This book takes the open system approach. In modern management, the open system theory has found a strategic role in operating a successful enterprise in a changing environment. To be successful, an organization must adapt to external change.

According to the open system theory, organizations are viewed as living entities that exist within, and are part of, a larger environment. The external environment consists of numerous forces, which can be classified into six broad environmental domains: social, political, economic, technological, informational, and ecological. Forces in these domains have varying degrees of influence on an entire industry and its member organizations. The nursing home industry is no exception. Over time, the long-term care industry in America has been shaped by such factors as innovations in medical care and technology, government regulations, national health policy, consumer advocacy groups, and people’s attitudes and commitments at work and home. Such external influences will continue to pressure the industry to change. While broad forces influence the whole industry, individual long-term care facilities are affected by their local
environment. Examples include market competition, shifts in local demographics, and makeup of the labor force in the area.

In the open system approach to long-term care management, facility administrators view their organizations as integrally linked to the external environment. Because the various environmental forces remain dynamic, administrators must be keen observers of emerging trends. They must assess the nature and degree of change in the environment, and evaluate the potential impact of external changes on the organization. Certain environmental changes can have a lasting effect on an individual facility’s or a nursing home corporation’s long-range survival. For example, when new competition enters the market, new regulations take effect, or payment methods are changed, they generally have lasting effects on long-term care facilities. Hence, the difference between success and failure often depends on the ability of top-level managers to identify changes in the external environment, evaluate their potential effect on the organization, make decisions, and take action. The dynamic environment not only presents challenges, it also opens up new opportunities. Long-term care administrators who understand and are attuned to external factors and their potential effect on the organizations they manage are likely to outperform those who do not pay attention to the changes or do not grasp their implications for the facility. Achieving this kind of success requires that nursing home administrators develop a high level of conceptual skills. They must be active in their local communities, exchange ideas with managers in other health care organizations, and actively participate in professional associations representing the long-term care industry.

A clear understanding of the external environment is essential for four main reasons:

- To meet the variety of care needs of all the patients served by a facility, the administrator must establish effective exchanges between the facility and key external agencies that are best suited to provide the services that the facility does not produce.
- Administrators must pursue opportunities to forge partnerships with external agencies that would result in serving the organization’s best interests.
- Administrators must persistently improve operational efficiencies as new health policies emerge, new regulations are passed, and new reimbursement methods are implemented.
The long-range direction of a facility must be driven by the current and anticipated changes in the external environment.

Strategic decision-making is vital for an organization's long-term success. Examples of strategy include deciding whether to add new services to meet changing health care demands or to curtail services for which the demand is declining; whether to expand an existing facility or to build a new one; and whether to acquire a facility or to merge with another organization. Periodically, all health facility administrators must confront external threats, take action to meet new environmental challenges, or take advantage of some opportunity to gain market share.

The major environmental components are discussed in this Part of the book. Chapter 1 explains the six environmental domains and discusses their implications. It also gives an overview of the long-term care system, describing the various services that can be arranged along a continuum of care. From a facility's perspective, some of the services are competitive whereas others are complementary. The chapter also addresses how long-term care services ought to be rationally linked to the rest of the health care delivery system. Chapter 2 provides more specific illustrations of the types of exchange relationships a nursing facility can establish with external agencies. Using a systems model of value exchanges, it emphasizes value-driven partnerships as the basis on which meaningful exchanges are built. Chapter 3 centers on the legal and regulatory environment. Chapter 4 covers details of financing and reimbursement, which constitute the life blood necessary for sustaining an organization.

The significance of the environmental domains for strategic management, and how the concepts of open and closed systems should be integrated into management practice, are more fully addressed later in Part III.
CHAPTER 1

System Concepts and Long-Term Care Delivery

LEARNING MODULES

1. Differences between closed and open systems. Open system cycle of exchanges. Organizational outputs that benefit the external agencies in open system partnerships. Outputs and benefits as necessary conditions to attract desirable resource inputs.


3. Operation of environmental influences in primary and secondary proximities, and at four proximal levels that require different types of responses from administrators. Competitive and complementary services, and their implications for nursing home administration.

4. Six main characteristics of long-term care. Differences between care based on the medical model and the holistic model. Reasons that a variety of services must be appropriately balanced. Four distinct categories for clas-
sifying the variety of long-term care services. Two major aspects of medical care.

5. Reasons that mental health needs may go unattended. The facility’s responsibility for total care. Importance of integrating social and residential services.

6. Physical and mental dysfunction and the goal of long-term care. Integration of holistic aspects and quality-of-life features into the delivery of care.


8. Types of institution-based long-term care services. Main differences between a skilled nursing facility and other types of institutional settings. Challenges posed by skilled nursing care.

9. Subacute care and specialized care services.


If we can find a logical point of departure to discuss effective management of long-term care organizations, it will be recognizing that no organization is self-contained. Organizations are not self-sufficient and cannot function effectively if isolated from their external environments. Organizational success requires establishing linkages with external agencies. It requires adapting to a changing environment. It requires managers to be proactive in assessing the potential effects of emerging trends. It requires perception, understanding, analysis, decision-making, and action on the part of managers. The open system theory embodies these concepts. An organization that is capable of pulling resources from its environment remains dynamic. Over time, it builds internal strengths that enable it to attract clients, serve them well, improve profitability, develop its staff, and benefit the community. Such an organization gains a certain momentum,
enabling it to meet new challenges and profit from new opportunities when other organizations may remain inert and suffer from atrophy.

In general, long-term care includes a complex array of services that have remained fragmented because no attempts have been made to integrate them into a seamless system of long-term care delivery. Nursing care facilities are a part of this uncoordinated “system,” and facility administrators should understand the other pieces of the long-term care puzzle. For example, a nursing home administrator should become familiar with complementary long-term care services available in the community. These services include home health care, outpatient rehabilitation, subacute care, specialized services for Alzheimer’s patients, and a variety of supportive living options for the elderly or disabled. A knowledge of other health care agencies and social services outside the long-term care sector is also critical.

THE CLOSED AND OPEN SYSTEMS

A system can be defined as “a set of elements standing in interrelation among themselves and with the environment” (Von Bertalanffy 1972). Whether or not an organization’s internal systems are linked to the external environment is what differentiates between closed and open systems.

Closed System

Organizations that function as a closed system emphasize only the interrelationships between the various internal components, while the interaction with the external environment is largely ignored. A closed system typically focuses on procedures for monitoring outputs, comparison of outputs with preset standards, evaluation of discrepancies between actual outputs and preset standards, and mechanisms for taking action to rectify negative variances between actual outputs and preset standards (Brown 1977). Effective closed systems management is essentially focused on organizational structures, productivity, effectiveness, cost control, profitability, and quality. In an effectively functioning closed system, the various departments of a nursing facility work together cohesively, support each other, and develop systems to improve quality and efficiency. Clearly, management must focus on improving the internal operations. However, even though these aspects of management are extremely important, a closed system functions as a self-contained entity, isolated from its environment. No matter how efficient the internal systems of an organization may become,
without the open system approach a nursing facility will stagnate and eventually lose any competitive advantage it may have once enjoyed.

