An AIT's View of the World

HERBERT P. WEISS

When the administrator in training (AIT) arrives at his or her internship, having left behind the safe and protective environment of the classroom, he enters the unknown territory of an authentic nursing home.

The relocation from the campus to the facility is especially difficult due to the complexity of the facility and the lack of flexibility in the rules. The AIT may know all about the theory of nursing home administration, but the time has come when he must face up to real responsibilities with serious consequences. The sheer task of remembering the names, positions, and duties of all the staff members, not to mention the patients and residents, is absolutely frightening. Everything is new and anything might be important.

Another problem the AIT encounters is trying to understand his status within the facility hierarchy. The intern is rarely considered an employee covered by employee benefits. If he is associated with a college program, it will not take him long to realize that he is not a student, either. The coping mechanisms which made academic life so comfortable simply are not acceptable as business or professional practices. In school, for example, a due date for a project could easily be extended by a student skillful in dealing with the faculty. Obviously, such attempts at extensions should not even be considered in the nursing home. Likewise, "loose" school practices such as borrowing notes for missed classes and redefining an assigned project to fit one's own interests and abilities are not applicable to the situation.

The real world is simply not so flexible. Therefore, the careful AIT preceptor will clearly convey the rules of professional behavior and his expectations about the student's behavior in the early stages of the internship.

Because the AIT's position is so difficult to define, there are certain tensions that must be dealt with. The preceptor can play an important role in helping the intern deal with them. During orientation, the AIT must gain insight into the basic structure of the program, and it is at this time that the preceptor needs to probe carefully the potential AIT's strengths and weaknesses. If possible, the preceptor should develop the basic structure and program plan to fit the individual needs of the intern. It is equally important for the preceptor to be well prepared for the intern and make him feel that he has a definite role to play in the facility's service and care mission. That is, the AIT must have "real work" to do.

If the AIT's coming is haphazardly planned and the preceptor feels deep down that the AIT is a frivolity or imposition, his attitude will be picked up by everyone else, including the AIT. If the preceptor is not really committed to the philosophy of the AIT program and concept, it is a waste of everyone's time.

The orientation should cover the facility's physical layout, policies, and an introduction to the department heads and key staff members. The initial conference should help the AIT gain some perspective into his role, function, and organizational identity.

The second important step the preceptor can take to make

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the AIT's transition more successful is to plan regular feedback and evaluation sessions. Weekly appointments should be set up for the intern to discuss his experiences, opinions, and frustrations with the preceptor, who, in turn, will help the intern understand the dynamics and total picture of what has transpired.

A communication gap between the preceptor and the AIT will almost certainly spoil the entire program, so any problems in this area must be worked out in the early stages. Evaluations should be objective and constructive, and positive feedback is needed to reward and encourage proper or outstanding action. Fair criticism is necessary to discourage incorrect practices.

It must be understood by both parties that the AIT is a novice and is apt to make mistakes, especially early on in the program. If both parties accept the fact that mistakes are a natural part of the learning process and intend to handle them professionally, learning will occur more effectively and mistakes will vanish at a rapid rate.

Criticism should be given privately and the AIT must be given an idea of what corrective action is expected of him, along with a relative timetable. In addition, the AIT may uncover problems with the preceptor or facility. If the preceptor is open to such feedback and provides an example of how a professional accepts and benefits from criticism, it will be a valuable learning experience for the AIT. Moreover, the AIT may well contribute to the facility's improvement.

Naturally, as the internship winds down, the AIT will be ready to seek regular employment. If the preceptor has done a good job at guiding the new professional, he will want to "advertise his work" by helping the AIT in his job hunt. The preceptor may have professional contacts which could turn up jobs potentially suitable for the intern. He may also alert the AIT to vacancies which occur in professional journals and association newsletters. Aid in the development of a personal marketing strategy to accentuate the AIT's desirability to a potential employer can be helpful as well. A "mock" or role-playing interview can give the intern experience in this crucial job-hunting skill.

Thus, the preceptor needs to understand how a new environment, regular conferences, and constructive criticism interact to mold a successful AIT program. The AIT comes into the facility with a strong desire to learn, enthusiasm, and curiosity. If these qualities can be cultivated and synthesized by means of a well-structured internship under expert guidance, all parties involved, the AIT, the preceptor, the profession, and most importantly, the resident, will benefit.

Acknowledgements

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The Nurse Shortage: Causes and Solutions

HERBERT P. WEISS

Through Improved Education
And Tightened Regulation, A Turn-Around
Might Be Realized

Every Sunday one can look through newspapers to see voluminous pages of nurse recruitment ads. This shortage of nurses is a nationwide phenomenon that can quickly drain the fiscal resources of health care institutions and reduce the quality of patient care.

