From the financial standpoint, health related nonprofits account for over 56% of the $1.4 trillion total nonprofit sector's reported revenue and almost 39% of the $2.6 trillion in assets. These economic perspectives of health sector nonprofits are striking, when we consider the current status of the US economy and the national debt going from under $6T in 2000 to its current position of almost breaking $15 trillion. Health related nonprofits receive a large amount of funding through grants awarded by federal, state, and local government entities. Health related nonprofits include but are not limited to: hospitals, nursing homes, research institutions, hospices, home care, community health centers, and health plans. Nonprofit hospitals account for an estimated 60% of all community hospitals in the US.

A historical perspective defines nonprofit organizations as "a body of individuals who associate for any of three purposes. The first purpose is to perform public tasks that have been delegated to them by the state. The next purpose is to perform public tasks for which there is a demand that neither the state nor for-profit organizations are willing to fulfill. The last purpose is to influence the directions of policy in the state, the for-profit sector, or other nonprofit organizations (Ben-ner & Van Hoomissen, 1991). Hansmann (1985) defines a nonprofit organization as one that is precluded, by external regulations or its own governance structure, from distributing its financial surplus to

those who control the use of the organizational assets. Despite sharing a non distribution constraint, nonprofits differ from one another in a variety of the following economically meaningful ways. First, some nonprofits deliver services whereas others (such as united fundraising organization, foundations, and donor-advised funds) make grants and program related loans to other nonprofits. Second, some nonprofits rely mostly on donations (gifts, grants, and volunteers), others on membership dues, and others on commercial activity (sales to the public or contractual provision of service to the government). Lastly, nonprofits differ in the way their governing boards are selected; and fourth, nonprofits differ in the services they provide (Powell & Steinberg, 2006). The economic evaluation and comparison of the nonprofit sector vastly differs from the for-profit counterparts. The largest reason being is the nonprofits mission of quality in service over creating a profit.

Weisbrod (1997) conveyed that as nonprofit organizations struggle to offset declining governmental support, they reach out for new markets, trying to find things they can sell profitably. He goes on to say the result is that nonprofits have thrust themselves into new arenas, generating increased competition and growing political attention. Tension has escalated between nonprofits and both private firms and governments, as competition between nonprofits and these other sectors has increased (Weisbrod, 1997).

In order to highlight organizational structure and administrative processes of nonprofit health care facilities, a case study of UF Health Shands Hospital is presented. Choice of this nonprofit hospital is due to its proximity, familiarity, and growing scope &

impacts on the health care of clients who represent communities from across the state of Florida, the nation, and the globe.

UF Health Shands Hospital

UF Health Shands Hospital is a 1,668-bed general medical and surgical facility established in 1958. It currently has 12,416 employees. The hospital had 80,448 admissions in the most recent year reported. It had more than one million outpatient visits in 2013. Its emergency room had 170,881 visits. UF Health Shands is a teaching hospital that works with University of Florida's College of Medicine. About 900 University of Florida faculty physicians practice at UF Health Shands Hospital in approximately 100 specialty and subspecialty areas of medicine. Source: https://ufhealth.org/health-system-facts-and-figures

UF Health Shands Hospital is a registered 501(c) (3) nonprofit corporation with the legal title of Shands Teaching Hospital and Clinics, Inc. The Hospital complex includes UF Health Shands Cancer Hospital, UF Health Shands Children's Hospital, UF Health Shands Psychiatric Hospital, UF Health Shands Rebab Hospital, a network of outpatient rehabilitation centers, and a home health organization.

The mission of UF Health Shands is: "to provide high quality clinical care and to promise every patient their best experience possible at UF Health." The vision of this health care organization is: "Together we strive to create unstoppable momentum toward the goal of improving individual and community health through discovery, clinical and translational science and technology, exceptional education and patient-centered, innovative, high-quality health care."

As a nonprofit, Shands is governed by a voluntary board of directors. The chair of Shands governing board is the President of the University Florida, who is a statutory designee for this role. However, the chair delegates all his roles and appointment authority of the rest of the board to University of Florida's Senior Vice President for health affairs. The administrative head of the organization is the Chief Executive Officer who reports to the Senior Vice president for health affairs, along with all the Deans of University of Florida College of Medicine, College of Dentistry, College of Health Policy and Health Professionals, College of Nursing, and College of Pharmacy. Thus, this nonprofit hospital is also the academic health center of the University of Florida.