**Open System**

An *open system* recognizes the effects of external factors and views internal operations in relation to changes in the external environment. The open system approach is based on the premise that “no organization can survive for long if it ignores government regulations, supplier relations, or the myriad external constituencies upon which the organization depends” (Robbins 2000, 606). The open system approach is necessary because organizations do not function in a stable and predictable environment. In this approach, internal operations are evaluated in terms of the demands of a changing environment. External forces impose new pressures and challenges, compelling the organization to respond, conform, adapt, and innovate. Appropriate responses to external demands also result in interactions that benefit the organization as well as the constituencies the organization serves. The organization depends on the environment to receive essential inputs, it transforms those inputs and supplies outputs that benefit the environment (Brown 1977).

Open systems theory suggests that an organization’s interface with its external environment should be viewed as an exchange relationship—a give-and-take relationship—between the organization and its environment. At the receiving end, the organization obtains from its environment various inputs in the form of resources such as staff, supplies, loans, fire and police protection, clients, and payments for services. At the giving end, the organization returns to the environment what it has produced in the form of jobs, taxes, market competition, education, and improved community health. Dill (1958) identified four factors in the environment that are particularly relevant for organizational goal setting and goal attainment. The four factors are:

- Customers
- Suppliers of labor, materials, capital, etc.
- Competitors for both markets and resources
- Regulatory groups

When properly exploited by astute management, each of these factors makes a contribution toward making a nursing facility more effective in delivering services.
Cycle of Exchanges
The relationship between an organization and its environment goes through a complete cycle of exchange, which has four identifiable phases, as illustrated in Figure 1-1.

Resource Inputs
Organizations rely on the environment to obtain the critical resources needed to accomplish their goals and objectives. Some of the major resources are human resources, capital financing, supplies and equipment, technology, complementary services needed by the organization’s clients, licensure by the state, and federal certification. These basic inputs are critical to a long-term care facility’s ability to deliver appropriate levels of patient care.

Clients and Payments
The nursing facility must attract clients who will benefit from the services provided by the organization. Clients establish the primary exchange whereby the organization produces services: clients receive services tailored to meet their individual needs, and the facility gets paid for the services it has rendered. This exchange relationship among the facility, its clients, and payers generates revenues that make an indispensable contribution to a nursing facility’s profitability.

FIGURE 1-1 Organizational Interface with the External Environment
Production of Outputs
As they deliver services to clients, nursing care organizations transform the resources obtained from the environment into critical outputs such as clinical quality, client satisfaction, staff satisfaction, and profits. Effectiveness and consistency in producing these outputs determine the long-range success of a nursing facility.

Returns to the Environment
Organizations provide jobs, pay taxes, contribute to cost-efficiency within the health care system by actively competing in the marketplace, engage in community outreach by providing education and information, and positively influence a community’s health and well-being. Thus, the organization creates external benefits by what it produces and returns to the environment. Finally, the cycle is completed as external agencies take into account a facility’s outputs and benefits returned to the community when the facility needs resources to sustain its operations. A facility’s ability to attract desirable resource inputs is often conditional upon its outputs and returns to the environment. For example, a long-term care facility that produces poor quality outputs will find it difficult to attract the most qualified staff members, a key resource the facility must obtain from the external environment. Such a facility is also likely to face difficulties attracting clients. Other health care providers, such as hospitals and physicians, may stop referring their patients. In extreme cases, the facility may risk losing its license and certification, which may put it out of business. An organization builds its reputation and image on the basis of what it delivers to the environment. When a facility fails to meet community expectations, it jeopardizes its prospects for attracting quality resource inputs and further weakens its ability to stay competitive.

THE ENVIRONMENT

Open System and Strategic Management
Although strategic management is one of the main themes in Part III of this book, it is appropriate here to emphasize that there is an inextricable link between the open system approach and strategic management. Figure 1-2 gives an overview of the strategic management process and includes examples of strategic planning and actions. Strategy formulation is a top-
management function that is driven primarily by environmental change. The purpose of strategy is to keep the nursing facility afloat during adverse circumstances and to make it more profitable by gaining a competitive edge. When a nursing facility administrator adopts the open system approach to management, he or she will monitor changes in the environment; decide on the type of strategic response that would be in the organization’s best interest according to organizational mission and values; plan a course of action; and carry out the plan. Using various formal and informal processes to identify significant trends and events on an ongoing basis is called environmental scanning. A formal analysis and evaluation of environmental trends to understand their potential implications for a facility’s long-term success is called environmental assessment. In strategic planning, administrators assess major trends and directions and make decisions to avert threats and pursue new opportunities
that may emerge. A careful environmental assessment is also often necessary when planning major changes in the internal operations.

**Environmental Domains**

Environmental scanning and assessment activities are greatly facilitated by a conceptual model that classifies the macro-environment of a long-term care facility into six main domains: social, political, economic, technological, informational, and ecological (Figure 1-3).

**Social Factors**

Social factors include demographic trends, social change, cultural factors, and lifestyle preferences. The demand for long-term care and the type of services are influenced by changes in the population's demographic composition, such as age, gender, and prevalence of disability. Greater longevity has given rise to the “sandwich generation” of middle-aged families who must take responsibility for their teenage and college-age children on the one hand, and for elderly parents on the other. An increasing number of women in the workforce means that married couples may need formal help
to care for their elderly parents. Strong family and social support enable people with disabilities to continue to live independently. Other trends, such as job mobility, often require making appropriate arrangements for the elderly parents who are left behind as close family members move away. Migration of retired people to areas of the country that offer a more temperate climate has important implications for the development of long-term care services in those areas. Lifestyle preferences of baby-boomers are giving rise to a new demand for nursing care settings that emphasize personal independence and lifestyle choices.

**Political Factors**

The **policy agenda** that sets priorities for political action, tax policy, the appropriation of tax dollars to various programs, and laws and regulations have a tremendous impact on the management of long-term care facilities. For instance, high taxes chip away profit margins in for-profit businesses. Federal and state funding appropriations for the Medicare and Medicaid programs determine how much nursing facilities will get paid. Federal and state legislatures pass new laws, and government agencies craft regulations. The political clout of the long-term care industry can influence how state and federal funds are appropriated or how the industry is regulated. Administrators can participate in the political process by establishing contacts with their state and federal representatives, by voicing their opinions, and by becoming members of professional associations representing their interests.

**Economic Factors**

Economic growth or recession, industrial development, and unemployment create demographic shifts that can bring people into an area or make them leave. Economic factors may also dictate whether people can afford to pay for long-term care, especially when public financing does not cover certain services. Changes in the labor market affect the availability of skilled workers and hence a facility’s ability to recruit qualified staff members. Tight labor markets, for example, ease up recruitment of nursing assistants, cooks, and housekeepers, because those workers have difficulty finding jobs in restaurants, hotels, motels, and other low-skilled service industries. The job market also governs wages and benefits necessary to attract and retain employees. Competition from other facilities, and from substitute services such as home health care, present challenges
that nursing home administrators must not ignore. Other major economic events, such as the growth of managed care since the late 1980s, have an enormous impact on every aspect of health care delivery, including long-term care.

Technological Factors
Technological innovation in medical sciences will continue to revolutionize health care. It also has social implications as people live longer and healthier lives, and as the elderly seek more independent lifestyles. Technology has enabled many individuals to receive long-term care services in less restrictive or non-institutional settings instead of getting that care in traditional nursing homes. Home health care, for instance, is not only a cheaper alternative to nursing homes, but is also preferred by clients when services such as intravenous antibiotics, oncology therapy, hemodialysis, and parenteral and enteral nutrition can be provided by home-care agencies. On the other hand, technology has enabled nursing care facilities to provide specialized services and has allowed these facilities to care for acutely ill patients who previously could receive such services only in a hospital. Examples include AIDS care, ventilator care, head trauma services, and post-orthopedic rehabilitation.

