



## Primary Care Providers

Physicians in general family practice are most commonly the providers of primary care in Europe. In the United States, primary care practitioners are not restricted to physicians trained in general and family practice, but also include physicians trained in internal medicine, pediatrics, and obstetrics and gynecology. One cannot assume, however, that these various types of practitioners are equally skilled in rendering primary care services (Starfield, 1994). Unless a medical training program is dedicated to providing instruction in primary care, significant differences are likely to exist between its graduates and other PCPs. In fact, some controversy and competition have arisen among practitioners as to which specialists should be providing primary care. The specialty of family practice, in particular, represents a challenge to internal medicine in providing adult primary care and to pediatrics in providing child primary care.

Nonphysician practitioners (NPPs) are also playing a larger role in the delivery of primary care in the United States. In light of the increasing emphasis on health care cost containment, NPPs—who include nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs), among others—are in great demand in primary care delivery settings, particularly in medically underserved areas (MUAs). Data from Medicaid managed care organizations (MCOs) demonstrate that patients receiving care from NPs at nurse-managed health centers experience significantly fewer emergency room visits, hospital inpatient days, and specialist visits, and female patients are at a significantly lower risk of giving birth to low birth weight infants, compared to





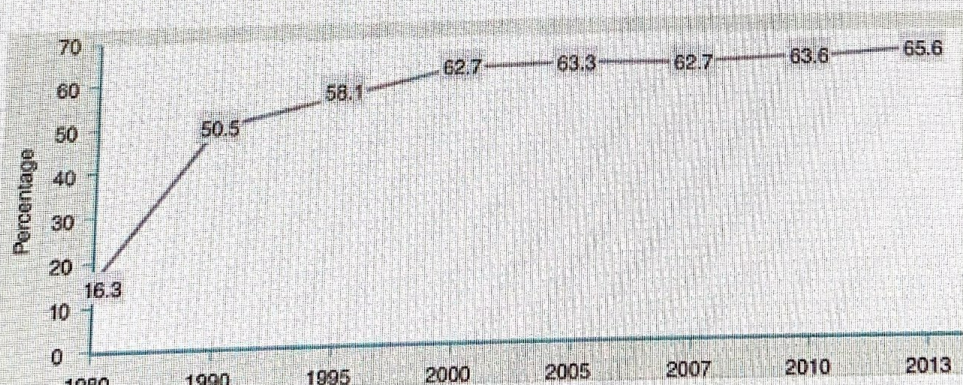
certified nurse midwives (CNMs), among others – are in great demand in primary care delivery settings, particularly in medically underserved areas (MUAs). Data from Medicaid managed care organizations (MCOs) demonstrate that patients receiving care from NPs at nurse-managed health centers experience significantly fewer emergency room visits, hospital inpatient days, and specialist visits, and female patients are at a significantly lower risk of giving birth to low-birth-weight infants, compared to patients in conventional health care (**National Nursing Centers Consortium, 2003**).

A recent retrospective cross-sectional analysis of national administrative data from Veterans Health Administration (VHA) primary care encounters showed NPs and PAs attended approximately 30% of all VHA primary care encounters, and NPs, PAs, and physicians fill similar roles in VHA primary care (**Morgan et al., 2012**). Similar results were also found in a study conducted in community health centers, with NPs and PAs providing 21% and 10%, respectively, of care for vulnerable populations (**Morgan et al., 2015**). Nevertheless, PCPs continue to fill an expert role that NPPs cannot match.



## Growth in Outpatient Services

In the United States, the proportion of total surgeries performed in outpatient departments of community hospitals increased from 16.3% in 1980 to 65.6% in 2013 (**FIGURE 7-2**). This decline in inpatient procedures has actually been outweighed by the growth of ambulatory procedures. Moreover, for patients older than 65 years, the rate of inpatient surgeries has not decreased (**Kozak et al., 1999; National Center for Health Statistics, 2010**). In a study performed by Wier et al. (**2015**), the 10 most common ambulatory surgeries performed in community hospitals in 28 states were lens and cataract procedures (9.3% of all ambulatory surgeries), other therapeutic procedures on muscles and tendons (5.8%), other operating room therapeutic procedures on joints (4.5%), cholecystectomy and common duct exploration (4.0%), excision of semilunar cartilage of the knee (3.6%), inguinal and femoral hernia repair (2.8%), other operating room therapeutic procedures on the skin and breast (2.5%), lumpectomy and quadrantectomy of the breast (2.4%), decompression peripheral nerve (2.4%), and other hernia repair (2.3%).





MD: U.S. Department of Health and Human Services. p. 281.

Over the years, several noteworthy changes have been instrumental in shifting the delivery of health care from inpatient to outpatient settings. These changes can be broadly classified as reimbursement, technological factors, utilization control factors, physician practice factors, and social factors.

## Reimbursement

Until the 1980s, health insurance coverage was usually more generous for inpatient services than for outpatient services. For years, many interventions that could have been performed safely and effectively on an outpatient basis remained inpatient procedures because third-party reimbursement for outpatient care was limited. These payment policies began to change during the 1980s. In response, hospitals aggressively developed outpatient services to offset their declining revenues from inpatient care.

In the mid-1980s, Medicare substituted a prospective payment system (PPS) for its traditional cost-plus system to reimburse inpatient hospital services (see the *Health Services Financing* chapter). PPS reimbursement, which is based on diagnosis-related groups (DRGs), provides fixed case-based payments to hospitals. In contrast, the outpatient sector was not subject to payment restrictions. Therefore, hospitals had a strong incentive to minimize inpatient lengths of stay and to provide continued treatment in outpatient settings—which led to mushrooming costs in the outpatient sector. In 2000, Medicare implemented prospective reimbursement mechanisms in an effort to contain these costs, such as the Medicare Outpatient Prospective Payment System (OPPS) for services provided in hospital outpatient departments





