Instructor Resources Sample

This is a sample of the instructor materials for *Dimension of Long-Term Care Management: An Introduction*, Third Edition, by Mary Helen McSweeney-Feld, PhD, LNHA, FACHCA, and Carol Molinari, PhD.

The complete instructor materials include the following:

- PowerPoint slides
- Discussion guide
- Sample syllabus

This sample includes materials for chapter 1.

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Dimensions of Long-Term Care Management: An Introduction, 3rd edition

Instructor Resources

Chapter 1

Dimensions of Long-Term Care

Learning Objectives

After completing this chapter, you should be able to

- define *long-term care* and *long-term services and supports*;
- explain changing patterns of demographics in the United States in terms of growing demand for long-term care services and supports;
- understand the history of long-term care service delivery;
- describe models for long-term care service delivery;
- discuss the providers and payers of long-term services and supports, including informal sources of support such as family caregivers;
- apply the theoretical foundations of long-term care service delivery to assess their impact on healthcare policy; and
- understand the impact of COVID-19 on health disparities in long-term care service delivery and new directions for long-term services and supports.

Summary

This chapter provides an overview of the consumers of long-term care services, as well as basic definitions, statistics, and trends in long-term care. The importance of including individuals with disabilities as consumers of long-term care is emphasized. A description of the larger environment that influences the demand for and consumption of long-term care services is then provided to give a context to this evolving field. Models of long-term care service are discussed, with a focus on the dimensions of long-term care model, which emphasizes a fluid, single point of entry to long-term care services, with the interaction of residential services, home and community-based care, and the use of technology as the key dimensions or elements of care. Providers and settings for long-term services and supports, payment and quality of long-term services and supports, as well as future directions for the field conclude the chapter.

For Discussion

1. What is long-term care, and who are long-term care consumers?

Long-term care is a wide range of health services, support services, and other assistance provided informally or formally to individuals who have chronic illnesses or disabilities and are unable to function independently on a daily basis. Long-term care consumers include older adults with long-term care needs, as well as individuals with disabilities who may be younger long-term care consumers.

2. What is the difference between formal and informal long-term services and supports (LTSS)?

Formal long-term services and supports may come from programs sponsored by governmental agencies, not-for-profit organizations, health care providers, employers as well as third-party payors such as insurance companies. They are considered formal services as there is typically a source of reimbursement for the service or support. Informal long-term services and supports are typically unpaid and may come from family members, friends, and community volunteers.

3. What are ageism and ableism? What is their impact, and why is it important to be aware of them?

Ageism is prejudice, stereotyping, or discriminating against individuals because of their age. Ableism is prejudice or discriminating against individuals because of a disability. Both ageism and ableism focus on biomedical aspects of human lives. These actions can be internalized, and individuals can illicit negative attitudes towards themselves.

4. Describe the process of accessing LTSS, and how it has evolved to a more coordinated, person-centered system of care.

Historically, LTSS were accessed through a medical model of care that emphasized institutional settings and charity care for individuals who could not pay for services or had no family members or friends to help them out. With the passage of laws, regulations, and policies emphasizing the right of individuals to receive LTSS in their homes, and the realization that healthcare outcomes improved by listening to the needs of consumers, our LTC delivery system evolved to a better-coordinated, person-centered system of care.

5. What are the periods of care in the history of LTC service delivery, and why are they significant?

In the first phase, lasting until 1930, all infirm people of limited means were put together in almshouses, sometimes referred to as poor farms for older adult "inmates," to maintain the cost of indigent care. A second phase started in the 1930s with the passage of the Social Security Act in 1935, pensions were provided to older people, but with the stipulation that anyone housed in a public facility such as an almshouse could not receive them. While the intent of this legislation was to bring about the end of almshouses, it helped to establish voluntary and proprietary nursing homes, which accepted persons with physical and mental infirmities. Residing in these private boarding homes allowed those with long-term care needs to be eligible for federal Old Age Assistance, hence the start of the Old-Age Income Security Solution era.

By the 1950s, numerous pieces of legislation were enacted that set the stage for the next phase of public financing of nursing home facility construction as well as public payment for long-term care services in the United States. This third period of expansion lasted until 1970. Amendments to the Social Security Act lifted the ban on payments to public long-term care institutions and permitted direct government payments to long-term care facilities, which made the industry appealing to small business owners. During this period, state licensure programs for nursing homes also started to appear. In 1954, amendments to the Hill-Burton Act of 1946 allowed federal grants to public and not-for-profit organizations to build nursing homes while mandating federal standards for their design and construction. However, these amendments stipulated that the homes must be affiliated with a hospital, thereby promoting the medical model of care within a nursing home environment.

