Healthcare Structure, Organization and Governance

[Institutional Affiliation(s)]

Author Note

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**HMO Models and its Types**

The five generally renowned models of HMOs are staff, group, network, IPA and direct contract. The main variations between these models relate to the relationship between the HMO and its contributing doctors. Newly specific HMOs typically could be neatly characterized into a solitary model type for descriptive determinations. Presently, several (if not most) HMOs have diverse associations with diverse groups of doctors. As a result, numerous HMOs cannot simply be categorized as a solitary model type though such strategies are occasionally denoted as mixed models.

**Staff Model**

In a staff model HMO, the doctors who aid the HMO's enclosed beneficiaries are hired by the HMO. These doctors classically are paid every month and may also obtain bonus or motivation payments that are grounded on their productivity and performance. This model must employ doctors in all the mutual specialties to deliver for the health care requirements of their associates. This model is often termed as a close model because physicians and the employees are infrequently delivering health services (Ganda, Mitchell, & Seibel, 2019). They have a higher proportion of control and can manage overall health care deliveries and ambulatory care services. This is the advantage of this model over other models.

**Group Model**

In group model HMOs, the HMO agrees with a multispecialty doctor group practice to deliver all doctor facilities to the HMO's associates. The doctors in the group HMO model work mutually in groups and not by HMO. They check all kinds of patients in some circumstances such as HMO patients and others. The doctors in the group practice are working by the group practice and not by the HMO. The group model HMO has various disadvantages such as the limited selection of participating doctors for potential HMO associates. The limited number of hospitals and the limited number of locations often have a lack of accessibility of doctors for the community and the HMO members due to geographical boundaries. This also results in less advertisement for the HMO.

**Network Model**

A network model HMO is comparable to a group model HMO in which they deliver contract therapeutic facilities for their members from one or more group medical practices. The dissimilarity between these two is that the members contact the group model for the services and the group model HMO contacts the network model HMO. They provide services to the number of patients who are not network members.

**Best Suitable Model**

Health maintenance organizations (HMOs) are accomplished care prepaid cluster practices in which an individual pays a continuing premium for inclusive health-care facilities. HMOs are concerned with anticipatory and ambulatory facilities envisioned to decrease stays of hospitalization (“Trauma Verification FAQs,” n.d.). The HCO's transfer is planned in nature, averting the auction of the hospice to its for-profit opponent, and will improve the area of its solitary emergency department level 2 (two) trauma center with helicopter transportation while providing the HCO the capacity to serve its rising HMO association in the region. The best suitable model HMO would be group model HMO or network model HMO (open panel model) for this region. In this model, several physicians have diverse associations and link with a group of members. They deliver preventive and anticipatory services to the members.

**Importance and Applicability of Various Levels of Emergency Department Level I Trauma Center**

A level I provides total and complete care for every aspect whether it is injuries, prevention related or rehabilitation (“Trauma Center Levels Explained - American Trauma Society,” n.d.). It is a resource center of a tertiary care unit and provides 24 hours services in the presence of physicians, orthopedic surgeons, neurosurgeons, anesthesia surgeons and emergency drug specialists, radiology specialists, plastic surgeons, oral and maxillofacial, pediatric and critical care surgeons.

**Level II Trauma Center**

A Level II Trauma Center is capable to pledge ultimate care for all injured patients. 24-hour instant treatment by general physicians, as well as treatment by the specialists from orthopedic, neurosurgery, anesthesiology, emergency medication, radiology and acute care (“Trauma Center Levels Explained - American Trauma Society,” n.d.). Through HMO model, it would be providing services to the community and marketing would be an additional benefit after moving.

**Level II Trauma Center**

A Level III Trauma Center has established a capacity to deliver rapid valuation, resuscitation, operation, intensive care and maintenance of wounded patients and emergency procedures. They deliver 24 hours of treatment services and provide back up for the rural communities.

**Level IV Trauma Center**

A Level IV Trauma Center has validated a capacity to deliver advanced trauma life support (ATLS) earlier to the relocation of individuals to an advanced level trauma center. It delivers assessment, stabilization and diagnostic proficiencies for wounded patients.

**Level V Trauma Center**

A Level V Trauma Center delivers early assessment, stabilization and diagnostic competencies and organizes patients for relocation to upper levels of care.

**Exemptions to Critical Care Rural Hospital**

Critical Care Hospital is a title given to appropriate rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The title is intended to decrease the economic susceptibility of rural hospitals and recover access to healthcare by possessing important facilities in rural societies. To achieve this objective, critical care hospitals obtain definite benefits, for example, cost-based reimbursement for Medicare services. They have to qualify for the designation by providing 25 or fewer acute care inpatient beds and delivery of services 24/7 with a maximum length of stay 96 hours for acute care patients (Casey, Evenson, Moscovice, & Wu, 2018). The other benefits and exemptions afforded to the critical care rural hospital include cost-based repayment from Medicare, flexible recruitment and facilities, allowed to avail Flex Program educational capitals.

References

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