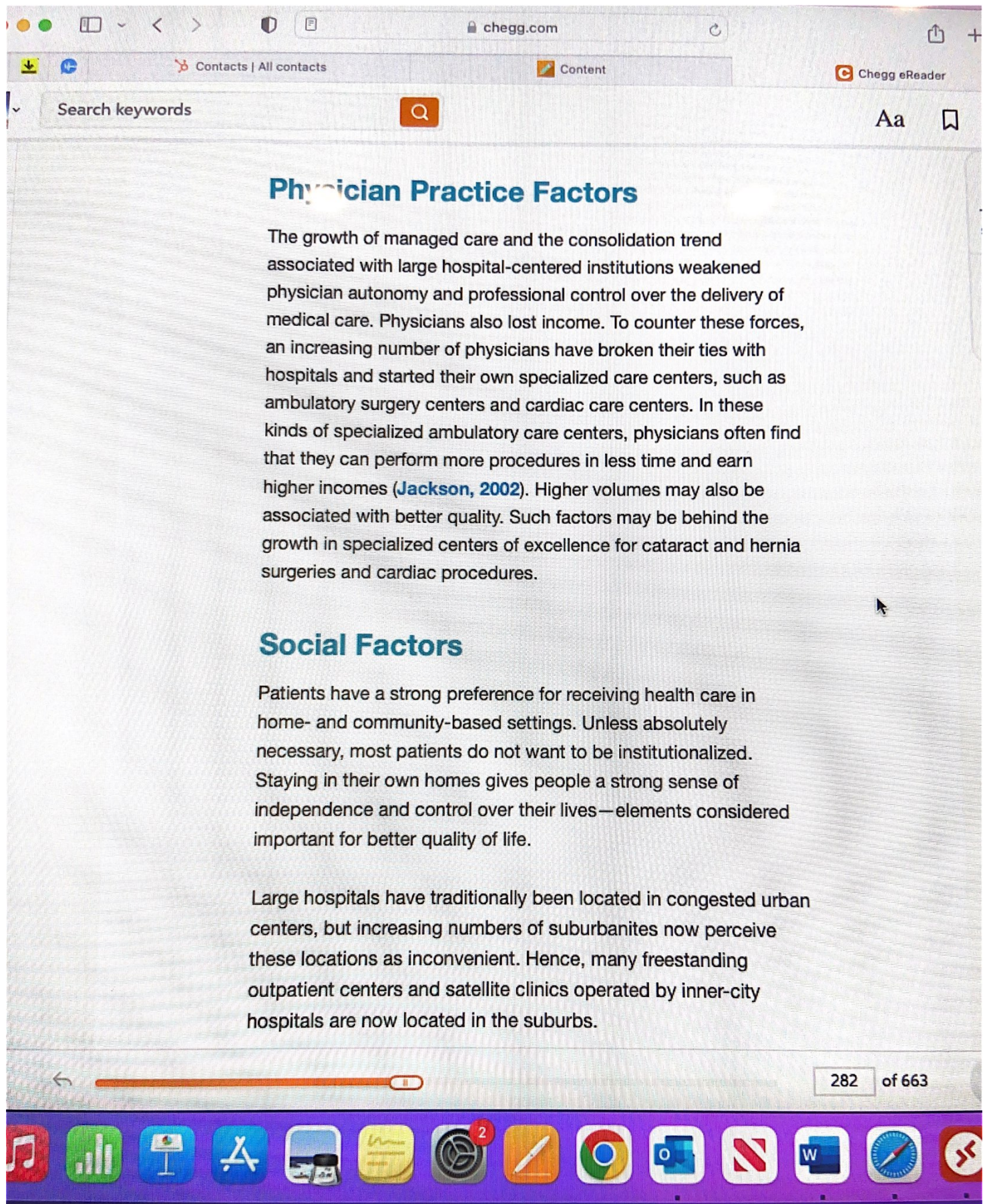
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To discourage lengthy hospital stays, payers have instituted prior authorization policies for inpatient admission as well as close monitoring during hospitalization. The *Managed Care and Integrated Organizations* chapter discusses the most widely adopted utilization control methods.







## Physician Practice Factors

The growth of managed care and the consolidation trend associated with large hospital-centered institutions weakened physician autonomy and professional control over the delivery of medical care. Physicians also lost income. To counter these forces, an increasing number of physicians have broken their ties with hospitals and started their own specialized care centers, such as ambulatory surgery centers and cardiac care centers. In these kinds of specialized ambulatory care centers, physicians often find that they can perform more procedures in less time and earn higher incomes (Jackson, 2002). Higher volumes may also be associated with better quality. Such factors may be behind the growth in specialized centers of excellence for cataract and hernia surgeries and cardiac procedures.

## Social Factors

Patients have a strong preference for receiving health care in home- and community-based settings. Unless absolutely necessary, most patients do not want to be institutionalized. Staying in their own homes gives people a strong sense of independence and control over their lives—elements considered important for better quality of life.

Large hospitals have traditionally been located in congested urban centers, but increasing numbers of suburbanites now perceive these locations as inconvenient. Hence, many freestanding outpatient centers and satellite clinics operated by inner-city hospitals are now located in the suburbs.





## ► Types of Outpatient Care Settings and Methods of Delivery

The services described in this section are not always operated independently of each other. For example, a hospital may operate physician clinics in addition to some of the freestanding facilities described here. Also, in a constantly evolving system, new settings and methods are likely to emerge. However, in general, the various settings for outpatient service delivery found in the U.S. health care delivery system can be grouped as follows:

- Private practice
- Hospital-based services
- Freestanding facilities
- Retail clinics
- Mobile medical, diagnostic, and screening services
- Home health care
- Hospice services
- Ambulatory long-term care services
- Public health services
- Community health centers
- Free clinics
- Telephone access
- Complementary and alternative medicine

### Private Practice

Physicians, as office-based practitioners, are the backbone of





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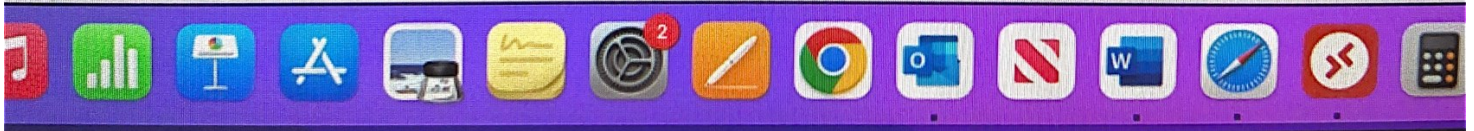


## Private Practice

Physicians, as office-based practitioners, are the backbone of ambulatory care and constitute the vast majority of primary care services. Most visits entail relatively limited examination and testing, and encounters with the physician are generally brief. Office waiting time is typically longer than the actual time spent with the physician.

In the past, the solo practice of medicine and small partnerships attracted the large numbers of practitioners. Self-employment offered a degree of independence not generally available in large organizational settings. Today, however, most physicians are affiliated with group practices or institutions, such as hospitals and MCOs. Several factors account for this shift: uncertainties created by rapid changes in the health care delivery system, contracting by MCOs with consolidated organizations rather than solo entities, competition from large health care delivery organizations, the high cost of operating a solo practice, complexity of billings and collections in a multiple-payer system, and increased external demands, such as the necessity of having up-to-date IT systems. Group practice and other organizational arrangements offer the benefits of a patient referral network, negotiated leverage with MCOs, sharing of overhead expenses, ease of obtaining coverage from colleagues for personal time off, and attractive starting salaries, with benefits and profit-sharing plans.

Group practice of medicine in the United States has experienced a sharp increase in recent years (**FIGURE 7-3**). An estimated 59.3% of physicians are now in solo or single-specialty group practices, whereas 24.7% are in multispecialty group practices (**American Medical Association, 2015**). Most of these groups are small, with





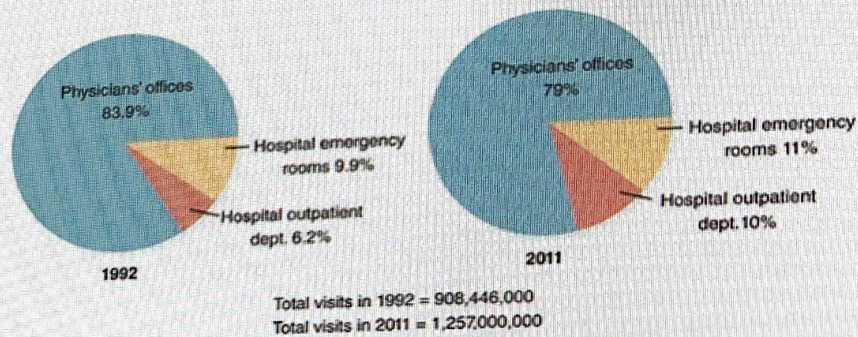
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Report and directory: Medical group practices. Chicago, IL: SMG Solutions.

Group practice clinics also offer important advantages to patients. In many instances, patients can receive up-to-date diagnostic, treatment, pharmaceutical, and certain surgical services in the same location. All but the most advanced secondary and tertiary procedures can be performed within these large clinics. Patients also often see cross-referrals among partner physicians located near each other as an added convenience.

Apart from physicians, other private practitioners often work in solo or group practice settings. For example, dentists, optometrists, podiatrists, psychologists, and physical, occupational, and speech therapists typically work under this practice model.

**FIGURE 7-4** shows the distribution of total ambulatory visits among physicians' offices, hospital-based outpatient departments, and hospital EDs in the United States. In 2011, approximately 79% of all ambulatory care visits occurred in physicians' offices. Hospitals have made substantial strides in gaining market share through their outpatient services.