In the late 1950s, the American Association of Nursing Homes was formed, and this group was successful in lobbying Congress to pass legislation allowing for-profit organizations to receive Small Business Administration (SBA) and Federal Housing Administration (FHA) financing for nursing homes. This legislation was followed by the Kerr-Mills Act of 1960, which provided federal–state matching funds for the medically indigent, including those in nursing homes, as well as federal funds for home care services.

The tradition of federal oversight and financing of long-term care services was continued into the Great Society legislation of the 1960s with the creation of the Medicare and Medicaid programs in 1965 and the provision in Medicare to cover post-hospital "extended care" of 100 days. In 1968, the Moss amendments to the Social Security Act set new operational standards for nursing homes accepting Medicaid.

In the early 1970s and continuing until 1990, a fourth phase began, which was characterized by government's aim to limit provider abuses by strengthening government program options; enforcement ensued. The Social Security amendments were extended to offer Medicare coverage to the disabled; the Supplemental Security Income (SSI) program was created; and by the late 1970s, federal health planning legislation extended into the creation of certificate-of-need

programs and the passage of Medicare and Medicaid anti-fraud and anti-abuse amendments. Concern about escalating cost increases in the US healthcare sector led to the passage of Medicare diagnosis-related groups (DRGs) in 1983, which helped to move post-acute care to nursing home facilities. The familiar theme of federal oversight of long-term care services emerged again in 1987 when the Omnibus Budget Reconciliation Act (OBRA) created the state survey and enforcement system for nursing homes.

The fifth period from the 1990s to 2010 can be characterized as a phase of market reforms, innovative demonstration programs, and expansion of private insurance covering long-term care expenses. Federal legislation has targeted payment for long-term care expenses and complementary regulations to ensure quality of care. In 1997, Congress passed the Balanced Budget Act, which established the prospective payment system for Medicare-funded post-hospital services, and in 2004, quality indicators were established for nursing homes accepting payment for services from Medicare. The US Supreme Court's 1999 *Olmstead* decision provided the impetus for expansion of home and community-based services, and by 2007, nearly 40 percent of Medicaid expenditures were for services provided in noninstitutional settings. New home-like models of care evolved, such as assisted living, Eden Alternative housing, and Green House cottages. However, the financial challenges remain for government programs, individuals, and families to pay for the increasing cost of long-term care services and to provide access to care to all individuals regardless of their geographic location or income.

A new period of long-term care was initiated by the passage of the Affordable Care Act in 2010, which helped to focus attention on the integration and coordination of long-term services and supports, as well as opportunities for innovative service delivery and reimbursement. The creation of the Administration for Community Living brought aging and disability service providers together to encourage development of programs that would benefit both populations of long-term care consumers, and the reauthorization of the Older Americans Act also helped to provide a stable source of funding for well-established long-term service and support programs.

6. What are activities of daily living, and why are they used as determinants of need for LTSS?

Activities of daily living **include bathing, dressing, eating, toileting, and transferring. Another category of measures are the *instrumental activities of daily living*—cooking, cleaning, medication management, money management, shopping, and telephoning. These sets of determinants are used to individualize the care provided to take into consideration the physical, mental, social, spiritual, and financial aspects of each client; and the type of care provided may evolve over time as the needs and resources of that person change. Long-term care services are oriented toward managing and living with chronic illness or disabilities, not curing them, and aim to ensure continuity of care rather than episodic interventions.**

7. In what settings are LTSS provided, and which settings may become more important in the future?

Long-term services and supports are provided in acute care, ambulatory care, home and community, residential, outreach and linkage, and technological settings. With the passage of the Affordable Care Act, service provision in ambulatory, home and community-based settings as well as through the use of technology will become more important so consumers are able to remain in their homes and receive high-quality care at an affordable cost.

8. What are some limitations faced by agencies and community organizations that provide LTSS in rural areas?

Rural areas experience limited availability of local health and social service providers, lack of transportation, and frequently vast distances for elders and their families to travel to obtain needed services. In addition, the elderly poor who live in rural areas have limited access to support services, often suffer from inadequate nutrition and substandard housing, and are less likely to be healthy than their urban counterparts.