There are many reasons why nursing homes throughout the nation are experiencing a severe nursing shortage. Among the more popular explanations: The women's movement and the broadening of career opportunities for women; a decline in the number of 18-year-olds in the population and the subsequent decrease in nursing program enrollments and applications, limited income advancement opportunities in the profession; poor public image of nursing; inadequate knowledge about nursing and increased demands for those working in the nursing service.[1]

Certainly, the commonly stated causes for this critical nursing shortage might give us insight into the problem of inadequate staffing at health care institutions. A review of the literature reveals five major factors influencing the nursing home's ability to retain adequate staffing.

The first factor in long-term care is the exponentially increasing elderly population. More nurses will be required to care for more individuals needing nursing home care. The percentage of the elderly in the population doubled between 1900 and 1950 and will increase 50 percent from 1950 to 2000. Similarly, the percentage of persons over 75 more than doubled between 1900 and 1950, and will double again between 1950 and 2000.[2]

Individuals will live longer with multiple chronic conditions, reducing their ability to function independently. That means more institutional care. Statistics show a 42 percent increase in the number of nurses working in the nursing home since the early 1970s.[3]

In 1972, the nation had 43,000 registered nurses and 72,000 licensed practical nurses working in nursing homes. It has been projected that 118,000 RNs and 210,000 LPNs will be needed in 1984 to adequately staff nursing homes throughout the country.[4] Demographics clearly show the demand for nurses in nursing homes will increase proportionally to the population requiring skilled nursing care.

Recruiting Costs

A second factor that creates extreme hardships for nursing homes is the high cost of recruitment, which is needed to compete with other health care settings. The National Association of Nurse Recruiters says that hospitals are spending on an average of $866 to recruit a nurse, with 55 percent of their recruiting budgets going into advertising.[5] Nursing homes also spend large amounts of money on recruitment.

A 1980 survey of 38 nursing homes located in metropolitan Washington, D.C., showed an annual expenditure of $38,256 for "help wanted" advertising, with one of the facilities spending $6,000 for the year.[6] Nursing homes cannot compete with hospital recruiters offering huge monetary incentives and flexible schedules. For example, two hospitals in Washington, D.C. offer nurses a two-day work week (ten hour shifts) at a full week's pay with full fringe benefits.

Though the gap is narrowing, nursing home salary rates are lower than those paid by private hospitals and state-operated health facilities. Lack of third party insurance payments and the existing Medicaid reimbursement system has institutionalized this salary "gap" for over a decade.

Clearly, the ability to recruit and retain RNs and LPNs in nursing homes is hampered by competition with other health care facilities that offer more in salaries, fringe benefits, third party insurance payments for patient care, and huge monetary incentives in combination with flexible work schedules.

A third factor affecting nurse recruitment is the growth and proliferation of the agency nursing pool. Many nurses prefer this alternative to institutional employment because the agency setting gives them flexibility in work schedules.

Nursing pools are growing and draining the market place of needed manpower and nursepower. They are expensive, and they quickly drain the budgets of nursing homes, especially those participating in Medicaid programs. A state-wide survey conducted in 1981 by the Health Facilities Association of Maryland revealed that nursing homes most affected by pool nurses were those located in the Baltimore and Washington D.C. areas. In these facilities, staff RNs were paid $7.20 per hour while agency staff nurses received $14.43 per hour.[7] Most administrators who responded to the nurse manpower survey felt pool nurses were too expensive and reduced the continuity of care for patients in their homes. The only positive benefit the administrators cited was the facility's ability to meet state licensing requirements.[8] Due to the critical nursing shortage, nursing homes are not able to recruit nurses who are attracted to agency nursing pools by higher salaries and more flexible work schedules.

Professional Recognition

A fourth factor influencing the retention of nurses in nursing homes is a lack of professional recognition by the medical community. Competitive salaries alone will not attract nurses into long-term care. Today's nurses demand recognition for their important role in patient care. No longer will the nurse allow herself to be considered the "handmaiden" to the physician.

Finally, a fifth factor affecting nurse recruitment in long-term care is the bias against old age, which is reinforced by educational preparation.[9] While many nursing schools in the country teach gerontological nursing courses, the clinical practicum is optional, not mandatory. This reduces the exposure and experience a student can gain from on-the-site training. It is important for the student to get exposure to the nursing home and its patient population. Barbara Nichols, president of the American Nursing Association has said: "Gerontological nursing requires sound judgment and the use of technical skills based upon a thorough knowledge of the normal aging process."[10]

Along with nurse educational programs not stressing gerontological nursing, there is a concerted campaign by the American Nursing Association to have its "1985" proposal adopted by nursing licensure boards. The proposal recommends that the baccalaureate degree be the entry level for professional nurses.