Informational Factors
Computer-based information systems and the Internet have numerous applications. Adoption of information systems is changing many of the processes of health care delivery. It is also providing more effective tools for managing health care organizations. Areas of application where information systems have made a positive difference include clinical records, patient assessment and care planning, patient-care protocols, inventory management, data collection and analysis, advertising, and computer support systems for both clinical and management decision-making. The Internet has also opened access to a barrage of information for practitioners and consumers alike.

Ecological Factors
New infections and diseases, as well as a carry-over of certain medical conditions into older populations will affect long-term care delivery. The incidences of infection with Human Immunodeficiency Virus (HIV) and Hepatitis C virus have shown the need for training in precautionary
measures and practice of stringent infection-control procedures. Also, new treatments seem to delay the onset of Acquired Immune Deficiency Syndrome (AIDS). As people infected with HIV live longer, AIDS is likely to become more prevalent among older people. People with developmental disabilities are also living longer and need specialized care. Other ecological factors such as natural disasters (earthquakes, floods, hurricanes, snowstorms, tornadoes, etc.) require that facilities undertake adequate planning and prepare for unforeseen eventualities, particularly if they are located in areas that may be prone to such events. The possibility of bioterrorism has raised new concerns for patient safety. It also requires that health care facilities work in close collaboration with local civil defense and public health agencies to address potential threats.

**Environmental Proximity**

Environmental proximity determines how closely certain influences surround the organization. An organization’s relationship to its environment and the degree of control it may have over environmental issues is often governed by the proximity. For instance, a facility administrator generally has much more control over managing relationships with the local hospital than he or she does over state or national policy that affects nursing home regulations and reimbursement.

First, in rather broad terms, we can think of primary and secondary proximities (Figure 1-3). The primary proximity is closer to the organization, and the six environmental domains operate in a local environment such as the community, which can be a neighborhood, a local district, or an entire metropolitan area. In other instances, such as facilities serving rural areas, an entire county would constitute the primary proximity. The secondary proximity consists of environmental domains operating at the state and national levels. Primary proximity offers the administrator opportunities for direct involvement in the community, it helps identify local agencies with which exchange relationships should be established, it creates heightened expectations for the organization’s social responsibility toward the community, and it influences the market’s competitiveness.

Another way to illustrate the interplay of external factors is through four proximal levels shown in Figure 1-4. In this four-level model, the first three levels comprise the primary proximity; the fourth level forms the secondary proximity.
Level One Proximity

The most proximal influence surrounding a nursing home is other similar facilities and substitute services that directly or indirectly compete against the organization. **Substitute services** are other long-term care options that clients may choose from. For example, home health can be a substitute for institutional care. Three-fourths of all elderly patients receiving home health care require nursing services, and almost 30% need physical therapy (U.S. Bureau of the Census 2003), which are services that are also provided by nursing care facilities. Competition is generally viewed as a threat, but it may also drive the organization to innovate and expand its range of services. For example, a nursing home may open an outpatient rehabilitation center, or expand into delivering home health care. Well thought-out strategic actions can maintain or enhance a facility’s competitive advantage.

Level Two Proximity

Level 2 proximity includes a wide variety of **complementary services**. These are services that are not directly rendered by the facility in which the patient resides, but are necessary to address the total health care needs of a patient. A nursing home must assume responsibility for the total care of all patients. **Total care** means recognizing any health care need that may arise, and ensuring that the need is evaluated and addressed by appropriate clinical professionals. When evaluation and treatment are beyond the
nursing home’s scope of services, a timely referral to an outside provider is necessary. For example, a skilled care facility is not a mental health institution. It must, however, recognize mental health needs when they arise, and coordinate the delivery of appropriate mental health care. In some cases, it may be necessary to move a patient temporarily to an acute care hospital. In other instances, a patient may need to be referred to a dentist, optometrist, or podiatrist. Community outreach efforts, marketing decisions, and liaisons with complementary service providers that would facilitate ready access to services needed by a facility’s patients can only be undertaken with a keen understanding of the level 2 proximity. Administrators must forge meaningful relationships with external providers with the goal of establishing a two-way patient referral system. For example, it is common for nursing homes to have contracts with selected dentists, podiatrists, optometrists, acute care hospitals, and other providers. Skilled nursing facilities can also make informal agreements with retirement centers, assisted living facilities, and home health agencies to transfer patients among them to accommodate the changing needs of their clients.

Level Three Proximity
At level 3, we can think of the environmental factors operating in a facility’s primary proximity. These are local environmental factors and various community and civil services that are not directly associated with health care delivery. Examples include the local economy, demographic shifts in the county, local job conditions, the level of local police- and fire-protection services, and local ordinances.

Level Four Proximity
Level 4 environmental factors affect the nursing home industry at the state and national levels. But in many instances these changes also affect local nursing homes. Examples are changes in the government’s payment methods for patients on public assistance, changes in rules and regulations, reports on nursing homes by state or national media, and major industry trends that may eventually become more localized, such as the spread of managed care or growth of substitute services. These influences often shape decisions that administrators must make. Administrative decisions in response to state or national influences often have long-range consequences for the nursing facility, and the type of response is generally quite different from what would be appropriate for the previous three lev-
els of proximity. The first three levels of proximity primarily call for establishing community exchanges and involvement, and for adapting facility services to meet local needs. Level 4 proximity generally requires changes in internal operations to respond to broader issues. Level 4 proximity also requires active participation in the professional and trade associations that represent the industry. Some of the major long-term care associations include the American Health Care Association (AHCA), the American Association of Homes and Services for the Aging (AAHSA), the Assisted Living Federation of America (ALFA), and the American College of Health Care Administrators (ACHCA). These organizations closely follow major economic and political developments, and they keep their members informed about these developments. These organizations maintain active lobbying efforts at the state and national levels in order to influence long-term care policy. From time to time, they also engage in mobilizing grass-root campaigns by directing their members to contact their elected representatives and to educate those representatives about specific nursing home issues.

THE NATURE OF LONG-TERM CARE

This section gives an overview of the main characteristics of long-term care. These characteristics are common to all long-term care services, regardless of whether they are delivered in an institution or in a community-based setting.

Long-term care can be defined as a variety of individualized services that are designed to promote the maximum possible independence for people with functional limitations, and these services are provided over an extended period of time to meet the patients’ physical, mental, social, and spiritual needs while maximizing their quality of life. This comprehensive definition covers six main aspects which apply to both institutional and non-institutional long-term care:

- variety of services
- individualized services
- promotion of maximum possible functional independence
- extended period of care
- meeting the patient’s physical, mental, social, and spiritual needs
- maximizing quality of life
**Variety of Services**

The delivery of most types of medical services is based on what is called the **medical model**, according to which health is viewed as the absence of disease. When a patient suffers from some disorder, clinical interventions that are widely accepted by the medical profession are used to relieve the patient’s symptoms. Prevention of disease and promotion of optimum health are relegated to a secondary status. By contrast, in long-term care, medical interventions are only a part of an individual’s total care. Emphasis is also placed on non-medical factors such as social support and residential services.

By its very nature, effective long-term care is holistic; medical and nursing care make up only one aspect of meeting the needs of the whole individual. On the other hand, the need for long-term care is not determined solely by social and residential factors. The need is triggered by physical factors, mental factors, or both; but once the need for long-term care has been established, a holistic approach must be used in the delivery of care.