The nonprofit serves its social mission and community health services in a variety of ways. In 2014, the total community benefit provided by UF Health Shands Hospital was more than $ 215 million. This includes: about 150 million on unsponsored charity health care services, about $3 million in community and regional health services, $2.4 million in donations and in-kind health services, about $42 million for health care professionals' education, and about $19 million for scientific and clinical research.

UF Health Shands Hospital supports communities in Florida as a part of the state's 'safetynet' hospital system by providing health care for people who have little or no medical coverage. If provides extensive community outreach through community health education programs and events to raise health awareness and promote community wellness. It plays a supportive role to local nonprofit organizations and civic groups that benefit communities. The hospital also plays a key role in community disaster response efforts.

UF Health Shands Hospital has achieved numerous accolades for is quality of health care. It has consistently earned several Top 50 spots in the “America’s Best Hospitals” ranking by the *U.S. News and World Report*. The hospital has received several awards from national and international health care and community development nonprofits such as the March of Dimes’ Order of the Bettered Foot Award, United way’s Top 10 Campaign Award, American Hearts Association’s Health Walk recognition, and American Cancer Society’s Top 10 Making Strides Against Breast Cancer Walk recognition.

Other major recognitions received by the hospital from nonprofits specializing in various health care areas include: American Nurses Credentialing Center’s Magnet Designation, Baby-Friendly USA’s (an international initiative of United Nations Children’s Fund and World Health Organization) Baby-Friendly Hospital award, American Association of Clinical Care Nurses’ Beacon Award of Excellence, and Cancer Center of Excellence. As a nonprofit health care system with such excellence and reputation, UF Health Shands Hospital has grown rapidly during the past decade with accelerated expansions of its health care facilities, programs and services during the past few years. The service mission focus, governance, and management of this nonprofit have directly contributed to its impressive growth and long lasting impacts on clients’ health care.

Government Health Facilities

Historically, the majority of governments run health facilities were state run psychiatric hospitals, Veterans Health Administration (VA) hospitals, and Department of Defense (DoD) medical treatment facilities. Currently, there are limited psychiatric

facilities left that are still run by the government. The remaining VA and DoD health facilities are dedicated to specific populations and besides under emergent conditions, non-eligible clients cannot receive care at them. Eligibility for care is a benefit authorized under US Code of Federal Regulations, and is not insurance. Operational funding is primarily provided by an annual prospective budget. The VA budget is based on the acuity of the enrolled veteran. While DoD funding is based on historical utilization rates and enrolled patients. VA facilities are authorized to create secondary funding streams outside of their annual prospective budget. DoD facilities are not able to create supplemental funding, but are able to receive reimbursement, as a secondary insurer from other health insurances an eligible client may carry. Besides funding of these remaining facilities, the government has taken a more regulatory and allocative approach to the facilities and provisioning of health care in the US.

Department of Defense Military Health System (D-o-D MHS)

Lillie and Sobel (2001) defined the Military Health System as "… a large and complex health care system designed to provide, and maintain readiness go the armed forces during military operations and to provide medical services and support to members of the armed forces, their dependents, and other entitled to Department of Defense (DOD) medical care."(Kongstvedt, 2001, p.1124) The MHS's authorization falls within Title 10, Chapter 55 of the US Code. This specific title and chapter not only authorizes the existence of the MHS, but it also provides specific guidelines in regards to defining eligibility of care, cost sharing, covered services, and many other provisioning particulars. It is imperative to understand, though the available coverage received can be compared with public and private sector high option plans, the medical

care provided to eligible beneficiaries within the MHS is part of a benefit and is not insurance.

Prior to the managed care restructuring within the MHS, the program for executing this defined mission was known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS included both the "direct care" and "purchased care in order to provide medical services. "Direct Care" is the medical care provided to the eligible population within the military owned facilities. While "purchased care" is the care bought within the civilian medical community as a form of augmentation of direct care. This augmentation is usually needed when the military does not provide for or have availability within the military treatment facilities (MTF).

