Effective Management of Long-Term Care Facilities

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You may read this book as a student of health care administration while you prepare for the professional licensure examination, when you need a ready reference, or when you consider a career in long-term care administration. You will not be disappointed. Dr. Singh provides a compendium of information needed for successful administration in long-term care.

This book clearly defines an administrator’s scope of responsibility in these four dimensions of care: physical, social, mental, and spiritual. Although regulations require that you create a “home-like” environment in the nursing home, elders and their families yearn for it to be a “home.” By using the physical design judiciously, empowering the staff, and engaging the community as partners in care, the leader-administrator creates an environment that both elders and caregivers want.

Dr. Singh frames many of these issues in a manner that familiarizes the reader with important theories and models, such as theories of aging and quality improvement models. He demonstrates to the reader the importance of functioning in an “open system” that is integrally linked to the external environment. The text clearly points out that using models, systems, and processes is essential for excellent outcomes in all areas of quality of life and quality of care.

Leaders must understand the realities of today while visioning the possibilities of tomorrow. While detailing what you must know to deal with today’s standards, the author also points to models that contain the seeds of future realities.

The challenges of managing long-term care are numerous. Our society demands near perfection in care, but does not support an adequate reimbursement system. Although regulation is highly prescriptive, it mandates maximum autonomy and choice. Students and candidates in health care
professions are frequently discouraged from working in long-term care by those oblivious to its many rewards. Being a leader in long-term care is one of the most rewarding and challenging positions in health care. As a health care administrator, you must ensure quality of care. As a leader in long-term care, you will create the quality of life experienced by those entrusted to you.

The American College of Health Care Administrators, the professional association for administrators in long-term care, conducted a survey of administrators in the fall of 2002. Their written comments were voluminous. This quote from one of those surveyed speaks to the reason that people working in the field find such rewards: *This is more than a job. I am in a position to affect change, to improve lives, to touch hearts. As administrators we should revel in the chance to make major differences in lives, patients, families, and staff. It is our privilege and our responsibility. Done correctly, the rewards are immeasurable.*

I hope that you will experience both the professional and personal rewards from working in long-term care.

Mary Tellis-Nayak, RN, MSN, MPH
President/CEO
American College of Health Care Administrators
ABOUT THIS BOOK

The primary focus of this book is to provide an in-depth source on how an effectively managed skilled-nursing facility should operate, and how prospective, as well as currently employed, nursing home administrators can hone their skills to deliver quality services cost-effectively.

The chapters are arranged in three major sections. The book begins with an overview of long-term care (LTC) and an explanation of the key external factors that can significantly affect long-term care organizations. The next section focuses on the organization of a nursing home, detailing how the physical structures, human resources, and delivery of services are arranged and integrated to provide total patient care. The final section concentrates on management and leadership skills that are necessary for managing the internal organization, as well as the external environment.

Using the open-system theoretical framework, the first two chapters emphasize why it is essential to understand changes in the facility’s external environment and how value-based community and client exchanges can be managed to accomplish strategic objectives. The legal and regulatory environment (Chapter 3) and financing and reimbursement (Chapter 4) are often regarded as the most critical external factors. The eight chapters in Part II (Chapters 5–12) cover building layout and architectural designs; contemporary systems of client-centered care; and traditional processes, personnel roles, and departmental functions that must be organized to deliver patient care and adjunct services. Achieving an appropriate blend of clinical and socio-residential aspects of care is the goal that guides the way in which the facility’s structures and processes are
managed to deliver holistic care. The internal structures and processes must also respond to the external demands, because major environmental forces change over time and compel the facility to either respond to external challenges or face adverse consequences. Hence, management practices must face current challenges and foresee the likely impact of new developments. The five chapters in Part III (Chapters 13–17) cover the management of the internal systems, the human resources, and the external environment. The critical roles of leadership, strategy, and management tools are discussed in Chapter 13. The remaining chapters cover human resource management and staff development; marketing, public relations, and customer relations; budgeting and financial controls; and improvement of productivity and quality.