Long-term care encompasses a variety of services so that needs that vary from one individual to another can be adequately addressed. The range of services an individual needs is determined by the nature and degree of his or her functional disability, and the presence of any other medical conditions and emotional requirements that the individual may have.

The full range of long-term care can be categorized into four distinct types of services: medical care, mental health, social support, and residential amenities. Although understanding the distinctive features of these services is important, in actual practice they should be appropriately integrated into the total package of care in accordance with individual needs.

**Medical Care**

Medical interventions in long-term care are primarily governed by the presence of two main health conditions: chronic illness and comorbidity. First, as opposed to the care for acute conditions, long-term care focuses on chronic ailments, particularly when they have already caused some physical or mental dysfunction. **Acute conditions** are episodic, require short-term but intensive medical interventions, generally respond to medical treatment, and are treated in hospitals, emergency departments, or outpatient clinical settings. **Chronic conditions**, on the other hand, per-
sist over time, are generally irreversible, but must be kept under control. If not controlled, serious complications can develop. Examples of chronic conditions include hypertension, diabetes, arthritis, asthma, heart disease, cancer, and multiple sclerosis. The mere presence of chronic conditions, however, does not indicate a need for long-term care. When chronic conditions are compounded by the presence of comorbidity—coexisting multiple health problems—they often become the leading cause of an individual’s disability and erode that individual’s ability to live without assistance. This is when long-term care is needed. The prevalence of comorbidity and disability rise dramatically in aging populations.

Services, devices, and living arrangements that enable a functionally impaired person to live independently are a part of long-term care. Examples include assistive devices for mobility, self-care, or eating. Intermittent assistance with household chores can promote independent living. And living with a family member or friend who can routinely give needed assistance, with or without external services, is also considered long-term care. Institutional care generally becomes necessary when part-time help or assistive devices can no longer compensate for a person’s loss of function caused by some health-related complications.

The medical aspect of long-term care has two main areas of focus:

- Preventing complications from chronic conditions by routine monitoring, promotion of healthful practices, medical treatment, and coordination of care with other providers, such as dentists, podiatrists, or optometrists
- Delivering treatment after acute episodes.

**Preventing Complications**

Onset of complications arising from chronic conditions can be prevented or postponed through preventive medicine that includes nutrition, vaccination against pneumonia and influenza, and well-coordinated primary-care services. Each nursing home patient must be under the medical care of a qualified primary-care physician, and the overall care regimen must emphasize prevention through adequate nutrition, hydration, ambulation, and various other preventive services. Ongoing monitoring and appropriate therapeutic regimens are important to keep chronic conditions under control and to minimize the development of medical complications. Coordination of care with various medical providers such as the
attending physicians, dentists, optometrists, podiatrists, dermatologists, or audiologists is often required to prevent complications or to deal with the onset of impairments at an early stage.

Delivering Treatment After Acute Episodes

Onset of an acute episode requires medical evaluation and treatment in a hospital where the treatment plan must also take into account the presence of chronic conditions and disabilities. Long-term care will generally continue after the acute condition is stabilized. Post-acute long-term care often consists of skilled nursing care, which is physician-directed care provided by licensed nurses and may include such treatments as intravenous feeding, wound care, dressing changes, or clearing of air passages. The patient may also require rehabilitation therapies such as physical therapy, occupational therapy, speech therapy, or respiratory therapy. Rehabilitation therapies are supplemented by ongoing restorative care from the nursing staff. Medical services associated with long-term care are typically provided by nurses and other professional staff members under the supervision of a physician, rather than directly by a physician who may only make periodic rounds for general follow-up.

Mental Health

Long-term care patients frequently suffer from mental conditions, most notably anxiety disorders, depression, and dementia. Mental disorders range in severity from problematic, to disabling, to fatal. Mental illness represents a grave threat, especially for older adults, who also have the highest rates of suicide in the United States (Hoyert et al. 1999). Approximately two-thirds of nursing home residents suffer from mental disorders, including Alzheimer's and related dementias (Burns et al. 1993). It is erroneous, however, to believe that mental disorders are normal in older people or that older people cannot change or improve their mental health. But major barriers must be overcome in the delivery of mental health care. Efforts to prevent mental disorders among older adults have been inadequate because present knowledge about effective prevention techniques is not as extensive as our understanding of the diagnosis and treatment of physical disorders. On the other hand, treatment of many elderly people may be inadequate because assessment and diagnosis of mental disorders in older people can be particularly difficult: the elderly often focus on physical ailments rather than psychological
problems (Department of Health and Human Services [DHHS] 1999). Another drawback is that many elder-care providers, including primary care physicians, are often not adequately trained in the diagnosis and treatment of mental health problems.

Mental health services are generally delivered by specialized providers in both ambulatory (outpatient) and inpatient facilities. Because long-term care facilities are responsible for a patient’s total care, nursing home employees must be trained to recognize the need for mental health care, and the facility must arrange to obtain needed services from qualified providers in the community.

Social Support
Social and emotional support are necessary for elderly residents to cope with changing life events. Various stressors commonly accompany the aging process itself and create such adverse effects as frailty, pain, increased medical needs, and the inability to do common things for oneself, such as obtaining needed information or running errands. Other stressors are event-driven. Events that force an unexpected change in a person’s lifestyle or emotional balance—such as moving to an institution, adjusting to a new environment, or the loss of a loved one—require coping with stress or grief. Even the thought of change brings on anxiety. Many people go through a period of “grieving” when coming to terms with change, which is a normal part of the transition process. Grieving may manifest in reactions such as anger, denial, confusion, fear, despondency, and depression (McLeod 2002). Social support is needed to help buffer these adverse effects (Feld & George 1994; Krause & Borawski-Clark 1994).

Social support includes both concrete and emotional assistance provided by families, friends, neighbors, volunteers, staff members within an institution, organizations such as religious establishments and senior centers, or by other private or public professional agencies. Such assistance may also include coordination of simple logistical problems that may otherwise become “hassles” of daily life, providing information, giving reminders, counseling, and spiritual guidance.

Residential Amenities
Housing is a key component of long-term care because housing features must be carefully planned to compensate for people’s disabilities to the
maximum extent possible. Residences for the disabled must have physical features and amenities that are designed to promote independence. Some simple examples include access ramps that enable people to go outdoors; wide doorways and corridors that allow adequate room to navigate wheelchairs; railings in hallways to promote independent mobility; extra-large bathrooms that facilitate wheelchair negotiation; grab bars in bathrooms to prevent falls and promote unassisted toileting; raised toilets to make it easier to sit down and get up; and pull-cords in the living quarters to summon help in case of an emergency. Adequate space, privacy, safety, comfort, and cleanliness are basic necessities. In addition, the residential environment must feel home-like, it must encourage social activities, it must promote recreational pursuits, and the décor must be both pleasing and therapeutic.

**Individualized Services**

Long-term care services are specifically tailored to the needs of the individual patient. Those needs are determined by an assessment of the individual’s current physical, mental, and emotional condition, as well as that individual’s past history of these conditions. A social history is also incorporated into the assessment. The social history encompasses the individual’s family relationships, former occupation, community involvement, leisure activities, and cultural factors such as racial or ethnic background, language, and religion. An individualized plan of care is developed so that each type of need can be appropriately addressed through customized interventions. Assessment and plan of care are addressed in Part II of this book.