In order to better meet the health demands of the eligible population while reducing the overall cost of care, the MHS reorganized their system of direct and purchased care to reflect that of the civilian managed care system. CHAMPUS was then reformed into TRICARE. "TRICARE stands for the triple option benefit plan available for military families" (TMA, 2013). Benefits of TRICARE include: a large proportion of both in and outpatient services, prescription drugs (and in some locations over the counter and wellness medications), durable medical equipment and supplies, a significant proportion of facility charges, and behavioral health services. The three options to receive these benefits are TRICARE: Prime, Extra, and Standard. TRICARE Prime is the equivalent to a health maintenance organization (HMO) within an MTF or within a specified network of civilian primary care providers. TRICARE Prime enrollment is voluntary and has no cost to the patient when utilizing it. The next option available is TRICARE Extra. TRICARE Extra resembles the preferred provider

organization (PPO) and has no annual or enrollment fees. However, there is cost-sharing of a discounted rate that is responsibility of the patient. The last available option is TRICARE Standard. TRICARE Standard is a fee for service (FFS) option that also comes with its own cost share for the patient. Standard provides a larger option for service to be selected from, but the cost is paid upfront by the beneficiary, and must submit a claim for the predetermined reimbursable amount (not always covers full OOP expenses).

Specific federal authorization for TRICARE is the 32 CFR Part 199. This provides regulatory guidance, operational features, and several similar topics that Title 10, Chapter 55 of the US code did for CHAMPUS. Additionally, the 32 CFR, Part 199.18 identifies the benefit changes from CHAMPUS. This applies to the DOD, Department of Homeland Security (Coast Guard), and the Department of Health and Human Services (Commissioned Corps of National Oceanic and Atmospheric Administration (NOAA) and the US Public Health Service) (Lillie & Sobel, 2001), and the law's provisioning and oversight is conducted by the TRICARE Management Agency (TMA). In order to execute the responsibilities, TMA divided the geographic area of responsibilities into regional offices. Currently, there are five TRICARE Regional Offices (TRO) responsible for three areas within the US (North, South, and West), Pacific, and Europe.

This benefit is extend to a potential estimated 22.7M veterans of which, 1,452,939 are current members of the Armed Services (as of 2010). These vast numbers do not include the responsibility of the MHS to the eligible spouses and children of the 22.7M.

Comparisons of the two Health Care Systems

Organizational structures and administrative processes of UF Health Shands Hospital and Department of Defense Military health care system health care systems are compared and contrasted by combining the authors' knowledge about them and the results of the survey.

Figure 1 contains the consolidated matrix of the results from the exploratory survey. It captures perspectives on the advantages and disadvantages of nonprofit health care organizations and Department of Defense Military health care systems in key administrative areas of (1) leadership & human resources, budget allocations, business planning, and patient records & data . Detailed Results of the exploratory survey, in their raw forms, are provided in Figure 2.

Organizational structures

In terms of organizational structures both health care systems have just a few commonalities such as human resources, staffing ratios, and physical facility related management structure. However, the differences lie within the labor pool they have. As a nonprofit, Shands has a more traditional structure for both the governance and staffing, whereas the MHS is vastly different. The MHS governing body is staffed by military professionals, and is governed by not only civilian guidelines and regulations, but must also adhere to military rules, regulation, and mission support. This military staffing is also seen throughout the facility in various departments and division's staff mixes. The client populations they serve are also vastly different in nature, as mentioned earlier.

Figure 1. Matrix Comparison of Health Care Facilities Under Analysis.

Perspectives of Health Care Facilities				
	Topic	**Facility**	**Perspective Position**	**Reasoning for Perspective**
ORGANIZATIONAL STRUCTURES	Leadership & Staff	SHANDS	ADVANTAGE	• Is representative of my interests • Long term continuity • I can always be seen because of the medical students being there
			DISADVANTAGE	• Perception of over privileged people • "Good old boy" system prevents change • Med school students not good doctors and use me as a guinea pig
		MIITARY HEALTH SYSTEM	ADVANTAGE	• Decision by military member is a lawful order and will be done quickly • Civilian have best interest for facility as long term employees • New ideas come in with new personnel
			DISADVANTAGE	• Military Leadership continually turns over every 2-3 years…no long continuity • GS employees are lower quality cause they are hard to fire • They send the worst personnel to remote locations
ADMINISTRATIVE PROCESSES	Budget	SHANDS	ADVANTAGE	• It is used to provide better services to me instead of stakeholders
			DISADVANTAGE	• Money is only used at the big facilities and not in the areas that need them the most
		MIITARY HEALTH SYSTEM	ADVANTAGE	• I don't have to worry about money being a barrier to access health care
			DISADVANTAGE	• It cripples my care because it is reliant on Congress to approve and is held hostage by sequestration and government shutdowns
	Business Planning	SHANDS	ADVANTAGE	• Provides better care through a more comprehensive and extensive system
			DISADVANTAGE	• They take too many risks when conducting mergers and acquisitions
		MIITARY HEALTH SYSTEM	ADVANTAGE	• Proper steps are taken to provide and not abuse the system
			DISADVANTAGE	• The system takes too long to get us what we need
	Records and Data	SHANDS	ADVANTAGE	• I do not have to worry about my records being digitally lost or stolen.
			DISADVANTAGE	• It takes too much time from every appointment to give my history. Then I have limited time to deal with the reason I am there in the first place.
			ADVANTAGE	• I know I will get good care because the provider has my complete history no matter where I am stationed in the world