9. Identify two major payers for LTSS in the United States. What are out-of-pocket expenditures for long-term care, and who pays them?

Major payers for long term services and supports include government programs such as Medicare and Medicaid, commercial insurance, and managed care companies. Consumers of long-term services and supports as well as their families may also make out-of-pocket expenditures, which come from their own financial sources.

10. What measures have been taken by CMS and other organizations to monitor the quality and safety of LTSS?

The quality of LTSS has been a growing concern, and CMS has attempted to address this issue through regulations affecting the assessment of long-term care needs, the staffing of LTC communities, and the requirement for all nursing homes to have a quality assurance and performance improvement plan. States have also increased their regulation of assisted living communities and other residential options for consumers. Additional initiatives will result from ACA provisions and from the Medicare Innovation Center's work to examine new alternatives for providing LTSS.

Case Study: Community Asset Mapping: Sharp HealthCare Senior Health Center

Jillian Warriner

Note: This case is generally based on the structure and attributes of Sharp HealthCare, but changes have been made for pedagogical purposes.

Case Overview

Sharp HealthCare (Sharp) is one of the dominant health systems serving the county of San Diego, California. The only major health system that focuses specifically on health for older adults, it has two Senior Health Centers (SHCs) and two Senior Resource Centers. As the aging population of San Diego County grows, Sharp is considering adding a third SHC to serve the community. This decision would be consistent with the findings of its recent community health needs assessment (Sharp 2019). The challenge is to determine where the center should be located and what specific programs and services it should offer.

Sharp recognizes the importance of providing an effective population health program for older adults, with some services offered directly, some through formal partners, and some through informal referrals. Sharp must identify appropriate community partners to build a robust care transitions program for older adults as well as their caregivers. Identifying and evaluating specific community assets are critical components of the program proposal. The staff has begun to gather an array of data to determine the location, service package, and community partners appropriate for the new SHC.

Background

Sharp HealthCare serves San Diego County with four acute care hospitals, three specialty hospitals, three affiliated medical groups, a commercial health plan (Sharp

Health Plan) that provides individual and family plans, employer-sponsored group plans, and Medicare plans, including a Medicare Advantage plan. Further, Sharp is also a leading provider of care for the Medi-Cal (Medicaid) population in San Diego County, and for Covered California (California's state Medicaid program). Sharp HealthCare locations are shown in the map in exhibit 1).

Exhibit 1: Map of Sharp Hospitals and Senior Health Centers

Source: Sharp HealthCare.

Currently, Sharp operates two Senior Health Centers and two Senior Resource Centers. The SHCs offer clinical services from geriatricians and geriatric nurse practitioners, as well as an array of other services tailored specifically for older adults.

Each of the SHCs has arrangements with local community providers who offer health-related and social services.

Sharp's Senior Resource Centers are on-site departments at two of its acute care hospitals. They engage primarily in education, outreach, screening, and support for senior patients and community members; they do not offer clinical services.

In evaluating the options for a new SHC, Sharp must answer the following questions: (1) where in San Diego County should the center be located, based on current and projected demographics; (2) what services should Sharp offer directly on site, and (3) what services should Sharp offer through collaboration with community partners.

Needs of Older Adults

People aged 65 or older require specialized care and often have multiple, complex, chronic health conditions that complicate performing activities of daily living (i.e., eating, bathing, dressing, etc.) as well as care delivery and transitions, and medication management. Older adults who lack a caregiver at home or who are otherwise socially isolated face increased fall risk, greater behavioral health risks, and more significant cognitive decline, as well as gaps in meeting their social determinants of health, such as transportation to medical appointments and access to nutritious food.

Care Transitions and Care Coordination

An array of services is necessary to meet the multiple needs of older adults. Elders might spend five days in a hospital, but for the remaining 360 days of the year

they receive care at home and tap into community resources. In considering a new SHC, Sharp must determine what additional age-related services are important to its patients, as well as which community-based organizations (CBOs) offer those services. Moreover, in light of the various payment programs that Sharp offers older adults, the new center's financial viability is affected by how CBO partnerships are formed, how they are managed for financial efficiency, and the measures used to access the success of the center.

Asset Mapping

The likely geographic location for Sharp's next SHC is "South County," or the area in the southern end of San Diego County. To assess potential partners for either formal or informal relationships, Sharp must first identify the agencies that are already serving elders in this general area as well as partners in other parts of San Diego County that could potentially expand to collaborate with the new SHC if the volume and funding were sufficient to attract their investment. Sharp embarks on asset mapping using hospital discharge disposition data as well as a model for mapping this discharge information.