**Functional Limitations and Promotion of Independence**

A key determinant of the need for long-term care is the degree to which an individual is unable to independently perform certain common tasks of daily living. The goal of long-term care is to enable the individual maintain functional independence to the maximum level that is practicable. Restoration of function may be possible to some extent through appropriate rehabilitation therapy, but in most cases a full restoration of normal functioning is an unrealistic expectation. The individual must be taught to use adaptive equipment such as wheelchairs, walkers, special eating utensils, or portable oxygen devices. Staff members must render care and assistance whenever the patient is either unable to do things for himself or herself, or absolutely refuses to do so.
In keeping with the goal of maximizing functional independence for the patient, nursing home staff members should concentrate on maintaining whatever ability to function the patient still has and on preventing further decline of that ability. For example, a patient may be unable to walk independently but may be able to take a few steps with the help of trained staff members. Assistance with mobility helps maintain residual functioning. Progressive functional decline may be slowed by appropriate assistance and ongoing restorative care, such as assisted walking, range of motion exercises, bowel and bladder training, and cognitive reality-orientation. However, in spite of these efforts, it is reasonable to expect a gradual decline in an individual’s functional ability over time. As this happens, services must be modified in accordance with the changing condition. In other words, long-term care must “fill-in” for all functions that can no longer be carried out independently. For instance, a comatose patient who is totally confined to bed presents an extreme case in which full assistance from employees is required. In most other instances, staff members motivate and help the patient do as much as possible for himself or herself.

**Extended Period of Care**

For most long-term care patients, the delivery of various services extends over a relatively long period because most recipients of care will at least require ongoing monitoring to note any deteriorations in their health and to address any emerging needs. Certain types of services, such as professional rehabilitation therapies, post-acute convalescence, or stabilization, may be needed for a relatively short duration, generally less than 90 days. In other instances, long-term care may be needed for years. In either situation, the period during which care is given is much longer than it is for acute-care services, which generally last only for a few days. Because patients stay in nursing care facilities over an extended time, holistic care and quality of life (discussed in the next two sections) must be integrated into every aspect of long-term care delivery.

**Physical, Mental, Social, and Spiritual Needs**

In sharp contrast to the medical model, the holistic model of health proposes that health care delivery should focus not merely on a person’s physical and mental needs, but should also go beyond those concerns to emphasize well-being in every aspect of what makes a person whole and complete. In this integrated model, a patient’s mental, social, and spiritual
needs and preferences should be incorporated into medical care delivery and all aspects of institutional living.

The social aspects of health care include housing, transportation services, information, counseling, recreation, and social contact with other residents, staff members, family, and other members of the outside community. For example, community members can participate in the lives of nursing home residents through a variety of volunteer programs. The success of such programs depends on a facility’s ability to form links with the outside community. Also, family and friends must be encouraged to visit the facility as often as possible. The social aspects of institutional living are explored in greater detail in some of the later chapters.

Spirituality and spiritual pursuits are very personal matters, but, for most people, they also require continuing interaction with other members of the faith community. The facility’s main responsibility is to make every reasonable accommodation that would allow each individual total freedom to practice or not to practice his or her faith. Most long-term care facilities invite local congregations to hold religious services for their residents’ convenience. Participation in these services is important to many residents, but others should have the freedom to refrain from any participation. The facility should also encourage a resident’s faith community to maintain contact with the patient through regular personal visits. Clearly, an important factor in building exchange relationships with the community (discussed in Chapter 2) should be to enhance the social and spiritual well-being of the facility’s residents.

**Quality of Life**

For institutionalized patients, quality of life refers to the total living experience that results in overall satisfaction with one’s life. It is particularly relevant to long-term care facilities because people typically reside there for an extended period. Quality of life is a multifaceted concept that recognizes at least five factors: lifestyle pursuits, living environment, clinical palliation, human factors, and personal choices. Quality of life can be enhanced by integrating these five factors into the delivery of care.

- Lifestyle factors are associated with personal enrichment and making one’s life meaningful through activities one enjoys. For example, almost everyone enjoys warm friendships and social relationships. Elderly people’s faces often light up when they see children. Many residents may still enjoy pursuing their former leisure activities, such
as woodworking, crocheting, knitting, gardening, and fishing. Many residents would like to engage in spiritual pursuits, or spend some time alone. Even those patients whose functioning has decreased to a vegetative or comatose state can be creatively engaged in something that promotes sensory awakening through visual, auditory, and tactile stimulation.

- The living environment must be comfortable, safe, and appealing to the senses. Cleanliness, décor, furnishings, and other aesthetic features are critical.
- Clinical palliation should be available for relief from unpleasant symptoms such as pain or nausea.
- Human factors refer to employee attitudes and practices that emphasize caring, compassion, and preservation of human dignity in the delivery of care. Institutionalized patients generally find it disconcerting to have lost their autonomy and independence. Quality of life is enhanced when residents have some latitude to govern their own lives. Residents also desire an environment that promotes privacy. For example, one field study of nursing home residents found that dignity and privacy issues were foremost in residents’ minds, overshadowing concerns for clinical quality (Health Care Financing Administration 1996).
- The nursing facility should make every effort to accommodate patients’ personal choices. For example, food is often the primary area of discontentment, which can be addressed by offering a selection of dishes. Many elderly resent being awakened early in the morning when nursing home staff begin their responsibilities to care for patients’ hygiene, bathing, and grooming. Patient privacy is compromised when a facility can offer only semi-private accommodations. But, in that case, the facility can at least give the patients some choice in deciding who their roommates would be.

**THE LONG-TERM CARE DELIVERY SYSTEM**

Nursing home administrators should have an understanding of the competitive environment. They must also understand the array of complementary services within the long-term care delivery system. The broad
discussion presented in this section provides an overview of the system. The full range of long-term care services is referred to as the **continuum of long-term care**.

The long-term care-delivery system has three major components:

- The informal system
- The community-based system
- The institutional system

The first component, informal care, is the largest, but it generally goes unrecognized. It is largely unfinanced by insurance and public programs, but it includes private-duty nursing arrangements between private individuals. The other two components have formalized payment mechanisms to pay for services, but payment is not available for every type of community-based and institutional service. In many situations, people receiving these services must pay for them out of their personal resources.

Although institutional management is the key focus of this book, the other two components, informal care and community-based service, also have important implications for administrators who manage long-term care institutions. The community-based services and informal systems compete with the institutional system in some ways, but are also complementary. As such, the community-based and informal components of long-term care are very much a part of the external environment of the institutional component.

The three subsystems that form the continuum of long-term care are illustrated in Figure 1-5. The patients’ levels of **acuity** and the complexity of services they need increase from one end of the continuum to the other. Informal care provided mainly by family members or friends involves basic assistance, and is at one extreme of the continuum. Next on the continuum are the various community-based in-home services and ambulatory services. Finally, there are different levels of institutional settings.

An evaluation of the extent of disability and personal needs determines which services on the continuum may be best suited, but client preferences often play a significant role. Most people in need of long-term care, for instance, prefer to stay at home or in an institution where the environment is less clinical than in a traditional nursing home. Medical needs, however, may override one’s personal preferences. Generally, a patient is admitted to a nursing facility when medical needs become the overriding
factor, and a patient’s long-term care needs cannot be adequately addressed in a less restrictive setting.

In recent years, numerous public and private health care organizations have proliferated, organizations that offer information to consumers on how to care for someone at home, how to find and pay for community-based services, and how to find an appropriate institutional setting. A list of Web sites at the end of this chapter names several such agencies.