		MIITARY HEALTH SYSTEM	**DISADVANTAGE**	• I don't know why they have to have so much information. It's like they are the CIA tracking me

Figure 2. Matrix Comparison of Health Care Facilities Under Analysis Based on Exploratory Survey.

Perspectives of Health Care Facilities				
	Topic	**Facility**	**Perspective Position**	**Reasoning for Perspective**
ORGANIZATIONAL STRUCTURES	**Leadership & Staff**	**SHANDS**	**ADVANTAGE**	• Single provider enables continuity and stabilization in care • Qualified personnel/medical teams ready to work • Better response times • More caring staff • Usually better access to physician • In most cases, freedom of choice in provider • Longevity of providers at location • Good leadership and dedicated staff will result in good and quality care • I am treated as a person deserving of care rather than as a person seeking their entitlements • You're not on a stop watch during your appointment; the providers care about all issues and take the time to assist them all
			DISADVANTAGE	• Not as strict of a chain of command to follow • Can be more costly • Too busy • Longer waits • Serving of larger populations • Military life is more of a learned concept - learned to the level they put into it
		MIITARY HEALTH SYSTEM	**ADVANTAGE**	• Chain of Command to follow • Designated chain of command to get resolution of problems • Provider rotates every so often • They are also military and should understand your job and unique needs • Better leadership • Good leadership and dedicated staff will result in good and quality care • Have a better concept and understanding of the military lifestyle, i.e. deployments, separation, family
			DISADVANTAGE	• Multiple care givers • Turnover due to military moves • More changes in providers caused by temporary fills of Reservist providers • Shortage of staff due to budgeting and cut backs • Wait times for certain clinics due to staffing • Provider rotates every so often • Frequent turn over in all types of staff

				• Change of processes with new commander • Military Leadership Motives are often driven by evaluation reports • Transitional - often employees are military/spouses and are only here short periods of time
ADMINISTRATIVE PROCESSES	Budget	SHANDS	ADVANTAGE	• State of the art equipment • Public or private controlled • More care choices • It is important to use resources efficiently. Better care for all • Better stewards of funds - due to hiring process • Not always profit driven- more patient care driven • Flexibility in purchases vs. contracted purchases (GSA) • Better stewards of funds- due to hiring process (see business planning)
			DISADVANTAGE	• Budget cut backs on staffing leads to longer wait times • Looking for profit • Looking to reduce costs through less care • It is important to use resources efficiently. Better care for all
		MIITARY HEALTH SYSTEM	ADVANTAGE	• More affordable • Dual budget; fixed cost and productivity based • It is important to use resources efficiently. Better care for all
			DISADVANTAGE	• Government controlled • Older equipment • Budget cut backs on staffing leads to longer wait times • Limited funds • Insufficient use of funds • Unfunded mandates • It is important to use resources efficiently. Better care for all • Swayed by congress • Budget spending, ex. If budget is $8000 and legitimately we spend $5000, to get the same budget back the following year, we now have to scramble to find how to spend the remaining $3000 • Supply doesn't meet the demand - decreasing funds while # of patients is increasing
	Business Planning	SHANDS	ADVANTAGE	• Long term focused • Based on needs of the community • Looking toward future • Upgrading facilities • Forecasting profit and expenses • It is important to use resources efficiently. Better care for all • Proper would keep the expense of quality health care lower without compromising quality of care • Less government influence/hierarchy • Flexibility with funds