As a college textbook, a major objective of this work is to enable the student to gain both a conceptual and “nuts-and-bolts” knowledge of health care facility management. After mastering the concepts in this book, the student can step into a management position as an administrator, assistant administrator, or trainee administrator, and find a level of comfort in dealing with various operational issues and problems encountered in day-to-day management situations. To accomplish this goal, the book incorporates numerous theories, models, illustrations, and examples to help the reader grasp the complexities of managing a long-term care facility. Practicing administrators can use this book as a handy reference for improving their skills, becoming more effective leaders in their organizations and their communities, and serving their noble profession by meeting the needs of the residents under their care. This book is also a valuable resource for administrator-in-training programs run by various nursing home corporations. Administrators can also use this book as a manual for training their department heads and other key personnel.

Each chapter begins with a list of learning modules. The chapters follow the learning modules, which describe the critical areas that students should master in order to develop their long-term care management skills. Discussion questions at the end of each chapter have been designed to provoke thought, and to make the student reason beyond what is obvious in the text itself. Some questions are designed to apply what is discussed in the text. A list of websites is included at the end of each chapter to promote further inquiry.
At the end, the book contains a comprehensive glossary, which is to be used as a dictionary of key terms encountered in the text. When first used in the text, each technical term has been highlighted. When the reader encounters the same term in subsequent readings, the Glossary can be used as a ready reference. Throughout the text, certain terms have been used interchangeably. Examples include: nursing home, nursing facility, facility, and long-term care facility; and patient, resident, and elder.

LONG-TERM CARE ADMINISTRATION

Skilled nursing care facilities are traditional nursing homes, which have evolved and developed into clinical centers for institution-based LTC. These are complex organizations to manage and have been the target of much regulatory oversight and public criticism. Yet demographic trends, especially the aging of more than 75 million baby boomers, suggest that these organizations will be needed more than ever before. Despite healthy lifestyles, advances in medical technology, and growth of community-based LTC services, the sheer number of people reaching old age and living longer implies that chronic conditions, comorbidity, and accompanying impairments will create high demand for nursing home care. It also means that a greater number of well-trained administrators will be needed to organize and manage skilled nursing, subacute care, and other types of long-term care services.

Nursing home administration entails much more than overseeing the various functions in an organization or following set routines. Of course, organizational stability and certain standard routines are signs of an effectively managed nursing facility. Such organizations also have predictable outcomes, according to recognized measures of patient care and financial expectations. In the long run, however, successes are achieved by (1) serving the community and creating meaningful partnerships with other health agencies and care delivery organizations, (2) understanding and working within the confines of what reimbursements will allow, (3) adapting to changing demands while complying with legal and regulatory requirements, (4) organizing internal operations within a nursing home to develop an integrated system in which services are delivered in a seamless fashion, and (5) managing the operations through effective leadership, human resource development, strategic marketing, financial control, and
quality improvement. The evidence of the dynamic nature of LTC delivery is ample, because in the past few years market competition has intensified, Medicare and Medicaid rules have placed new demands on managers, public scrutiny has increased, and litigation has intensified. Risk taking and innovation will mark successful administrators of the future.

To be the person in charge of a long-term care facility that takes care of frail and vulnerable individuals is a solemn responsibility. The nursing home administrator (NHA) must understand the clinical, social, and residential aspects of care delivery and also be directly responsible for managing the facility as a business. The NHA position is, in many respects, similar to that of a general manager in a complex human-service delivery organization. The NHA must have a 24-hour-a-day, 7-days-a-week commitment to an organization that must meet the patients’ clinical needs, ensure their social and emotional well-being, preserve their individual rights, promote human dignity, and improve their quality of life. In addition, the NHA must manage staff relations, budgets and finances, marketing, and quality. Hence, NHAs typically have a broad range of management responsibilities and are closely involved with day-to-day operational details. Being an NHA is a rewarding career, both financially and professionally. The psychological rewards that can come from delivering quality care to patients, helping family members, supporting community health initiatives, coaching the staff, and building excellence into the organization often exceed the financial rewards.