The Informal System

The informal long-term care system is very large. An accurate estimate of its size is difficult, mainly because the system is not formally organized and it cannot even be called a system in the true sense. Hence, there is no reporting on how many people are cared for informally at home, and exactly what type of services family, friends, or privately paid help may be providing. For the most part, services rendered are believed to be basic, such as general supervision and monitoring, running errands, dispensing

FIGURE 1-5 The Continuum of Long-Term Care
medications, cooking meals, assistance with eating, grooming and dressing, and, to a lesser extent, assistance with mobility and transfer.

The extent of informal care that an individual receives is highly dependent on the extent of the social support network the individual has. People with close family, friends, neighbors, or surrogates, such as members of a religious community, can often continue to live independently much longer than those who have little or no social support. For those who do not have an adequate informal support network, community-based services provided by formal agencies can become an important resource for allowing an individual to continue to live independently.

**The Community-Based System**

Community-based long-term care consists of formal services provided by various health care agencies. Community-based long-term care services have a threefold objective:

1. To supplement informal caregiving when more advanced skills are needed than what family members or surrogates can provide to address the patients’ needs,
2. To delay or prevent institutionalization, and
3. To provide temporary respite to family members from caregiving stress.

Community-based long-term care services can be categorized as intramural and extramural.

**Intramural Services**

Intramural services are taken to patients who live in their own homes, either alone or with family. The most commonly used intramural services include home health care and **meals-on-wheels** (home-delivered meals). Limited social-support programs that provide services such as homemaker, chores and errands, and handyman assistance also exist, but the funding to pay for such services is not well-established and varies from community to community. In **home health care**, services such as nursing, therapy, and health-related homemaker or social services are brought to patients in their own homes because such patients do not need to be in an institution and yet are generally unable to leave their homes safely to get the care they need.
Extramural Services
Extramural services require that patients come and receive the services at a community-based location. This category mainly includes ambulatory services, such as adult day care, mental health outpatient clinics, and congregate meals provided at senior centers. Respite care is another type of service that can be classified as extramural.

Adult day care enables a person to live with family but receive professional services in a daytime program in which nursing care, rehabilitation therapies, supervision, and social activities are available. Adult day-care centers generally operate programs during normal business hours five days a week. Some programs also offer services in the evenings and on weekends. Senior centers are local community centers where seniors can congregate and socialize. Many centers offer a daily meal. Others sponsor wellness programs, health education, counseling services, information and referral, and some limited health care services. Respite care can include any kind of long-term care service (adult day care, home health, or temporary institutionalization) when it allows family caregivers to take time off while the patient’s care is taken over by the respite care provider. It allows family members to get away for a vacation or deal with other personal situations without neglecting the patient.

The Institutional System
A variety of long-term care institutions form the institutional continuum, with facilities ranging from independent-living or retirement centers at one extreme to subacute care and specialized care facilities at the other extreme (See the lower section of Figure 1-5). Based on the level of services they provide, institutional long-term care facilities may be classified under six distinct categories, keeping in mind, however, that the distinctions among these facilities are not always clear-cut because services provided in some of the settings frequently overlap:

- Independent or Retirement Living
- Residential or Personal Care
- Assisted Living
- Skilled Nursing
- Subacute Care
- Specialized Care
A continuing-care retirement community (CCRC) integrates and coordinates the independent living and institutional components of the long-term care continuum. CCRCs offer the advantage and convenience of having a range of living and care options located on one campus. Based on the concept of aging-in-place, people’s changing needs are met within the same organizational setting. In addition to retirement and residential living apartments or cottages, CCRCs have personal care and assisted living services available in an adjoining facility. A separate skilled nursing facility provides intermittent as well as permanent accommodations based on changing needs.

**Independent or Retirement Housing**

Independent housing units and retirement living centers are not long-term care institutions in the true sense. They do not deliver clinical care but emphasize privacy, security, and independence. Their special features and amenities are designed to create a physically supportive environment to promote an independent lifestyle. The living quarters are equipped with emergency call systems. Many of these facilities provide monthly blood pressure and vision screenings, and most organize programs for social activities, recreation, and local outings for shopping and entertainment. **Hotel services** such as meals, housekeeping, and laundry may or may not be included. Apartment units or detached cottages, equipped with kitchenettes and private baths, are the most common types of retirement institutions. Common laundry rooms are often shared with other residents. Nursing or rehabilitation services, when needed, can be arranged with a local home health agency. Many upscale retirement centers abound, in which one can expect to pay a fairly substantial entrance fee plus a monthly rental or maintenance fee. But some communities have government-subsidized housing units available for low-income elderly and disabled people.

**Residential or Personal Care Homes**

Domiciliary care facilities, board-and-care homes, and foster-care homes fall into this category. Residential or personal care can be defined as non-medical custodial care which is characterized by the least intensive level of inpatient care. In addition to providing a physically supportive environment, these facilities generally provide light assistive care such as medication use management, and assistance with bathing and grooming.
Other basic services such as meals, housekeeping, laundry, and social and recreational activities are also included. Beyond the very basic nursing care, more advanced services can be arranged with a local home health agency on an as-needed basis.

For many people, adult foster-care homes, which are also called group homes, have become a preferred alternative to large institutions. Adult foster care (AFC) is defined as a service characterized by small, family-run homes that provide room, board, and varying levels of supervision, oversight, and personal care to non-related adults who are unable to care for themselves (AARP Studies Adult Foster Care 1996). The environment in these homes promotes the feeling of being part of a family unit because caregiving families reside in part of the home, and the number of residents is relatively small, generally between 6 and 10. Employed staff generally consists of nursing paraprofessionals, such as personal-care aides who do not require a license or professional certification to deliver care. Similar workers employed in nursing homes must be certified by the state.

Because personal care homes are located within residential communities, they are sometimes regarded as a community-based rather than an institutional service.

Assisted Living Facilities

In the past few years, assisted living has been the fastest-growing type of long-term care facility in the United States. An assisted-living facility can be described as a residential setting that provides personal care services, 24-hour supervision, scheduled and unscheduled assistance, social activities, and some nursing care services (Citro and Hermanson 1999). Common nursing services include assistance with eating, bathing, dressing, toileting and ambulation, which are rendered by paraprofessionals. Most residents also require help with medications. Some facilities have a skeleton staff of licensed nurses, generally licensed practical (or vocational) nurses, who perform admission assessments and deliver basic nursing care. Advanced nursing care and rehabilitation therapies can be arranged through a home-health agency. The services are specially designed for people who cannot function without assistance and therefore cannot be accommodated in a retirement-living or residential-care facility. Due to increased acuity level, approximately one-third of the residents in assisted-living facilities are discharged because they need the higher level of service that is provided in skilled care nursing homes.
Assisted living is paid for on a private basis for the most part. Monthly fees are between $2,000 and $2,800, but costs vary according to amenities, room size and type (e.g., shared versus private), and the services required by the resident. Most facilities charge a basic monthly rate that covers rent, board, and utilities. Additional fees are charged for nursing services. Many facilities also charge a one-time entrance fee, which may be equal to one month’s basic rent. In some states, assisted-living care may be covered under the Medicaid program for SSI recipients, or may be funded through Title XX Social Services Block Grants or 1915(c) HCBS (home and community-based services) waivers. The main purpose of these grants and waivers is to extend Medicaid services to people who otherwise would have to reside in nursing homes at a much higher cost to the Medicaid program. Although most states license assisted-living facilities, the trend is toward increasing the regulatory oversight of these facilities.