This would be detrimental to long-term care because associate degree nurses, hospital diploma nurses and LPNs are heavily utilized in the facility. The nursing education program of the university will influence the attitude and choice of employment for RNs after graduation. Coupled with the adoption of the ANA's "1985" proposal, this will create a greater hardship on the nursing home.

Recommendations

The five factors that contribute to the vicious cycle of the critical nursing shortage in nursing homes will not be solved overnight. Nevertheless, to reduce the severe impact of the nursing shortage, these recommendations should be considered:

1. Associate Degree, Hospital Diploma, Baccalaureate Programs for RN and LPN training programs are needed. Masters and doctoral programs are also needed to prepare clinical specialists, nurse researchers, and educators specializing in long-term care, with each group contributing to the gerontological knowledge base of nursing. Nursing programs should provide

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mandatory gerontological nursing clinical experience for the student nurse.

2. Agency nursing pools must be regulated for the quality of services as well as the prices they charge. Agencies should be required to provide in-house, in-service training programs on gerontological nursing to RN employees who are placed in nursing homes.

3. Medicare and Medicaid reimbursement programs must allow for intense competition among health facilities in attracting nurses, and to provide them with salaries and fringe benefits comparable to other health care institutions.

4. Excess paperwork in nursing homes should be reduced so that the nursing staff can spend more time in direct patient care.

5. State governments should provide funds for scholarship programs to attract more nurses into gerontological nursing. Enrollment in nursing programs has decreased at all entry levels due to increased tuition costs. With the federal government's reduced fiscal support for nursing education programs and student aid programs, individuals now have no place to turn for loans.

6. Universities should begin a cooperative effort with the nursing homes in their states to develop and implement the "teaching nursing home concept" for the training of students in nursing, allied health professions, and medicine, in nursing homes.

7. Nurse Licensure Boards throughout the country should be given more flexibility in licensing nurses from other states.

Footnotes

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Good Housekeeping Stretches Dollars

HERBERT P. WEISS, MA, NHA and J.P. LONG

Planning, Organizing, And Controlling Are Viewed As Essential Steps In Curbing Costs While Accomplishing Objectives

Housekeeping is coming of age in an era of advanced technology. No longer can the tools of the trade be viewed simply as a broom and a mop. Governmental regulations to ensure the health of the long-term care patient demand a sophisticated housekeeping staff, one specially trained in the latest infection control and cleaning techniques.

Increasingly, the service worker is recognized as part of the health care team and one who promotes the quality of care by providing a clean and safe living environment for the patient. Inflation, inadequate Medicaid reimbursement, inefficient use of supplies and equipment, and improper staffing patterns can quickly reduce the quality of patient care, services and, ultimately, the profit of the health care facility. An effective, well-managed, cost containment program initiated by the Housekeeping Executive can assist the administration of the facility in "stretching" the health care dollar without reducing the quality of the service.

The operating expenses in a housekeeping program can effectively be controlled by the utilization of these cost containment measures: proper planning, organizing and controlling; lowering absenteeism; and reducing accidents.

Planning, as a continuing function of the management structure, can promote efficient utilization of limited fiscal and manpower resources. The development of the housekeeping budget, the determination of appropriate staffing patterns, and periodic inspections of the facility, are ways in which planning can be instrumental in reducing expenses.

Historical data showing past expenditures for supplies, equipment, and salaries can be provided to the Administrator in detail by the Housekeeping Executive. The information can be used in planning the annual budget. The data also will help in accurately planning future fiscal and manpower needs to accomplish the goals and objectives of the housekeeping department.

Planning appropriate staffing patterns for any task can reduce unnecessary overtime as well as idleness of service workers. To determine the appropriate man-hours to accomplish a task, the following formula can be utilized:

Time × Frequency = Man Hours

Scheduling with this formula will increase the effective utilization of manpower and will drastically minimize departmental expenses as well as overhead.

Periodic inspections can be most effective in planning for future workloads. But the most knowledgeable employee in cleaning procedures should be assigned to initiate this continuing function. Inspections will provide a mechanism to spot potential problems and eliminate them before overtime and staffing increases become necessary.

Organization as a function of the management structure will ensure an efficiently operated housekeeping department. A policy and procedures manual as well as departmental meetings can increase effective utilization of manpower, supplies, equipment, and training.

The policy and procedures manual can be an important "guide" to the management of a well-operated department. It should consist of an organizational chart, departmental goals and objectives, and a detailed job description for all employees in the department. Standardized cleaning procedures for all tasks performed by the housekeeping staff, and a cleaning schedule listing frequency in which a task must be performed, should be incorporated.