The process of Sharp's asset mapping includes the following steps:

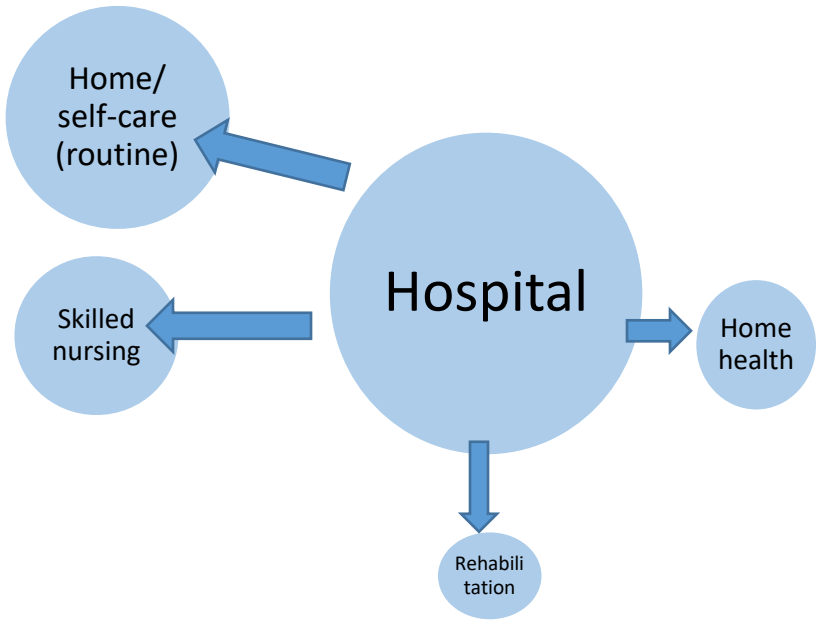
1. *Mapping the service area.* Sharp uses internal hospital discharge data to map its service area—that is, the communities (often at the zip code level) where its patients reside and the types of services most commonly used after discharge (see exhibits 2 and 3).

Exhibit 2: Sharp Hospital Discharge Dispositions for Patients Aged 64 or Older, 2017

Discharge Disposition	Age 64–74	Age 75–84	Age 85+	Total
Home/self-care (routine)	55.89%	44.24%	29.24%	44.79%
Skilled nursing	17.44%	24.22%	31.63%	23.53%
Home health service	14.96%	18.84%	21.29%	17.94%
All other	6.55%	8.00%	12.56%	8.69%
Short-term acute	2.25%	2.12%	1.98%	2.13%
Board/care residential	0.74%	0.40%	0.37%	0.53%
Rehab	0.69%	0.74%	0.66%	0.70%
Long-term acute	0.62%	0.64%	0.32%	0.54%
Psychiatric hospital	0.49%	0.20%	0.06%	0.28%
Assisted living	0.37%	0.60%	1.89%	0.87%

Source: Sharp HealthCare (2019).

Exhibit 3: Mapping of Discharges



Note: Size of bubble indicates magnitude.

2. *Identifying potential partners.* The types of agencies/partners sought are based on the need for effective care transitions and care coordination. Sharp begins by asking hospital staff—including social workers, case managers, and discharge planners—which agencies currently serve as collaborators to address patients' needs upon discharge. Sharp may also check with 211 San Diego, the San Diego Department of Health and Human Services office serving that region, Aging and Independence Services, and other current partners to obtain contact information for new CBOs with which it might collaborate. Sharp conducts key informant interviews with nurses or administrators of physician practices in the area, and it contacts local churches to ask what social support services might be available. Sharp's planners also meet with representatives from the county's Department of

Transportation to learn about public transportation routes, dial-a-ride programs, and local proprietary agencies, ranging from taxis to ride-sharing companies.

3. *Evaluating partners.* Armed with a list of potential community assets, Sharp's planning staff begin the process of evaluating each of the potential partners for quality indicators, reputation, financial stability, service area, and capacity of staff to provide services, as well as power within the community. For most services, accreditation or licensing bodies provide information and metrics on select criteria. However, each service has distinct accreditation or quality measures, so a separate assessment is done for quality (see exhibit 4). In addition, potential partners must meet criteria for risk and financial performance.

Exhibit 4: Organizational Partnership Assessment for Quality

Service	**Accreditation Body**	**Quality Sites**	**Measures of Quality**
A			
B			

Note: List continues for all community providers.