Because of the phenomenon of aging-in-place, the distinction between residential/personal care and assisted living is being blurred, from the standpoint of the level of services. However, compared to personal-care homes, assisted-living facilities are generally larger in size and offer some nursing services that were previously available only in traditional nursing homes.

**Skilled Nursing Facilities**

These are the typical nursing homes at the higher end of the institutional continuum that will be the focus of attention in the remainder of this book. Skilled nursing care is medically oriented care provided by a licensed nurse. It includes monitoring of unstable chronic conditions, evaluation of the patient’s care needs, and nursing and therapy treatments. The patient’s treatment plan is individualized and involves multidisciplinary input from various health care professionals, such as the attending physician, nurses, the social worker, the dietician, therapists, and others. Compared to the institutions discussed earlier, the environment in skilled nursing facilities is more institutionalized and clinical. Yet, many facilities have implemented creative ideas in layout and design to make their living environments as pleasant and homelike as practicable. Some of these ideas are discussed in Chapters 5 and 6.

These facilities employ full-time administrators who must understand the varied concepts of clinical and social care and have been trained in management and leadership skills. The facility must be adequately equipped to care for patients who require a high level of nursing services.
and medical oversight, yet the quality of life must be maximized. A variety of disabilities—including problems with ambulation, incontinence, and behavioral episodes—often coexist among a relatively large number of patients. Compared to other types of facilities, nursing homes have a significant number of patients who are cognitively impaired, besides having physical disabilities and conditions requiring medical intervention. The social functioning of many of these patients has also severely declined. Hence, the nursing home setting presents quite a challenge to administrators in the integration of the four service domains discussed earlier—medical care, mental health care, social support, and residential services.

Subacute Care Units

Subacute care is a blend of intensive medical, nursing, and other services. It has become a substitute for services that were previously provided in acute care hospitals, and it has grown because it is a cheaper alternative to hospital stay. Now, patients who no longer need hospital-based acute care, but require more nursing intervention than what is typically included in skilled nursing care, can receive subacute services in specialized settings. The patients may still have an unstable condition requiring active monitoring and treatment, or they may require technically complex nursing treatments such as wound care, intravenous therapy, blood transfusion, or AIDS care. According to the National Subacute Care Association (NSCA), the severity of a patient’s condition often requires active physician contact, professional nursing care, involvement of an interdisciplinary team in total care management, and complex medical or rehabilitative care (NSCA 1996). Subacute services are generally found in two types of locations:

1. Long-term care units, known as transitional care units (TCUs) or extended care units (ECUs), located in acute care hospitals. Hospitals entered into this service after they started facing severe occupancy declines because of payment restrictions from the government, starting in the mid-1980s.
2. Many nursing homes have opened subacute units by raising the staff skill mix by hiring additional registered nurses and having therapists on staff. Some subacute type services are also rendered by community-based home health agencies.
Specialized Care Units or Facilities

By their very nature, both subacute care and specialized care place high emphasis on medical and nursing services. Some nursing homes have opened specialized-care units for patients requiring ventilator care, treatment of Alzheimer’s disease, special rehabilitation, or closed head trauma care. There are also freestanding facilities that specialize only in treating Alzheimer’s or in rehabilitation. Other specialized facilities include intermediate care facilities for the mentally retarded (ICF/MR). The key distinguishing feature of the latter institutions is specialized programming and care modules for patients suffering from mental retardation and associated disabilities. Physical incapacity and mental retardation often accompany developmental disabilities arising in early childhood. Specialized pediatric long-term care facilities fulfill the care needs for such children.

THE NON-LONG-TERM HEALTH CARE SYSTEM

Health care services described in this section are complementary to long-term care. Even though these services fall outside the long-term care domain, they are often needed by long-term care patients. Hence, ideally, the two systems—long-term care and non-long-term care—should be rationally linked. Following are the main non-long-term care services that are complementary to long-term care:

- Primary care delivered by community-based physicians located in solo or group practices and walk-in clinics. By definition, primary care is medical care that is basic, routine, continuous over time and coordinated. It is rendered and coordinated by a primary-care physician or a mid-level provider such as a physician’s assistant or nurse practitioner. Primary care is brought to the patients who reside in nursing homes, whereas those residing in less institutionalized settings such as retirement living communities or personal care homes commonly visit the primary care physician’s office.
- Mental health care delivered by community-based mental-health outpatient clinics and psychiatric inpatient hospitals.
- Specialty care delivered by community-based physicians in specialty practices, such as cardiology, ophthalmology, dermatology, or oncology. Certain services are also delivered by free-standing chemother-
apy, radiation, and dialysis centers. Other services are provided by dentists, optometrists, opticians, podiatrists, chiropractors, and audiologists in community-based clinics or mobile units that can be brought to a nursing home. In case of frequently needed services, such as dental, optometric, and podiatric care, nursing homes establish contracts with providers, and in many instances these providers make periodic rounds of the facility for screening and preventive care.

- Acute care delivered by hospitals and outpatient surgery centers. Acute care is short-term, intense medical care for an episode of illness or injury, which generally requires hospitalization. Hence, acute conditions require transfer to a hospital by ambulance. Depending on the patient’s condition, surgical procedures may be performed in an outpatient center or a hospital.

- Diagnostic and health screening services offered by hospitals, community-based clinics, or mobile medical services. Some common types of services brought to nursing homes include preventive dentistry, x-ray, and optometric care.

- Hospice care that can be directed from a hospital, home health agency, nursing home, or free-standing hospice. Also referred to as end-of-life care, the term hospice is used for a cluster of special services for the terminally ill. It blends medical, spiritual, legal, financial, and family-support services. However, the emphasis is on comfort and pain management, and on social support over medical intervention. The option to use hospice means that temporary measures to prolong life will be suspended. The services are generally brought to the patient, although a patient may choose to go to a free-standing hospice center if one is available.

Rational Integration of Long-Term Care and Complementary Services

The system of long-term care is part of a larger continuum of health care services. Types of services comprising the broader health care continuum are summarized in Table 1-1. Long-term care patients, regardless of where they may be residing, frequently require a variety of services along the health care continuum, dictated by the changes in the patient’s condition and episodes that occur over time. As an example, a person living at home may undergo partial mastectomy for breast cancer, return home under the
care of a home health agency, require hip surgery after a fall in the home, and subsequently be admitted to a skilled nursing facility for rehabilitation. This individual will need recuperation, physical therapy, chemotherapy, and follow-up visits to the oncologist. Once she is able to walk with assistance and her overall condition is stabilized, she may wish to be moved to an assisted living facility. To adequately meet the changing needs of such a patient, the system requires rational integration, but the flow of care is not always as smooth as it should be. Integrated care also requires an evaluation of the patient’s needs in accordance with the type and degree of impairment, and a reevaluation as conditions change. Depending on the change in condition and functioning, the patient may move between the various levels and types of long-term care services and may also need transferring between long-term care and non-long-term care services. Figure 1-6 illustrates these concepts.