Becoming a Nursing Home Administrator

Since all NHAs must be licensed to practice, the first step is to contact the state’s licensing agency and obtain a copy of the state’s licensure requirements. The prospective administrator must meet the minimum educational qualifications. Most states require a college degree; some states also require completion of a short course in long-term care. All states require passing a national examination prepared by the National Association of Boards of Examiners of Long-Term Care Administrators (NAB). In most states, certain private firms hold a one- or two-day seminar, which many have found to be quite adequate to prepare for the NAB examination. In addition to the NAB, there is also a shorter examination on state nursing home regulations. Some states may also require an internship with a state-certified preceptor who is also a practicing NHA. Many states have reciprocity agreements, meaning that an administrator licensed in one state
can obtain a license in another state if that state has a reciprocity agreement with the other state.

Administrator Licensure Issues
At least one major reason that U.S. nursing homes have been targets of national scandals for delivering poor quality of care can be traced to a lack of proper NHA training. Since the licensing of NHAs is a state function, qualifications required for managing nursing facilities vary widely from one state to another. Only a handful of states stipulate a bachelor’s degree in health services administration as an educational requirement. Over the years, state and national licensing policies have been crafted under the false assumption that a degree in English or History, a self-study course on long-term care, a score of 75% on a 150-question multiple-choice NAB test, and some internship hours with an experienced NHA adequately qualify someone to become responsible for the care of 100 or more residents in a nursing home. When most of the nation’s NHAs have educational backgrounds in areas that are totally unrelated to delivering long-term care to the elderly, it should come as no surprise that substandard quality is rampant. At least two landmark reports by the Institute of Medicine have reached this conclusion. In fact, administrative skills and behavioral factors associated with NHAs may be more important for delivering quality than facility constraint or resource factors. While there is growing evidence that high turnover among NHAs may be associated with low-quality patient care, many administrators find the challenges of managing a nursing home to be overwhelming. The starting point to remedy these circular problems is a licensure requirement of a bachelor’s degree in health care management.

LONG-TERM CARE POLICY OVERVIEW
The LTC delivery system in the United States comprises various types of community-based and institutional options, and there are wide variations in payment for services and regulation of different kinds of facilities. For instance, residential care facilities, such as board-and-care homes, sheltered-care facilities, and assisted living are not even licensed in some states. Also, the type and level of services can vary substantially because of a lack of standard terminology and criteria for differentiating between
various levels of care. However, nursing homes, which health care professionals generally know by their regulatory title as skilled nursing facilities (SNFs), have been the prime targets of policy oversight.

Public policy in long-term care has evolved in three main directions: financing, utilization, and quality. The evolutionary process, however, did not progress according to some planned design. This follows the general pattern of American health policymaking. Since the U.S. does not have a national health insurance system, which would be more amenable to uniform and comprehensive policymaking, issues pertaining to health care financing and delivery in the U.S. are addressed incrementally, in a piece-meal fashion. Long-term care policy has been no exception to this disjointed, ad hoc approach.

The three policy areas discussed here have a tremendous impact on the management of long-term care facilities, because nursing homes must render services that meet at least the minimum standards defined by regulations, implement operating systems to comply with laws and regulations, and manage within the financial parameters set by reimbursement levels. Health policy can also have a major effect on access to services, shifts in utilization, market competition, and an adequate and well prepared workforce.

**Financing**

The major initiatives in LTC policy can be traced back to 1965, when the Medicare and Medicaid programs were created under Social Security Amendments. Of these two programs, Medicare was never designed to pay for long-term care. Although Medicare was designed primarily to finance hospital-based acute care services for the elderly, short-term post-acute convalescence was included as a benefit for two main reasons: (1) to ensure continuity of care after discharge from a hospital, and (2) to save money on otherwise lengthy and more expensive hospital stays once the acute phase of an illness was over. Medicaid rules, on the other hand, provide for comprehensive medical care services for the indigent who meet the state-established income criteria. Medicaid benefits include financing for nursing home care, and the length of nursing home stay is generally not limited, as long as need is demonstrated.

The problem with such fragmented public policies is that access becomes restricted for many who need the services for a long period of time, because Medicare pays only for post-acute short-term stays, and

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Medicaid requires people to exhaust their financial resources to become eligible. Thus, Medicaid has become the payer of last resort for many middle-class elderly who have run out of their own private funds to pay for nursing home care. But many elders who do not qualify for either program have to pay on a private basis. In 2000, 44.4% of the funding for nursing home care was derived from Medicaid, and only 9.5% came from Medicare. Private out-of-pocket payments financed 24.9%, and 7.4% was financed through privately purchased long-term care insurance (Friedland 2003).