**FIGURE 7-4** Ambulatory care visits in the United States





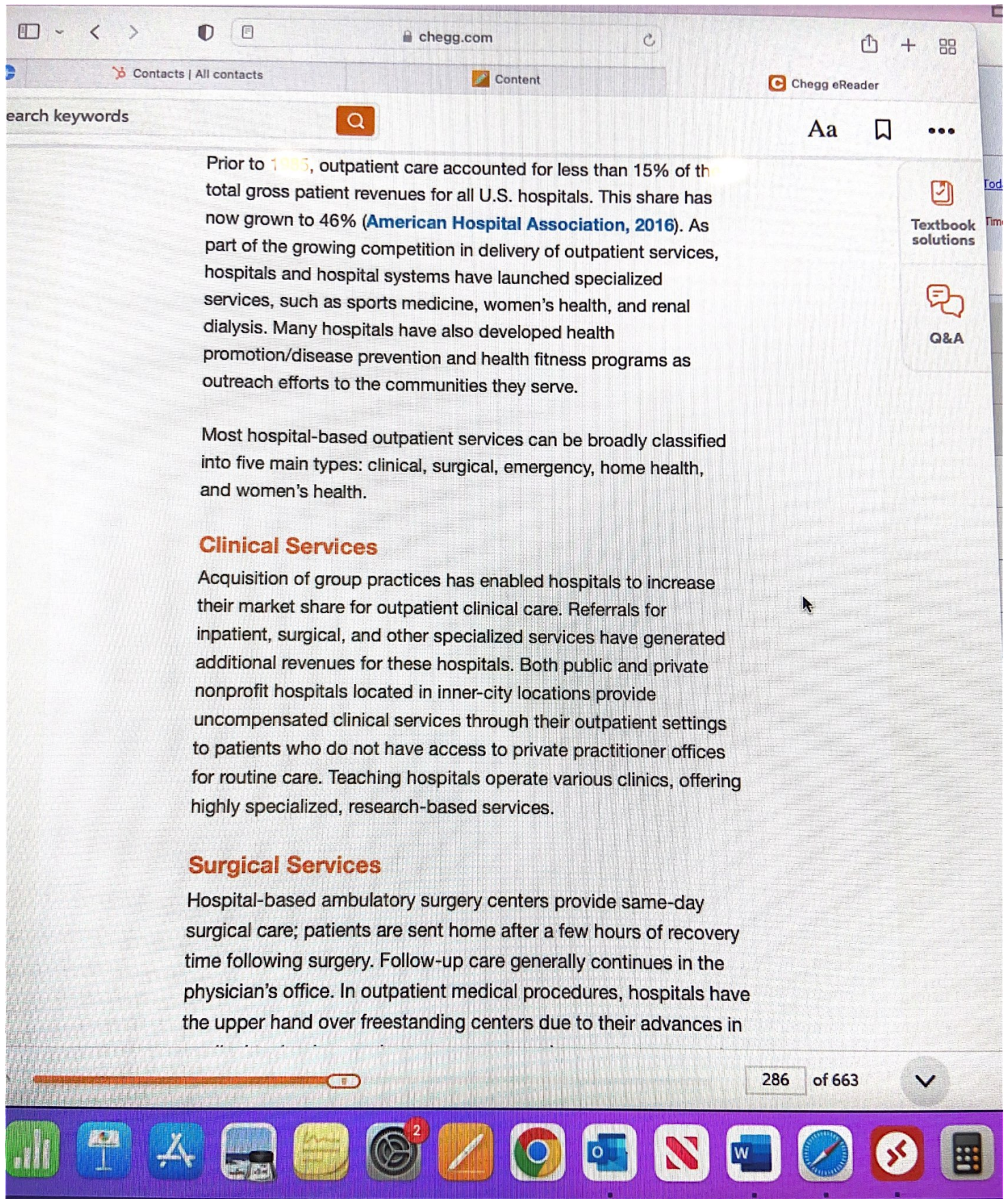
## Hospital-Based Outpatient Services

A few years ago, hospital administrators regarded the outpatient departments of urban hospitals with a certain level of contempt. The outpatient department was often viewed as the "stepchild" of the institution and the least popular area of the hospital in which to work. Even today, some hospital outpatient clinics in inner-city areas may function as the community's safety net, providing primary care to medically indigent and uninsured populations. For the most part, however, outpatient services are now a key source of profit for hospitals. Consequently, hospitals have expanded their outpatient departments, and utilization of these services has grown (see **FIGURE 7-4**). This trend is the result of fierce competition in the health care industry; as MCOs emphasize preventive and outpatient care, there has been a relentless drive to cut costs. To compensate for the steady erosion in inpatient revenues stemming from MCO frugality, hospitals have begun sprucing up and expanding their outpatient services.

A hospital-developed continuum of inpatient and outpatient services offers opportunities for cross-referrals among services that keep patients within the same delivery system. For example, a hospital that provides both inpatient and outpatient services can enhance its revenues by referring postsurgical cases to its affiliated units for rehabilitation and home care follow-up. Patients receiving various types of outpatient services constitute an important source of referrals back to hospitals for inpatient care. By offering both inpatient and outpatient services, hospitals can also expand their patient base.

Prior to 1985, outpatient care accounted for less than 15% of the





Prior to 1985, outpatient care accounted for less than 15% of the total gross patient revenues for all U.S. hospitals. This share has now grown to 46% (American Hospital Association, 2016). As part of the growing competition in delivery of outpatient services, hospitals and hospital systems have launched specialized services, such as sports medicine, women's health, and renal dialysis. Many hospitals have also developed health promotion/disease prevention and health fitness programs as outreach efforts to the communities they serve.

Most hospital-based outpatient services can be broadly classified into five main types: clinical, surgical, emergency, home health, and women's health.

### Clinical Services

Acquisition of group practices has enabled hospitals to increase their market share for outpatient clinical care. Referrals for inpatient, surgical, and other specialized services have generated additional revenues for these hospitals. Both public and private nonprofit hospitals located in inner-city locations provide uncompensated clinical services through their outpatient settings to patients who do not have access to private practitioner offices for routine care. Teaching hospitals operate various clinics, offering highly specialized, research-based services.

### Surgical Services

Hospital-based ambulatory surgery centers provide same-day surgical care; patients are sent home after a few hours of recovery time following surgery. Follow-up care generally continues in the physician's office. In outpatient medical procedures, hospitals have the upper hand over freestanding centers due to their advances in





## Emergency Services

The ED has long been a vital outpatient component of many community hospitals. The main purpose of this department is to have services available around the clock for patients who are acutely ill or injured, particularly those with serious or life-threatening conditions requiring immediate attention. When deemed medically appropriate, prompt hospitalization can occur directly from the ED. This department has various specialists on call and is commonly staffed by physicians who have specialized training in emergency medicine. In small hospitals, the staff may be members of the regular medical staff in rotation. Another option is to contract ED staffing to physician groups specializing in emergency medicine.