				• Provider to patient ratio
			DISADVANTAGE	• Malpractice coverage • It is important to use resources efficiently. Better care for all • Proper would keep the expense of quality health care lower without compromising quality of care • not always profit driven - more patient care driven • Flexibility in purchases vs. contracted purchases (GSA)
		MIITARY HEALTH SYSTEM	**ADVANTAGE**	• Government covers for malpractice • It is important to use resources efficiently. Better care for all
			DISADVANTAGE	• Length of tour of leadership • Based on "Army's" medicine • Looking to meet metrics at the expense of care • Insufficient use of appointment times • Lack of provider availability • It is important to use resources efficiently. Better care for all • Employment - driven by Gov. standards of priority placement by CPAC vs. employer interview process • Poor planning for new facilities, i.e. poor communication between the contractor and the government • Business plans are generated from reports that are often wrong due to miscalculations and poor data
	Records and Data	**SHANDS**	**ADVANTAGE**	• Standardized • Better electronic record • EHR implementation has is creating a more portable and complete record
			DISADVANTAGE	• Takes longer to get records • Not always having complete records • With a more mobile population, there is a potential danger in loss of privacy
		MIITARY HEALTH SYSTEM	**ADVANTAGE**	• Standardized and automated • Centralized storage • With the constant movement of military personnel and families, it is important that all medical records are immediately available to doctors and medical facilities for best treatment • The all-inclusive systems are great (AHLTA), though too many people with access to system could/do create issues
			DISADVANTAGE	• Records not kept well • Records not easily accessed • Inefficient electronic health record • Slow on adapting to electronic messaging • With the constant movement of military personnel and families there is a potential danger in loss of privacy • Data is DEERs driven; if DEERs not updated the data is incorrect

Administrative processes

The Joint Commission (hospital certifying body) creates this normalization and similarity between all hospitals. However, there are differences created by the sector the facility belongs. These differences included, but are not limited to: budget, business planning, and records and data.

The budget of Shands is produced through philanthropic donations, billing for services rendered, grants, and other means. The income stream is not greatly limited in nature of origination. However, by being a nonprofit, it cannot disperse funds as for-profits due to stakeholders. On the other end of the spectrum is the MHS. MTF funding is based on historical utilization rates and enrolled patients. MTF facilities are not able to create supplemental funding, but are able to receive reimbursement, as a secondary insurer from other health insurances an eligible client may carry.

Business planning is also different between Shands and MHS Facilities. Shands is able to identify opportunities to expand services by purchase, or other acquisition means. Additionally, the purchasing of newer or more equipment is by discretion of the facility and its means to purchase them. Again, this course of action is not the case for the MHS. By no means is the MHS allowed to expand past their authorizations, especially in mergers and acquisitions. Any increase in services, facility space, staffing, and/or equipment must be requested by a business case analysis, and submitted up the chain of command. Dependent on the level of funding, the authorization and appropriation could literally take an act of Congress.

The last area for comparison is records and data. Records in this case are the health records of the individual patients. Both facilities have utilized the paper records in the past. Paper records are artifacts in today's health care facilities; electronic health records (EHR)

are the standard. Though the standard, Shands is slow to implement a system wide EHR. Additionally, Shands implementation was just recently spurred by government mandate and allocation of implementation grant money. However, the MHS has had an EHR for longer than a decade now; a worldwide accessible system. This longevity with the EHR provides for ample and reliable data. Data is identified as the availability to retain useful information for future use. Since the military owns all aspects of health operations, all data has been stored and maintained since 2001. This provides unrestrictive and universal perspective of all components of the MHS health care. This is not the same for Shands. Besides the fact that Shands just recently stood up a data retention program, any data collected was done by circumstance. This circumstance does not provide the ability to look retrospectively and over long periods of time. We believe this is the biggest advantage the MHS has over all other health care facilities.

Conclusion

This paper has provided insight into representative health care facilities from two different organizational sectors. This was accomplished by first providing a glimpse into a nonprofit health care system and the US Military health care system. Subsequent insight was gained through the identification and analysis of two systems within the sectors of nonprofit and government military health care facilities. The information was presented from the authors' experience and perspectives, and further enhanced by the inclusion of external and unique perspectives through the exploratory survey. From the afore mentioned information, charts of advantages and disadvantages was provided from the perspective of the client(s). Though both organizations share the same foundational mission of providing quality health care for their patients, they have only a few similarities in their operational

structures and vast differences in their administrative processes. Future research is needed to identify and analyze details of these similarities and differences for a better understanding of these two systems.

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