Sharp must project the approximate demand for each service based on the total client pool expected at the SHC, as well as the health and social needs (i.e., the social determinants of health) likely to be observed. The selection of CBO partners must have the capacity to meet the needs of the projected patient volume. Additionally, the CBOs must have their own incentives to participate in a collaborative effort with Sharp.

Financial Arrangements

The proportion of payments for Sharp's two existing SHCs is shown in exhibit 5. The new center is expected to be financed primarily through managed care health plans, including Medicare, Medicare Advantage, Medi-Cal (Medicaid), and other government programs. The financial composition is anticipated to be in relation to the demographics of the area.

Exhibit 5: Payment Arrangements for Sharp's Existing Senior Health Centers

Sharp Senior Health Center: Claremont

Category	Pct.
Medicare (traditional)	88.14%
Medicare Advantage	6.76%
Dual Medicare & Medi-Cal	4.90%
Other government	0.11%
HMO	0.05%
Self-pay	0.03%
PPO	0.02%

Sharp Senior Health Center: Downtown

Category	Pct.

Medicare (traditional)	36.89%*
Dual Medicare & Medi-Cal	49.12%
Medicare Advantage	12.88%
Self-pay	1.04%
PPO	0.07%

*In 2017, nearly 18% of this category was aligned with Sharp HealthCare's NextGen ACO.
Source: Data from Sharp Healthcare internal databases, 2017.

In addition to the incentives associated with payment through Medicare Advantage, Sharp has a financial interest in improving care transition and care coordination as a way to reduce avoidable costs. For instance, significant cost savings can be achieved when CBO programs and support serve as a supplement to patients' medical care, helping to meet the social determinants of health of patients after discharge from the hospital. Such services not only can help patients avoid inpatient readmissions and emergency room visits; they can also enable older adults to thrive in the management of their health outside the hospital walls, thus greatly improving quality of life.

Sharp's SHC team has compiled a wealth of data related to the location, services, partners, and expected financial performance of the new center, but decisions about each of these areas remain to be made. The staff submit their report and recommendations to the leadership team of Sharp HealthCare and await the results.

Discussion Questions

1. What is asset mapping? Why is it important in facilitating care transitions and care coordination?

   Asset mapping is a process where a community's assets are identified, described, and sometimes visualized through representation on a map of that area or region. This type of identification and visualization of the geographic location of resources, compared with the location of individuals needing access to those resources, helps to identify opportunities for expansion of resources, as well as communication to individuals of the location of resources they need to support their care transition process to their home or other locations.

2. What are social determinants of health, and how can addressing these patient needs improve their coordination of care?

   Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Identifying a patient's SDOH needs can improve care outcomes by making sure that they have supportive services for nutrition, transportation, safe housing and other needs when they return home after medical procedures of care. Knowing a patient's SDOH needs before they receive a medical procedure can also assist health care providers in assembling a set of supportive services that improves health outcomes and quality of care once a person transitions back to their community.

3. How many organizations should Sharp identify as potential partners for its Senior Health Center? Which ones should be the highest priority? What criteria should they use to decide?

   Organizations that have resources that can address a patient's SDOH needs, and possibly provide community health workers to support a patient before, during and after medical care would be the best choice of providers. Any organizations that have experience working with health care organizations in partnerships would also make good selections for Sharp Health Care.

4. Once Sharp establishes relationships with partners and starts operation of its new SHC, what criteria and methods will it use to evaluate the success of those partnerships?

   Metrics for success for the SHC partnerships should be set at the start of the CBO partnership, as well as regular meetings between Sharp HealthCare and their CBO partners. Some measures for success of the project should emphasize the ability of each CBO to respond to service referrals in a timely and complete manner. The financial impact that addressing the SDOH of consumers has on their care outcomes and quality of care should be captured as well.