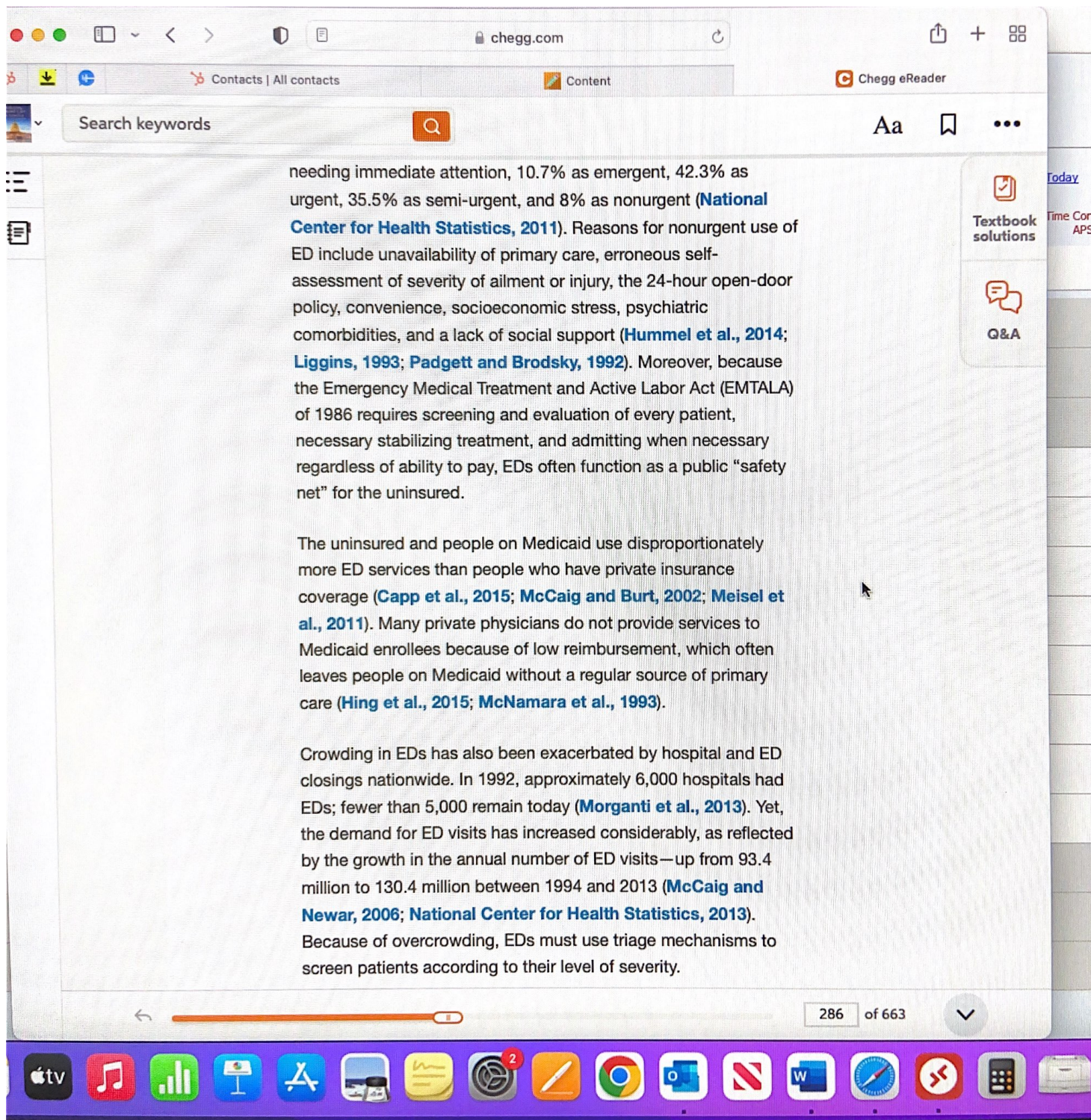
Weinerman and colleagues (1966) defined three categories of conditions for which patients present themselves to the ED:

- **Emergent conditions** are critical and require immediate medical attention; time delay is harmful to the patient, and the disorder is acute and potentially threatening to life or function.
- **Urgent conditions** require medical attention within a few hours; a longer delay presents possible danger to the patient, and the disorder is acute but not severe enough to be life threatening.
- **Nonurgent conditions** do not require the resources of an emergency service, and the disorder is nonacute or minor in severity.

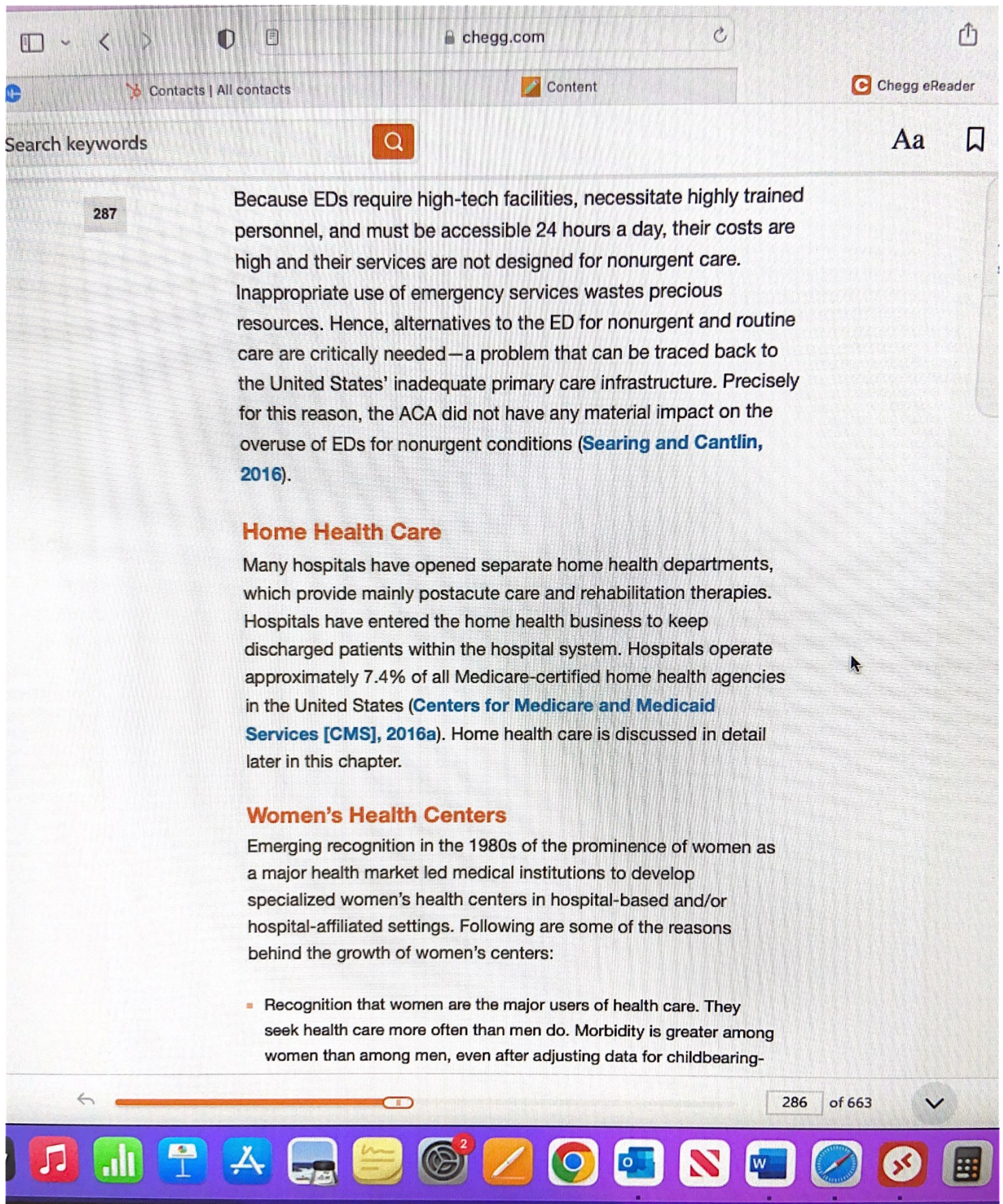
It has been well documented that in the United States, EDs are overused for nonurgent or routine care that could be more appropriately addressed in a primary care setting. Of the 136.3 million ED patient visits reported to the National Ambulatory Medical Care Survey in 2011, for example, 1.2% were triaged as needing immediate attention, 10.7% as emergent, 42.3% as











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Because EDs require high-tech facilities, necessitate highly trained personnel, and must be accessible 24 hours a day, their costs are high and their services are not designed for nonurgent care. Inappropriate use of emergency services wastes precious resources. Hence, alternatives to the ED for nonurgent and routine care are critically needed—a problem that can be traced back to the United States' inadequate primary care infrastructure. Precisely for this reason, the ACA did not have any material impact on the overuse of EDs for nonurgent conditions (Searing and Cantlin, 2016).