Despite the gaps in access, policymakers have shown little concern for LTC coverage. Some believe that this neglect can be attributed to fears that improving the system will result in increased health care expenditures, especially because family members currently provide most LTC to their elderly parents or relatives in their private homes without getting paid for the services they render (Friedland 2003). However, gains in life expectancy which, for a newborn, has risen from 68.2 years in 1950 to 77.2 years in 2001; over 75 million baby boomers who are about to enter retirement age in 2011 and beyond; and dwindling birth rates have already set in motion the demographic imperative, with potentially serious consequences at two main fronts: (1) With fewer working people and a burgeoning elderly population, the financial burden for LTC on future generations is expected to be enormous (Shi and Singh 2004, 412). This is an impending dilemma that policymakers are reluctant to bring up for public policy debates. (2) A labor force crisis for LTC delivery is already beginning to emerge, as a smaller proportion of people from a shrinking pool of new workers are choosing employment in health care delivery settings (Stone and Wiener 2001). Stone (2003) believes that a shortage of stable and qualified workforce may be the most important and most neglected policy concern. Training in geriatrics is particularly lacking among physicians, nurses, therapists, and social workers, and there are not enough trained administrators to provide leadership in the long-term care field. There is also a need to prepare and sustain a qualified workforce of direct-care personnel, such as certified nursing assistants, who provide

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1 According to data from the U.S. Department of Health and Human Services.

2 The crude birth rates (live births per 1,000 population) were 24.1 for 1950 and 14.5 for 2001 according to data from the U.S. Department of Health and Human Services.
most of the daily hands-on care to patients in nursing homes. According to Stone (2003), policies are needed to promote collaboration between education, labor, welfare, and immigration agencies to evaluate the labor issues and to create positive incentives for workforce development.

Other policy issues related to financing surround the levels of reimbursement from Medicare and Medicaid. Nursing home operators have long contended that payments from public payers have been inadequate to support quality services. On the other hand, Medicaid and Medicare administrators have been concerned about rising expenditures, while the public is not inclined to pay more in taxes. Even though independent experts continue to voice their opinions that reimbursement levels should be raised, the demographic imperative suggests that the government will have to find new ways to keep payments in check. The irony is that, unlike many other industries, nursing home care is highly labor intensive, and few options are available to increase productivity or slash operating costs.

Coverage for nursing-home services from private long-term care insurance has increased slightly in recent years, but fewer than 10% of people 50 years of age and older purchase private insurance for LTC (Seff 2003). The elderly population most likely to benefit from private LTC coverage also has a lower average income than the general population. Hence, LTC insurance is difficult to market, because premiums must be high enough to cover costs but low enough to attract clients. Insurance is based on the principle of adequately spreading risk among a large segment of the population. However, younger healthy groups have shown little interest in buying LTC insurance because they see the need for LTC only as a remote possibility (Shi and Singh 2004, 412). A few states offer tax deductions or credits for purchasing private LTC insurance, but the incentives appear to be too small to induce many people to purchase LTC plans (Wiener et al. 2000). Thus, financing for nursing home care is likely to remain a major dilemma as time progresses. In such an environment, NHAs will have to be skillful leaders who can motivate their staff to become more efficient providers of care. NHAs are also challenged to find cost-effective ways to deliver services without compromising the quality of care.