References

Sharp HealthCare. 2019. "Community Health Needs Assessments." Accessed May 30. www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

Useful Resources

- Older Americans Act (https://acl.gov/about-acl/older-americans-act-oaa)
- US Department of Health and Human Services—Aging (www.hhs.gov/aging)
- US Department of Health and Human Services—Programs for Seniors (www.hhs.gov/programs/social-services/programs-for-seniors/index.html)
- "What Is Asset Mapping?" by AmeriCorps VISTA Campus (www.vistacampus.gov/what-asset-mapping)

CHAPTER 1
DIMENSIONS OF LONG-TERM CARE

Dimensions of Long-Term Care Management: An Introduction

3rd edition

Health Administration Press

Learning Objectives

After completing this chapter, you should be able to:

- define *long-term care* and *long-term services and supports*;
- explain changing patterns of demographics in the United States in terms of growing demand for long-term care services and supports;
- understand the history of long-term care service delivery;
- describe models for long-term care service delivery;
- discuss the providers and payers of long-term services and supports, including informal sources of support such as family caregivers;
- apply the theoretical foundations of long-term care service delivery to assess their impact on healthcare policy; and
- understand the impact of COVID-19 on health disparities in long-term care service delivery and new directions for long-term services and supports.

Older Americans

- Compared with previous generations, Americans today are living longer, are more racially and ethnically diverse, and are more prosperous.
- By 2050, the number of people aged 65 or older is expected to double to 89 million, and the number of people aged 85 or older is expected to triple to 18 million.
- Heart disease and cancer affect a large number of older adults in the United States, as do other chronic conditions such as stroke, chronic lower respiratory diseases, Alzheimer's disease, and diabetes.

Adults with Disabilities

- According to a CDC report (2015), 22 percent of adults in the United States have some type of disability.
- Historically, the needs of older adults and the needs to adults with disabilities were addressed through separate laws and by different government organizations (i.e., the Older Americans Act [OAA] and the Developmental Disabilities Assistance and Bill of Rights Act of 2000).
- In 2012, the US Department of Health and Human Services established the Administration for Community Living (ACL).

Long-Term Care

- **Long-term care (LTC)** consists of a variety of health services, support services, and other assistance provided informally or formally to individuals who have chronic illness or disability and are unable to function independently.
- **Long-term services and supports (LTSS)** are services and supports provided to individuals at any age, and in a wide range of settings that correspond to problems in performing ADLs and IADLs.

Administration for Community Living (ACL)

- **Administration for Community Living (ACL):** an umbrella agency of the US government that provides services and supports for older adults and individuals with disabilities.
- The Administration on Aging and the Administration on Disabilities (as well as other centers) are all under the ACL.

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

- **Activities of Daily Living (ADLs):** basic and routine daily activities such as easting, bathing, dressing, toileting, and walking.
  - A person's ability to perform ADLs determines the level of long-term care needs.
- **Instrumental Activities of Daily Living (IADLs):** activities that are not necessary for fundamental functions but allow people to live independently.
  - Ex: shopping, house cleaning, cooking, and managing finances.

Informal Care and Caregiving

- Caregivers are individuals who provide healthcare or supportive long-term care services on a formal, paid basis or on an informal, unpaid basis.
- Nearly 18 million Americans provide care for chronically ill, disabled, or aged family member of friend during any given year.
- Caregivers are more likely to be women and 50 percent are between the ages of 45 and 64.
- Two-thirds of individuals aged 65 or older rely exclusively on unpaid care for their personal care needs.

The History of Long-Term Care Service Delivery

First and Second Periods	• During the first period, from the early 1900s and lasting until 1930, all infirmed were put together in almshouses, sometimes referred to as poor farms for elderly "inmates." • Residing in these private boarding homes allowed those with long-term care needs to be eligible for federal Old Age Assistance, which started the second period— the Old-Age Income Security Solution.
Third Period	• By the 1950s, much more legislation emerged, establishing the next phase of public financing for nursing-home facility construction and public payment for long-term care services. • The Hill-Burton Act of 1946 , the American Association of Nursing Homes , the Kerr-Mills Act of 1960, Medicare and Medicaid were signed into law in 1965, and the Moss amendments to the Social Security Act
Fourth Period	• The fourth period (1970- 1990) of government programs further expanding governmental attempts to control provider abuses. • Social Security amendments were extended, Supplemental Security Income (SSI) program was activated in in 1974, certificate-of-need programs and amendments to the Medicare and Medicaid anti-fraud and abuse provisions were passed, creation of Medicare diagnosis-related groups (DRGs), and passage of the Omnibus Reconciliation Act
Fifth Period and Sixth Periods	• The 1990s to 2010 can be characterized as a phase of market-based reforms, innovative demonstration programs, and expansion of private insurance for LTC expenses. • Balanced Budget Act, Prospective Payment Program System, and 1999 Supreme Court Olmstead Decision • 2010 to the Present: The ACA, creation of the ACL, reauthorization of the OAA

Hill-Burton Act of 1946

- Was amended in 1954 and provided federal grants (along with construction and design guidelines) to public and not-for-profit companies interested in building nursing homes, but required that nursing homes be affiliated with hospitals.
- Throughout the years, the 1959 Housing Act and the Kerr-Mills Act of 1960 has since changed the law
- Today, it is a law under which the federal government provided interest-free loans to healthcare providers interested in building nursing homes affiliated with hospitals, with the provision that they would have to provide charity care in the future for residents.