### Home Health Care

Many hospitals have opened separate home health departments, which provide mainly postacute care and rehabilitation therapies. Hospitals have entered the home health business to keep discharged patients within the hospital system. Hospitals operate approximately 7.4% of all Medicare-certified home health agencies in the United States (Centers for Medicare and Medicaid Services [CMS], 2016a). Home health care is discussed in detail later in this chapter.

### Women's Health Centers

Emerging recognition in the 1980s of the prominence of women as a major health market led medical institutions to develop specialized women's health centers in hospital-based and/or hospital-affiliated settings. Following are some of the reasons behind the growth of women's centers:

- Recognition that women are the major users of health care. They seek health care more often than men do. Morbidity is greater among women than among men, even after adjusting data for childbearing-



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women than among men, even after adjusting data for embarrassing related conditions.

- A change in philosophy in American culture toward women, as the idea of gender equality becomes more popular.
- Recognition that the female majority in the United States will continue to grow, as the aging population includes more females.

TABLE 7-2 shows current population trends.

**TABLE 7-2** Growth in Female U.S. Resident Population by Age Groups Between 1980 and 2014 (in Thousands)

|        | Age Groups (in Years) |        |        |        |       |       | Total   |
|--------|-----------------------|--------|--------|--------|-------|-------|---------|
|        | < 15                  | 15-44  | 45-64  | 65-74  | 75-84 | ≥ 85  |         |
| 1980   | 25,073                | 52,833 | 23,342 | 8,824  | 4,862 | 1,559 | 116,493 |
| 2014   | 29,882                | 63,356 | 42,790 | 14,049 | 7,789 | 4,053 | 161,921 |
| Growth | 4,809                 | 10,523 | 19,448 | 5,225  | 2,927 | 2,494 | 45,428  |

Data from National Center for Health Statistics. 2016. *Health, United States, 2015*. Hyattsville, MD: U.S. Department of Health and Human Services. p. 65.

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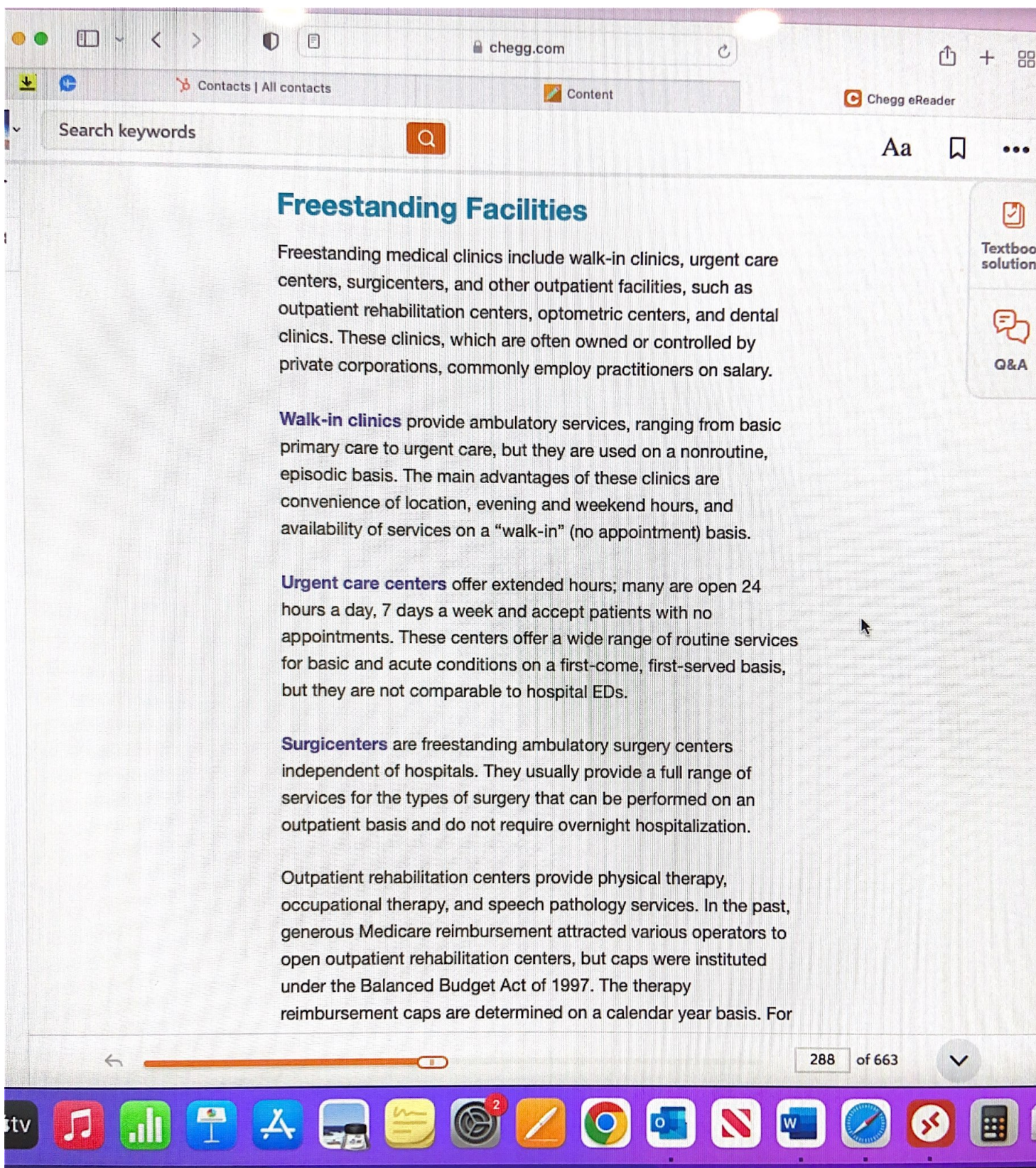
Hospital-sponsored women's health centers rely on a variety of service delivery models. These models exist on a continuum that includes telephone information and referral, educational programs, health screening and diagnostics, comprehensive primary care for women, and mental health services. In addition to services in obstetrics, gynecology, and primary care, women's health centers offer mammography, ultrasound, osteoporosis screening, and other health screenings. Women's health is discussed in greater detail in the *Health Services for Special Populations* chapter.

## Freestanding Facilities

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## Freestanding Facilities

Freestanding medical clinics include walk-in clinics, urgent care centers, surgicenters, and other outpatient facilities, such as outpatient rehabilitation centers, optometric centers, and dental clinics. These clinics, which are often owned or controlled by private corporations, commonly employ practitioners on salary.