Table 1-1 The Continuum of Health Care Services

<table>
<thead>
<tr>
<th>Types of Health Services</th>
<th>Delivery Settings</th>
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<tbody>
<tr>
<td>Preventive care</td>
<td>Public health programs</td>
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<td></td>
<td>Community programs</td>
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<tr>
<td></td>
<td>Personal lifestyles</td>
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<tr>
<td>Primary care</td>
<td>Physician’s office or clinic</td>
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<td></td>
<td>Self-care</td>
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<td></td>
<td>Alternative medicine</td>
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<tr>
<td>Specialized care</td>
<td>Specialist provider clinics</td>
</tr>
<tr>
<td>Chronic care</td>
<td>Primary care settings</td>
</tr>
<tr>
<td></td>
<td>Specialist provider clinics</td>
</tr>
<tr>
<td></td>
<td>Home health</td>
</tr>
<tr>
<td>Long-term care</td>
<td>Long-term care facilities</td>
</tr>
<tr>
<td>Subacute care</td>
<td>Home health</td>
</tr>
<tr>
<td></td>
<td>Special subacute units (hospitals, long-term care facilities)</td>
</tr>
<tr>
<td>Acute care</td>
<td>Home health</td>
</tr>
<tr>
<td></td>
<td>Outpatient surgical centers</td>
</tr>
<tr>
<td>Rehabilitative care</td>
<td>Hospitals</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation departments (hospitals, long-term care facilities)</td>
</tr>
<tr>
<td>End-of-life care</td>
<td>Home health</td>
</tr>
<tr>
<td></td>
<td>Outpatient rehabilitation centers</td>
</tr>
<tr>
<td></td>
<td>Hospice services provided in a variety of settings</td>
</tr>
</tbody>
</table>
Having primary responsibility for ensuring that each patient’s total health care needs are met, administrators must institute working relationships with external agencies. As basic needs change, or episodes occur, the facility must coordinate delivery of appropriate services. In some instances, the patient may be actually moved to a more appropriate facility. This responsibility includes determining which residential setting will be the most appropriate, given the level of support offered by community-based services. Linkages with agencies in both the long-term care and the broad health care delivery sectors are established through contracts in some cases, and through mutual working relationships in others. Some types of transfer arrangements, such as those with acute care hospitals, are

**FIGURE 1-6** Key Characteristics of a Well-Designed LTC System
mandated by state and federal regulations. Alliances with other service providers often create mutual advantages for the two parties in each exchange when a patient referral base is established. Administrators can also develop community outreach programs, such as screening and educational programs, case management, or meals-on-wheels, to enhance their facility's image and to create goodwill in the community. A clear understanding of the continuum of services can also enable the administrator to see strategic opportunities to establish new services. For instance, a nursing home can open a home health agency, a hospice program, an outpatient rehabilitation clinic, a respite-care program, specialized care units, or other types of operations.

CONCLUSION

Effective management is founded on open system theory. To obtain critical resources, a nursing facility has no choice but to depend on the external environment. What the facility receives is a function of what it gives back. Also, external trends and events shape management decisions and strategic action. To guide major decision-making, nursing facility administrators should understand the six external environmental domains to identify the nature of external demands and their likely impact on the facility's internal operations.

The need for long-term care services is triggered by the degree of functional impairment, but a variety of services must be provided in a holistic context to meet the varied needs of a long-term care patient with the goal of promoting the maximum level of self-functioning. Long-term care comprises a number of different services along a continuum of care to address the changing needs of patients over time. The rational integration model suggests that facility administrators must institute working relationships with external agencies—both long-term care and non-long term care—because the administrators are primarily responsible for ensuring that each patient’s total health care needs are met.

DISCUSSION AND APPLICATION QUESTIONS

1. As a nursing home administrator, would you adopt the closed-system or the open-system approach to management? Explain.
2. Is the open-system approach needed only when the organization faces challenges or tries to take advantage of emerging opportunities? Explain?

3. W.R. Dill identified four environmental factors that are necessary for organizational goal achievement: (1) customers; (2) suppliers of labor, materials, capital, etc.; (3) competitors for both markets and resources; and (4) regulatory groups. What contribution, if any, does each of these factors make in enhancing the organizational effectiveness of a nursing facility? What is the interrelationship between these four factors?

4. Both formal and informal processes can be employed to carry out environmental scanning. Discuss some of the formal and informal means that a nursing home administrator can employ to identify significant environmental trends.

5. Identify the various entities in a nursing facility’s primary proximity. What influences might each have on the organization? Again, using the four-level model of proximities, discuss the influences various entities may have on a nursing facility.

6. How does long-term care differ from other types of medical services?

7. Why is it important that employees in nursing facilities not perform every task of daily living for a patient? How much should employees do for patients who have functional impairments?

8. What type of exchanges can be created to enhance the social and spiritual well-being of a facility’s patients?

9. Identify some staff practices that will promote each individual resident’s privacy and dignity.

10. As an administrator of a skilled nursing facility, how can an understanding of the long-term care continuum help you operate the facility effectively?

INTERNET RESOURCES FOR FURTHER LEARNING

AARP (formerly, American Association of Retired Persons): The nation’s foremost consumer-oriented agency that concerns itself with numerous issues related to aging and long-term care.

www.aarp.org
Alliance for Aging Research: The nation’s leading citizen advocacy organization for improving the health and independence of Americans as they age. The Alliance was founded in 1986 to promote medical and behavioral research into the aging process. http://www.agingresearch.org

ARCH National Respite Network and Resource Center: This organization assists and collaborates with those who run programs that provide respite for caregivers of adults and the elderly. http://www.archrespite.org

Assisted Living Federation of America: A group that offers basic consumer-oriented information on assisted living and gives a directory of assisted living facilities. This trade organization represents assisted living and other senior housing facilities. www.alfa.org

Family Caregiver Alliance: A nonprofit organization set up to provide information and resources to address the needs of families and friends providing long-term care at home. http://www.caregiver.org

The George Washington Institute for Spirituality and Health: Affiliated with the George Washington University, the Institute is a leading organization on educational and clinical issues related to spirituality and health. http://www.gwish.org/

Hospice Foundation of America: A nonprofit organization that provides leadership in the development and application of hospice and its philosophy of care. http://www.hospicefoundation.org

The Meals On Wheels Association of America: This organization represents those who provide congregate and home-delivered meal services to people in need. www.mowaa.org

Medicaid: A jointly funded federal-state health insurance program for the indigent. http://cms.hhs.gov/medicaid
Medicare: A federal program of health insurance for the elderly and some disabled persons.  
http://cms.hhs.gov/medicare

National Adult Day Services Association: This organization represents the adult day-care industry and also furnishes consumer information.  
http://www.nadsa.org/

National Association for Home Care and Hospice: The nation's largest trade association representing the interests and concerns of home care agencies, hospices, home care aide organizations, and medical equipment suppliers.  
http://www.nahc.org

National Citizens’ Coalition for Nursing Home Reform: This consumer watchdog organization lobbies to influence long-term care policy, promotes quality standards, and works to empower nursing home residents.  
www.nccnhr.org

National Council on Aging: A private, nonprofit organization providing information, training, technical assistance, advocacy, and leadership in all aspects of care for the elderly. It provides information on training programs and in-home services for older people. Publications are available on topics such as lifelong learning, senior center services, adult day care, long-term care, financial issues, senior housing, rural issues, intergenerational programs, and volunteers serving the aged.  
www.ncoa.org

National Family Caregiver Support program: A government program established under the Administration on Aging to provide information and support services to family caregivers.  
http://www.cfda.gov/public/viewprog.asp?progid=1547

National Hospice Foundation: A nonprofit, charitable organization affiliated with the National Hospice and Palliative Care Organization that provides support and information about hospice care options.  
www.hospiceinfo.org

National Mental Health Association: The country’s oldest and largest nonprofit organization that addresses all aspects of mental health and mental illness.  
www.nmha.org
REFERENCES