Medicare and Medicaid

- **Medicare:** federal health insurance program in the US
  - Eligibility criteria:
    - Aged 65 and older
    - Individuals Social Security disability benefits for more than 2 years
    - Individuals diagnosed with Lou Gehrig's disease
    - Individuals with end-stage renal (kidney) disease
  - Covers care provided in skilled nursing facilities, and home care, for up to 100 days
- **Medicaid:** means-tested federal insurance program in the US that covers medical care and other supportive services
  - Eligibility criteria:
    - low-income individuals
    - people living with disabilities
    - poor older persons

Olmstead v. United States

- A 1999 decision of the US Supreme Court that required states to eliminate discrimination against people with disabilities
- **Olmstead** ensures that individuals with disabilities receive services in the most integrated setting that is appropriate.
- Provided the impetus for the expansion of home and community-based services.
- New homelike models of care evolved, such as assisted living, Eden Alternative housing, and Green House cottages.

COVID-19 Pandemic

- A worldwide epidemic that marks the beginning of the "Seventh Period"
- Impacted healthcare and senior living providers, as well as global economies, and opened new concerns about long-term care services and support delivery while growing awareness of health and racial disparities affecting older adults

The Passage of the ACA: A New Period

- The passage of the ACA focused attention on integration and coordination of long-term care services, as well as opportunities to innovate service delivery and reimbursement.
- A new focus on preventive care service and primary care services delivery
- Innovative uses of technology for long-term care service delivery
- Support for informal services provided by caregivers

Aging, Disability, and Chronic Health Conditions

- There is an aging process
- The International Classification of Functioning, Disability, and Health (ICF) defines functioning and disability
- Chronic health conditions develop as individuals age.
- **Geriatrics** is the branch of medicine that deals with the health and care of older
- adults. **Gerontology** is the branch dealing with the process of aging and the problems of older adults.

Genetic and Environmental Factors

- The way an individual ages depends on a variety of genetic and environmental factors, as well as on access to healthcare services.
- About 20 percent of a person's health is because of genetics, about 20 percent is because of the medical care received, and the other 60 percent is because of social, behavioral, and environmental factors.

Physical Signs of Aging

- Changes in a person's height, skin, and senses are normal parts of the aging process. The way the body regulates its various systems (e.g., circulatory, nervous, respiratory, digestive) is also affected by age.

Disabling Conditions

- Under the ICF, a disability is defined as an impairment that refers to individual functioning and encompasses physical, sensory, cognitive, and intellectual impairment as well as various types of chronic disease.
- **Disability can be a multidimensional experience,** and three dimensions of disability: (1) bodily function, (2) activity restrictions, and (3) participation restrictions.
- **Disability studies** is a new field that looks at issues pertaining to disabilities and people with disabilities.

Chronic Health Conditions and Wellness

- A chronic condition is a persistent health condition or disease that lasts for an extended period and typically does not have a cure.
  - Can affect both physical and intellectual functioning and can be medical or psychological in nature.
- The emergence of a growing number of individuals with multiple chronic conditions has become an important issue.

Models of Long-Term Care Delivery: Continuum of Long-Term Care and Single POE

- **Continuum of Long-Term Care:** A holistic system comprising services and mechanisms that assist individuals over time with a wide range of physical health, mental health, and social services needs across all levels of care intensity.
- **Single-point-of-entry (POE) model:** model of long-term care in which patients can obtain all the services they need through a single agency or organization.

Models of Long-Term Care Delivery (cont.)

- **Dimensions of Long-Term Care model:** A fluid, nonlinear approach to long-term care that acknowledges the services identified in the continuum of care model
- It allows consumers to have a single point of entry into the LTC delivery system Emphasizes the option for LTC consumers to use technology and supportive services to remain independent within their community.

Where Are Long-Term Services and Supports Provided?

- Long-term services and supports are typically provided in the following types of settings:
  - Acute care
  - Ambulatory care
  - Home and community
  - Residential
  - Outreach and linkage
  - Technological

What Kinds of Organizations Provide Long-Term Services and Supports?