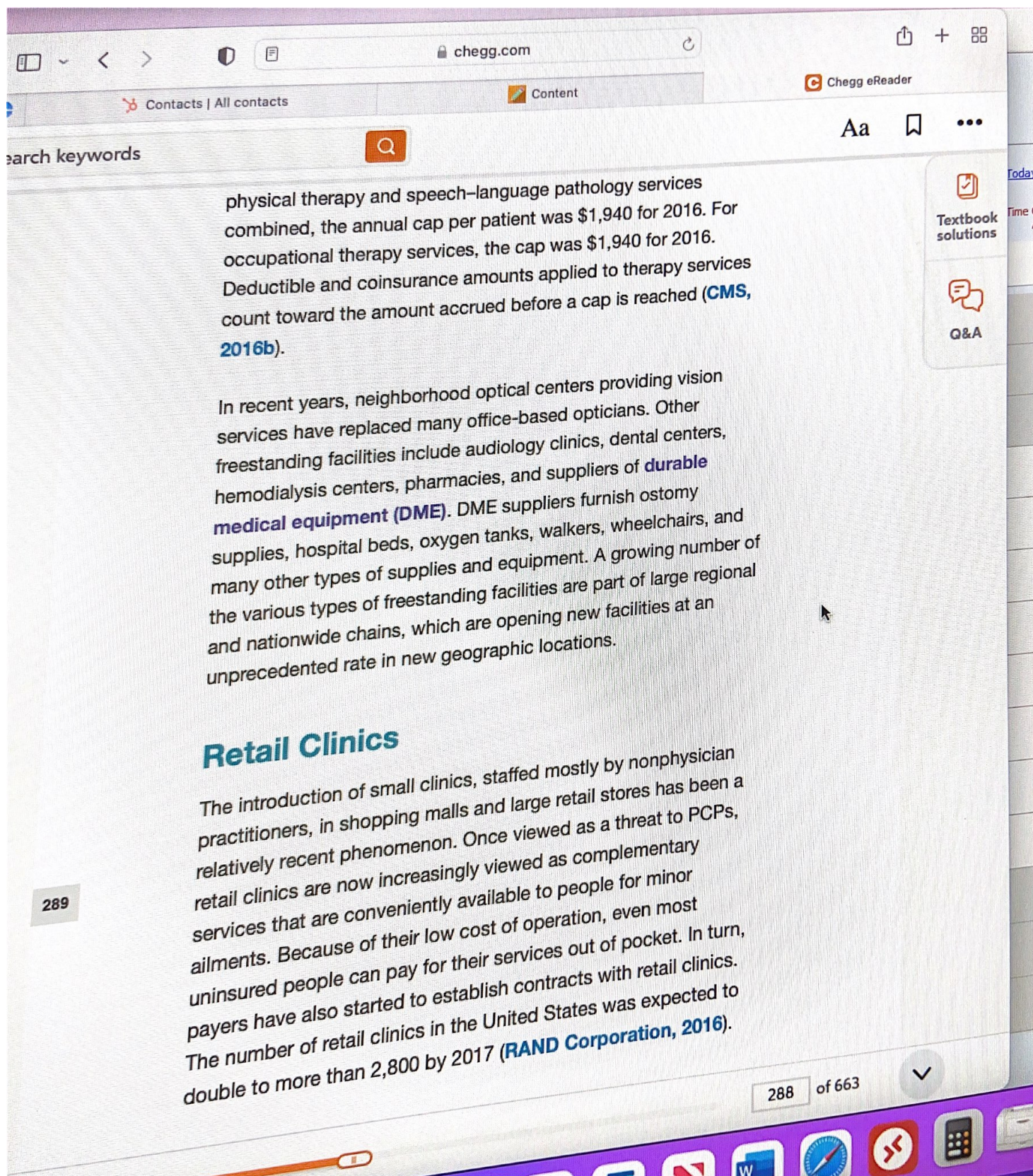
**Walk-in clinics** provide ambulatory services, ranging from basic primary care to urgent care, but they are used on a nonroutine, episodic basis. The main advantages of these clinics are convenience of location, evening and weekend hours, and availability of services on a "walk-in" (no appointment) basis.

**Urgent care centers** offer extended hours; many are open 24 hours a day, 7 days a week and accept patients with no appointments. These centers offer a wide range of routine services for basic and acute conditions on a first-come, first-served basis, but they are not comparable to hospital EDs.

**Surgicenters** are freestanding ambulatory surgery centers independent of hospitals. They usually provide a full range of services for the types of surgery that can be performed on an outpatient basis and do not require overnight hospitalization.

Outpatient rehabilitation centers provide physical therapy, occupational therapy, and speech pathology services. In the past, generous Medicare reimbursement attracted various operators to open outpatient rehabilitation centers, but caps were instituted under the Balanced Budget Act of 1997. The therapy reimbursement caps are determined on a calendar year basis. For





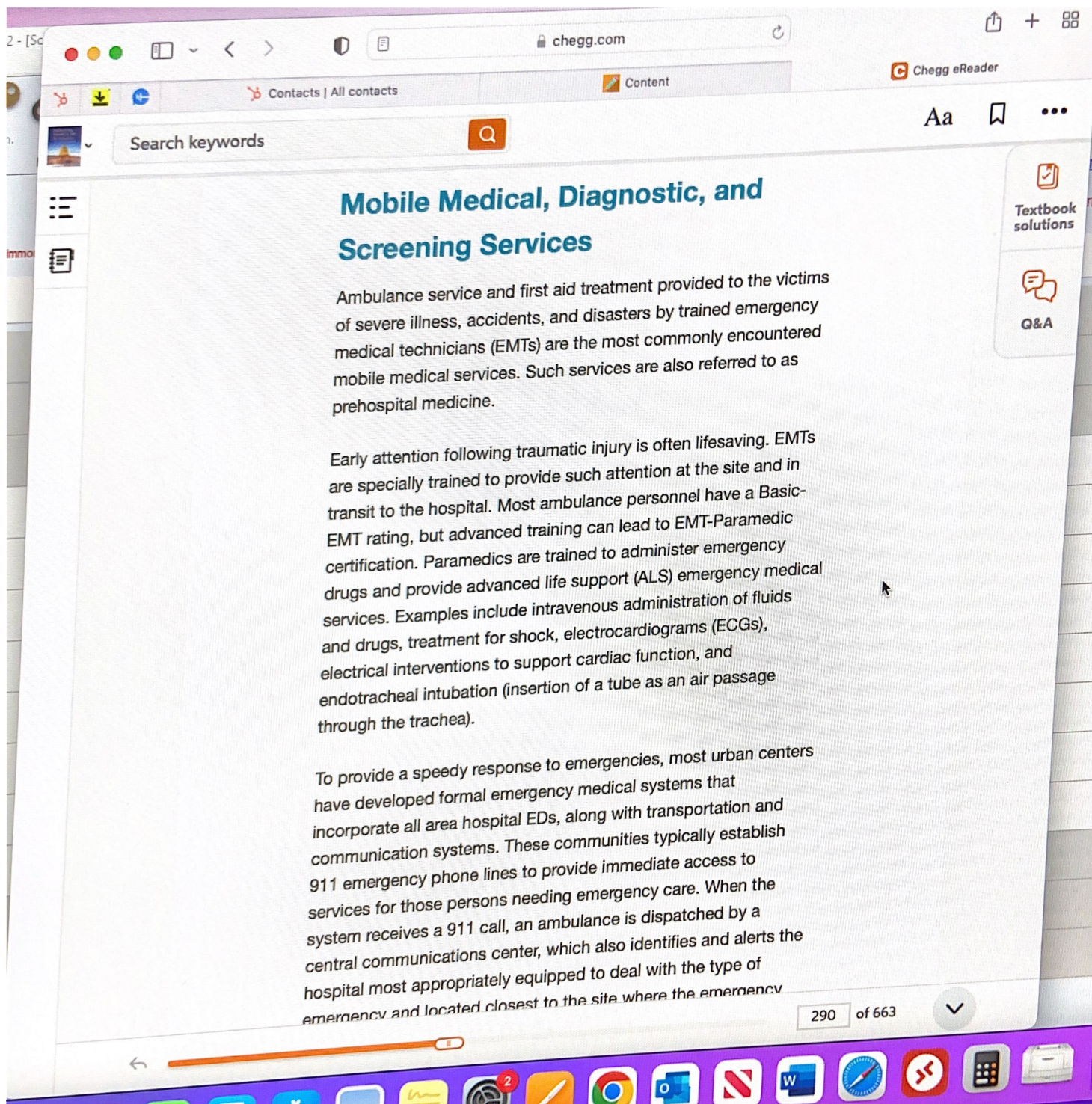
physical therapy and speech-language pathology services combined, the annual cap per patient was \$1,940 for 2016. For occupational therapy services, the cap was \$1,940 for 2016. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached (**CMS, 2016b**).