**Utilization**

Table 1 provides capacity and utilization data for nursing home beds. Even though capacity has increased, occupancy rates have been falling during the decade of the 1990s. However, both capacity and utilization have declined since the early 1980s (although accurate data are not available because of
inconsistencies in data reporting methods). The downward trend in nursing home utilization during the last decade is very likely a function of shifting configurations of the services offered by various long-term care providers (Bishop 2003). During the 1980s, nursing homes entered the post-acute (or subacute) and rehabilitation market, mainly as a result of the DRG-based prospective payment system implemented in hospitals, which created incentives for early discharge of acute-care patients. The trend accelerated during the 1990s, as the proliferation of managed care put further pressures on reducing the length of stay in hospitals. While these trends should have increased nursing home utilization, other factors in play since the 1980s promoted the use of alternative settings such as home health care, other community-based long-term care services, and assisted-living care, an industry that has experienced tremendous growth. For example, the implementation of the Pre-admission Screening and Annual Resident Review (PASARR) program restricted placement in nursing homes of persons with psychiatric diagnoses (Institute of Medicine 2001). The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) gave states the authority to implement Home and Community-Based Services programs as an alternative to institutional care through Medicaid waivers created under section 1915(c) of the Social Security Act. Almost all states opted for the 1915(c) waivers as a means of reducing their financial burden by curtailing nursing home utilization and providing less costly community-based long-term care services. Using a combination of federal grant money and their own matching funds, a number of states have programs, although limited in scope, to cover adult day care, home health care, homemaker services, and assisted living for some of the neediest people.

The 1988 court ruling on a class-action lawsuit, Duggan v. Bowen, opened up broad access to Medicare-covered home health services, and for some time, home health had become the fastest growing health care ser-

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</tr>
</thead>
<tbody>
<tr>
<td>Number of nursing homes</td>
<td>15,846</td>
<td>16,389</td>
<td>16,886</td>
</tr>
<tr>
<td>Number of beds</td>
<td>1,692,123</td>
<td>1,751,302</td>
<td>1,795,388</td>
</tr>
<tr>
<td>Occupancy rate</td>
<td>86.0%</td>
<td>84.5%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Beds utilized</td>
<td>1,455,226</td>
<td>1,479,850</td>
<td>1,479,400</td>
</tr>
</tbody>
</table>

vice in the U.S. On the other hand, private paying patients have found the residential and social lifestyles in assisted living facilities to be much more appealing than those in skilled nursing facilities. Many people have figured that they might as well spend their personal savings in an upscale assisted living home, and later apply for Medicaid if they need care in a skilled nursing facility. However, the impending demographic shifts will increase the number of people with functional impairments who will need nursing home services. On the other hand, policymakers will continue to explore new ways for providing cost-effective LTC services without turning LTC into an expanded social program. As part of these efforts, funding for community alternatives will continue, but many recipients of care in the home and community-based settings will eventually need to be institutionalized. Nursing home administrators with the savvy to establish community exchange partnerships (discussed in Chapters 1 and 2) will be ahead of the curve in an increasingly competitive environment.

Quality

Quality has been a well-recognized issue in long-term care for some time. Since Medicare and Medicaid have financed more than half of the nation’s nursing home care, government regulations have played a major role in establishing standards to ensure at least the minimum level of quality. Research has demonstrated that the effects of this regulation have been positive. For example, the sharp decline in the use of physical and chemical restraints has been attributed to the requirements of OBRA-87. Other positive care practices since the implementation of OBRA-87 standards include more accurate medical records, comprehensive care planning, greater use of advance directives, increased use of incontinence training programs, and increased participation of residents in activity programs (Hawes et al. 1997; Marek et al. 1996; Teno et al. 1997). OBRA-87 also mandated a comprehensive patient assessment program, which led to the development of a standardized Resident Assessment Instrument. The assessment protocols are designed to help a nursing facility identify and treat or manage chronic conditions, the onset of acute illnesses, adverse effects of medications, or other factors that caused or contributed to a clinical problem (Hawes 2003). In future, successful nursing facilities will go beyond the minimum quality standards enforced by regulations, will make total quality management a part of the daily operations, and will build organizations in which a culture of quality will prevail.
INTERNET RESOURCES FOR FURTHER LEARNING

National Association of Boards of Examiners of Long-Term Care Administrators (NAB). This organization administers the national licensure examination for nursing home administrators. It has publications available to prepare for the examination. The website also provides links to the licensing agencies in all states.
http://www.nabweb.org

Improving the Quality of Care in Nursing Homes (1986)
Institute of Medicine (IOM). The full text of this publication is available online.
http://books.nap.edu/books/0309036461/html/243.html#pagetop

Improving the Quality of Long-Term Care (2001)
Institute of Medicine (IOM). The full text of this publication is available online.
http://www.nap.edu/books/0309064988/html/

REFERENCES


INTRODUCTION