- Healthcare systems, nursing homes, and other residential care organizations provide a large proportion of long-term care services.
- These providers may be privately owned for-profit or not-for-profit organizations, governmental entities, or faith-based organizations.

Who Pays for Long-Term Services and Supports?

- Payment for formal LTSS in the United States comes primarily from government sources such as Medicare and Medicaid.
- Medicaid covered 51 percent of total expenditures
- Other public programs paid 21 percent
- Consumers' out-of-pocket funds (i.e., payments for services directly by individuals) covered 19 percent
- Private insurance (commercial insurance, managed care plans, and LTC insurance plans) accounted for 8 percent.

Quality and Safety in Long-Term Care Services

- The quality of LTSS has been a growing concern
- CMS has attempted to address this issue through regulations
- There are new requirements for assessment of long-term care needs, staffing of LTC communities, and for all nursing homes to have a quality assurance and performance improvement plan.

Looking Ahead

- The LTC delivery system remains fragmented and patched together, and an increasing number of clients will likely enter the system as America ages.
- The US is facing the strains of response to the COVID-19 pandemic, declining tax revenues, expensive public health and retirement programs, and rapid growth in the population of people eligible to collect benefits from these programs.
- The passage of the Affordable Care Act and the reauthorization of the Older Americans Act provide a philosophical foundation for wellness and health promotion throughout all stages of our lives

Sample 8 Week Course Syllabus: Dimensions of Long-Term Care

Course Overview
This course will provide undergraduate students with a basic overview of long-term care services and housing in the United States, as well as management issues for long-term care organizations. Readings, assignments, case studies, and discussion boards are requirements for this course.

Textbook
McSweeney-Feld, M. H. and C. M. Molinari, editors. 2023. *Dimensions of Long-Term Care: An Introduction* (3rd ed.). Chicago: Health Administration Press.
(ISBN 978-1-64055-367-5.)

There is a Facebook page for this book, with blogs from the authors of this book as well as others on emerging issues in long-term care. Materials from this site may be utilized throughout the course.

Course Assignments

Midterm Exam	200 Points
Final Exam	200 Points
Assignments/Case Study (6)	300 Points
Discussion Boards (6)	300 Points
Total Points =	1000 Points

Course Schedule

Week	Topic	Reading Assignment	Assignment	Due Date
Week 1	Intro to LTC LTC Policy and the ACA	Module 1 Chapters 1, 2	DB Intro and DB #1 Assignment #1	
	This module covers an Introduction to Long-Term Care, Models of Long-Term Care Service Delivery, and Long-Term Care Policy after the ACA. Assignment 1 provides practice in applying concepts.			
Week 2	Residential LTC HCBS & Care Transitions	Module 2 Chapters 3, 4, 5	DB #2 Assignment #2	
	This module provides an overview of Residential Long-Term Care Services, Home and Community-Based Services, and Care Transitions Systems. Assignment 2 provides practice in applying concepts.			
Week 3	Population Health End-of-Life Care	Module 3 Chapters 6, 7	DB#3 Assignment #3	
	This module provides an overview of Population Health, Chronic Health Conditions and End-of-Life Care (including Hospice and Palliative Care Services). Assignment 3 is a case study focusing on these concepts.			
Week 4	**Midterm Exam**	Module 4		
Week 5	LTC Management LTC Operations & HR	Module 5 Chapters 10, 11, 12	DB#4 Assignment #4	

This module provides an overview of management, operations, and human resources issues in the field of long-term care. Assignment #4 is a case study focusing on marketing concepts.

Week 6 LTC Laws/Ethics LTC Regulation	Module 6 Chapters 13, 14	DB #5 Assignment #5

This module provides an overview of laws and regulations in long-term care, as well as ethical issues in long-term care. Assignment #5 is a case study focusing on legal issues.

Week 7 LTC Finance LTC Risk/Quality/Safety	Module 7 Chapters 15, 16	DB#6 Assignment #6

This module provides an overview of healthcare finance and reimbursement issues in long-term care, as well as LTC risk management, quality and safety processes. Assignment #6 provides practice in applying these concepts.

Week 8 DEI and LTC	Module 8 Chapters 8, 9	**Final Exam Due**

This module provides an overview of diversity, equity and inclusion issues, as well as international approaches to long-term care. The Final Exam is due at the end of this Module.