In recent years, neighborhood optical centers providing vision services have replaced many office-based opticians. Other freestanding facilities include audiology clinics, dental centers, hemodialysis centers, pharmacies, and suppliers of **durable medical equipment (DME)**. DME suppliers furnish ostomy supplies, hospital beds, oxygen tanks, walkers, wheelchairs, and many other types of supplies and equipment. A growing number of the various types of freestanding facilities are part of large regional and nationwide chains, which are opening new facilities at an unprecedented rate in new geographic locations.

## Retail Clinics

The introduction of small clinics, staffed mostly by nonphysician practitioners, in shopping malls and large retail stores has been a relatively recent phenomenon. Once viewed as a threat to PCPs, retail clinics are now increasingly viewed as complementary services that are conveniently available to people for minor ailments. Because of their low cost of operation, even most uninsured people can pay for their services out of pocket. In turn, payers have also started to establish contracts with retail clinics. The number of retail clinics in the United States was expected to double to more than 2,800 by 2017 (**RAND Corporation, 2016**).





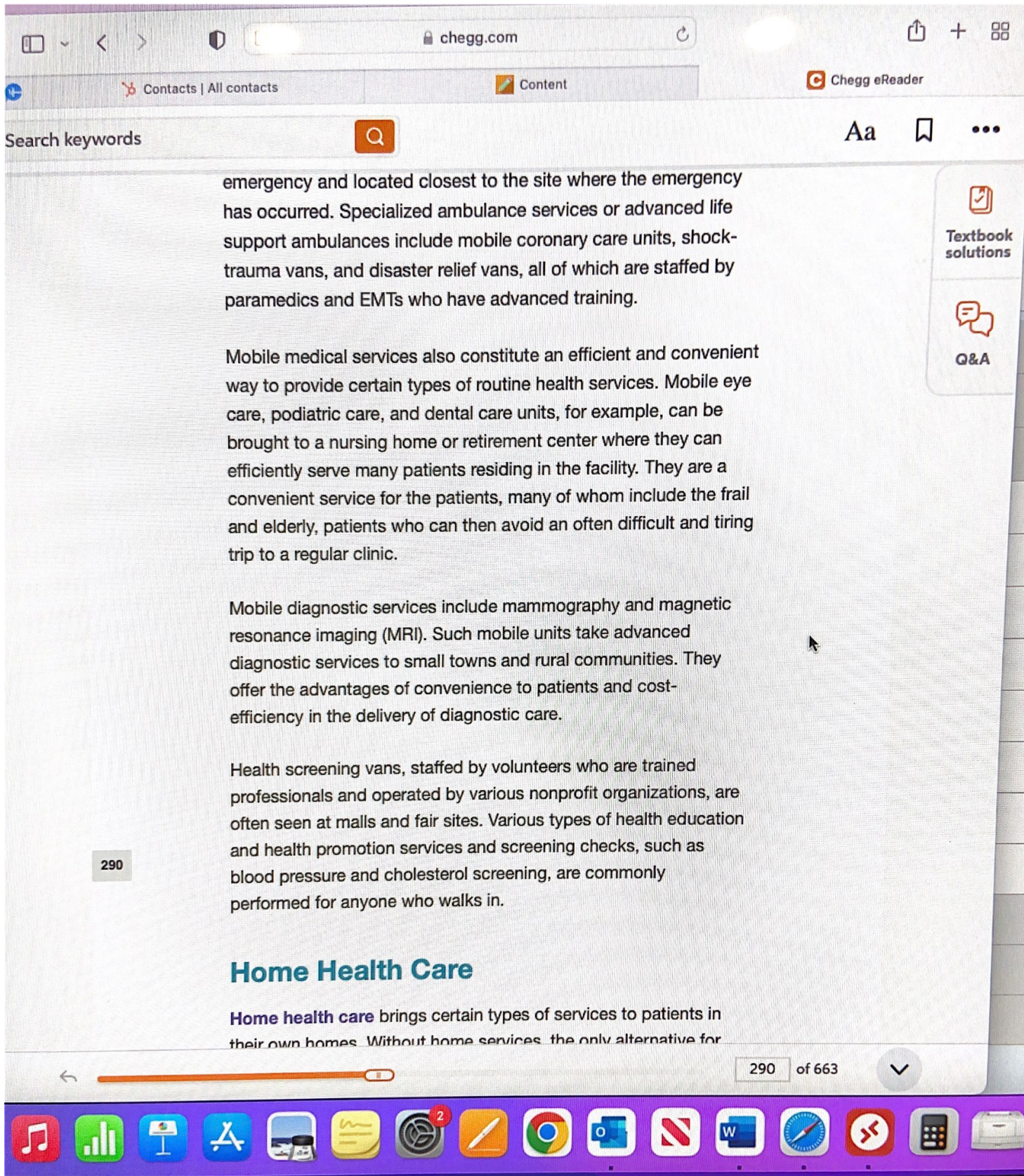
## Mobile Medical, Diagnostic, and Screening Services

Ambulance service and first aid treatment provided to the victims of severe illness, accidents, and disasters by trained emergency medical technicians (EMTs) are the most commonly encountered mobile medical services. Such services are also referred to as prehospital medicine.

Early attention following traumatic injury is often lifesaving. EMTs are specially trained to provide such attention at the site and in transit to the hospital. Most ambulance personnel have a Basic-EMT rating, but advanced training can lead to EMT-Paramedic certification. Paramedics are trained to administer emergency drugs and provide advanced life support (ALS) emergency medical services. Examples include intravenous administration of fluids and drugs, treatment for shock, electrocardiograms (ECGs), electrical interventions to support cardiac function, and endotracheal intubation (insertion of a tube as an air passage through the trachea).

To provide a speedy response to emergencies, most urban centers have developed formal emergency medical systems that incorporate all area hospital EDs, along with transportation and communication systems. These communities typically establish 911 emergency phone lines to provide immediate access to services for those persons needing emergency care. When the system receives a 911 call, an ambulance is dispatched by a central communications center, which also identifies and alerts the hospital most appropriately equipped to deal with the type of emergency and located closest to the site where the emergency





emergency and located closest to the site where the emergency has occurred. Specialized ambulance services or advanced life support ambulances include mobile coronary care units, shock-trauma vans, and disaster relief vans, all of which are staffed by paramedics and EMTs who have advanced training.

Mobile medical services also constitute an efficient and convenient way to provide certain types of routine health services. Mobile eye care, podiatric care, and dental care units, for example, can be brought to a nursing home or retirement center where they can efficiently serve many patients residing in the facility. They are a convenient service for the patients, many of whom include the frail and elderly, patients who can then avoid an often difficult and tiring trip to a regular clinic.

Mobile diagnostic services include mammography and magnetic resonance imaging (MRI). Such mobile units take advanced diagnostic services to small towns and rural communities. They offer the advantages of convenience to patients and cost-efficiency in the delivery of diagnostic care.

Health screening vans, staffed by volunteers who are trained professionals and operated by various nonprofit organizations, are often seen at malls and fair sites. Various types of health education and health promotion services and screening checks, such as blood pressure and cholesterol screening, are commonly performed for anyone who walks in.

## Home Health Care

**Home health care** brings certain types of services to patients in their own homes. Without home services, the only alternative for



their own homes. Without home services, the only alternative for most such patients would be institutionalization in a hospital or nursing home. Home health is consistent with the philosophy of maintaining people in the least restrictive environment possible.

Home health care encompasses a wide range of services and supplies that a person receives at home under a plan of care established by a doctor. It can include skilled nursing and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, DME (e.g., wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services provided in the individual's home (**National Council on Aging, 2016**). Home health is delivered in the United States by a combination of large and small home health providers, both for-profit and nonprofit. More than 12,400 home health agencies serve patients across the United States, with approximately 12,100 of those agencies being certified to treat Medicare patients (**CMS, 2015b; National Council on Aging, 2016**). The total number of home health aides employed in the home health care services industry increased from 208,130 in 2004 to 348,740 in 2014 (**Alliance for Home Health Quality and Innovation, 2015**).

Growth in expenditures going to freestanding home health care agencies (additional services of home health care are provided in hospital-based facilities and are considered hospital care) accelerated from 2014 to 2015, with this spending increasing 6.3% to reach \$88.8 billion in 2015; by comparison, the growth rate was 4.5% from 2013 to 2014. Stronger growth in spending by both Medicare (2.6%) and Medicaid (6.0%)—the two largest payers, which collectively accounted for 76% of U.S. home health



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spending—along with faster growth in private health insurance and out-of-pocket spending drove the overall acceleration of home health expenditures in 2015 (CMS, 2016a).

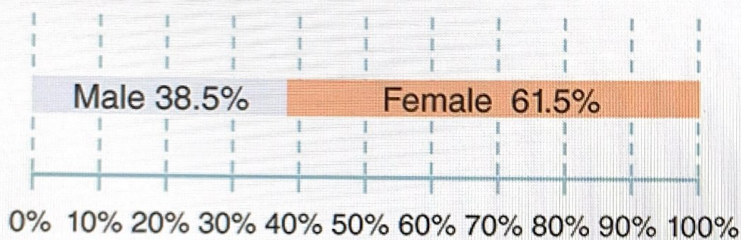
According to publicly available data published in 2015 by “Home Health Compare,” patient outcomes improve after receiving home health care. These data show that, after receiving home health care, 89% of wounds improved or healed after an operation, 68% of patients had less pain when moving around, 68% got better at bathing, and 65% had improved breathing (Alliance for Home Health Quality and Innovation, 2015; CMS, 2015b). A patient being discharged to home health care immediately following hospitalization is generally the least costly setting in which to deliver care, compared to discharging patients to skilled nursing facilities, inpatient rehabilitation facilities, or long-term acute care hospitals as the first setting post discharge. For example, Medicare expenditures for a patient treated in the home after hospital discharge average \$20,345, compared to an average of \$28,294 for post-discharge care across all settings (Dobson, 2012).

Home health providers often leverage technology to enable the provision of care at home. In varying degrees, these providers use a diverse array of technologies ranging from remote monitoring, including phone calls (including the growing array of mobile technologies and applications), to health information technology, to in-home therapeutic and diagnostic technologies. Such technologies are often key tools that enable home health providers to improve quality and reduce the cost of care delivered to patients (Alliance for Home Health Quality and Innovation, 2014).

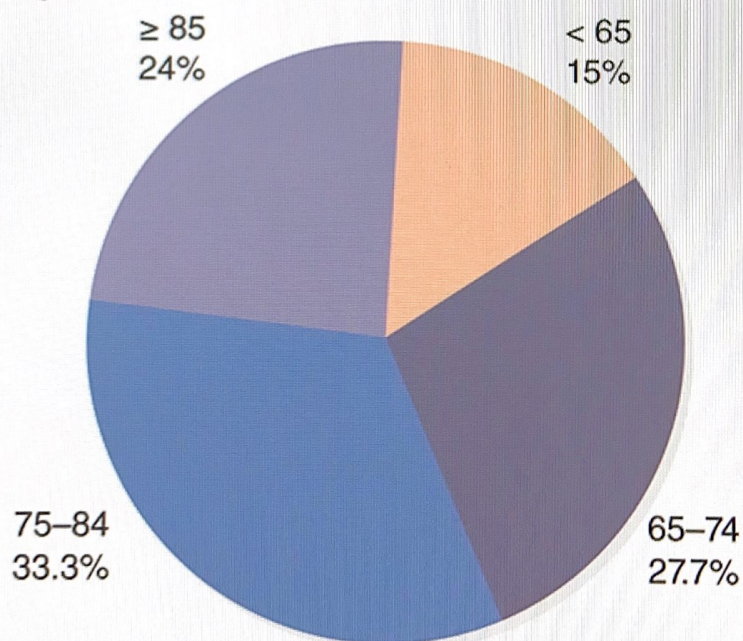


**FIGURE 7-6** shows the demographic characteristics of patients who received home health care in 2013. According to the Alliance for Home Health Quality and Innovation (2015), 3.4 million patients received home health care in the United States in that year. Home health care patients tended to be age 65 or older (85%), female (61.5%), and white (79%).

#### Gender



#### Age



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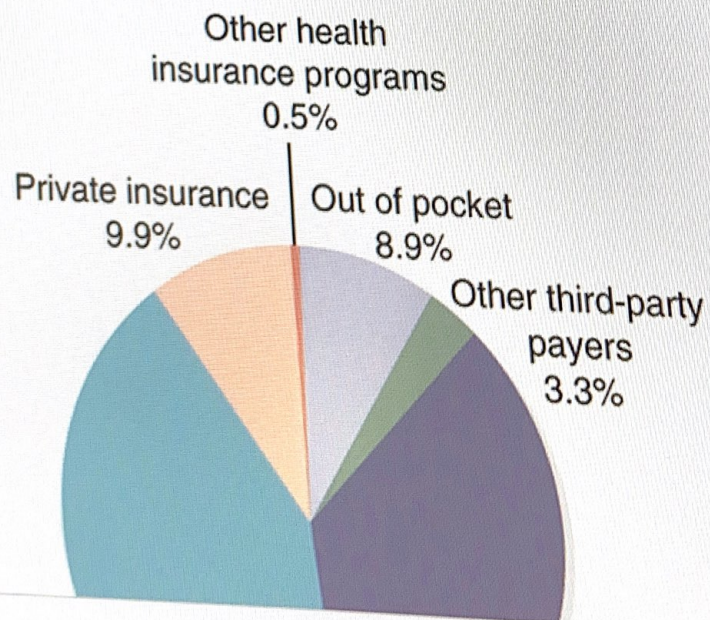




[http://ahhq1.org/images/uploads/AHHQ1\\_2015\\_Chartbook\\_FINAL\\_October\\_Aug2016Update.pdf](http://ahhq1.org/images/uploads/AHHQ1_2015_Chartbook_FINAL_October_Aug2016Update.pdf).  
Accessed February 2017.

Because of variations in data sources, national expenditures for home health care are difficult to calculate. The CMS (2015a) estimates that total expenditures for home health amounted to \$88.8 billion in 2015. Medicare and Medicaid accounted for 76% of home health spending (CMS, 2015a). Payments to home health agencies were sharply cut under the Balanced Budget Act of 1997. As a result, home health expenditures accounted for only 2.6% of total Medicare spending in 2015, compared to 9% in 1997 (CMS, 2015a; National Association for Home Care and Hospice, 2010).

**FIGURE 7-7** shows revenue sources for home health care providers and the average distribution of revenues from these sources. **TABLE 7-3** and **TABLE 7-4** provide additional statistics on home health.





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and hospice care agencies by organizational characteristics and services provided: United States, 2007. *National Health Statistics Reports* no. 30: 1–23.

## Hospice Services

The term **hospice** refers to a cluster of comprehensive services for terminally ill persons with a medically determined life expectancy of 6 months or less. More than half of all patients in hospice programs are diagnosed with cancer upon admission. Hospice, whose programs provide services that address the special needs of dying persons and their families. It is a method of care, not a location, and services are taken to patients and their families wherever they are located. Thus, hospice can be a part of home health care when the services are provided in the patient's home. In other instances, hospice services are taken to patients in nursing homes, retirement centers, or hospitals. Services can be organized out of a hospital, nursing home, freestanding hospice facility, or home health agency (FIGURE 7-8).

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| Location           | Percentage |
|--------------------|------------|
| Free-              | ~58.7%     |
| Home health based  | 16.3%      |
| Hospital based     | ~18.0%     |
| Nursing home based | 5.0%       |

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