Departmental meetings should be scheduled at least biweekly, and will bring the housekeeping staff together to discuss policy, workload, and scheduling. The meetings will offer an opportunity for communication between the Housekeeping Executive and the staff. At

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FIGURE 1
Inventory Checklist

Last Price	Packed	Items	Brand-names	Last Inventory	Amount Purchased	Total	Present Inventory	Amount Used
$3 per case	8 gal/ case	handsoap	S/M	6 gal.	16 gal.	22 gal.	18 gal.	4 gal.
$47 per case	12 qt./ case	Stainless Steel Polish	J.H.M.	1/case	2/case	36 qt.	29 qt.	7 qt.

FIGURE 2

Average Annual Savings (One Hour Per Person Per Day)

Hourly Wage Per Person	Average Annual Savings By Staff Size 1 person	5 persons	10 persons	20 persons
$4.00	$1,000	$5,000	$10,000	$20,000
$4.50	$1,125	$5,625	$11,250	$22,500
$5.00	$1,250	$6,250	$12,500	$25,000

FIGURE 3

Housekeeping Attendance Report _____Shift _____Wk or Month _____

	Budgeted Hours	Work Hours	Sick	Absent	Late
Supervisor					
Asst. Supervisor					
Service Workers					

List Repeated Absences: _____ List Repeated Tardiness: _____

the same time, the meetings will increase staff awareness as to what is acceptable departmental productivity.

Controlling is the third function of management structure in which the Housekeeping Executive can lower departmental expenditures. It is accomplished by developing a policy on purchasing, combined with proper use of supplies and equipment.

Controlling the use of the existing inventory and purchasing products only when appropriate can reduce waste and the potential misuse of supplies. The cost-conscious Housekeeping Executive can use these methods to reduce the cost of supplies:

1. Purchase multi-purpose cleaning products that can be used to clean more than one type of surface.
2. Bulk supplies should be purchased if adequate storage space is available in the facility.
3. Hand spray-bottles with pump action applicators should be used wherever possible. This will assure that liquids will not be wasted.
4. Periodic review of vendors' lists to examine pricing, delivery time, and quality of products will determine whether new vendors should be contacted for supply purposes.
5. An inventory check-list should be reviewed weekly to determine usage rate of supplies and will quickly show what should be re-ordered. Figure 1 is a sample inventory checklist.

After the existing inventory has been used, additional savings can be obtained through a sound purchasing policy. Poor decisions in purchasing new products can increase expenditures for supplies and reduce the quality of the cleaning work.

A new product should not be purchased without testing its performance level at the facility. Currently used products should be compared with new products in order to determine which one will adequately meet the needs of the housekeeping department. After a comparison of performance, the "real cost" (purchase price plus labor and maintenance cost) must be determined for both products. The performance level and "real cost" comparison will provide the Housekeeping Executive and the Administrator with appropriate information to make the right purchasing decisions without sacrificing product performance.

Finally, proper utilization of equipment can reduce the manpower levels required to provide housekeeping services in the facility while increasing departmental productivity. Figure 2 was developed by J.P. Long, sanitation consultant and director of housekeeping at the Hebrew Home of Greater Washington, a 540-bed comprehensive care facility located in Rockville, Maryland. It illustrates how one hour per person, per day, saved by proper utilization of equipment in daily tasks, will produce substantial annual savings to the health care facility.

Many cost-saving methods were found to be effective by on-the-job testing. Some examples utilized by J.P. Long to reduce housekeeping expenses:

1. To increase productivity, a 36-inch sweeping apparatus was used by the service worker instead of a 12-inch apparatus.
2. To increase productivity, a wet/dry vacuum cleaner was used instead of an upright in cleaning floors.
3. To increase productivity, one service worker was trained in using an automatic scrubber instead of utilizing three service workers to operate a standard machine and mopping unit.

Clearly, a service worker receiving $4 per hour can potentially save the housekeeping department $1 annually in man-hour expenses if equipment is properly utilized on a daily basis.

Controlling Absenteeism

Increased absenteeism will decrease the productivity of the housekeeping department. For example, an absent employee who is specially trained to perform a particular task may have to be replaced by a new, inexperienced, and untrained worker. This individual will have to be specially trained by another individual to adequately perform the assigned task. One can see how an absent service worker will increase the number of individuals involved in performing a specific task.

Under these conditions, manpower costs will escalate with unbudgeted overtime payments to employees who are asked to work extra hours to bring departmental productivity to an acceptable level.

It is the responsibility of the Housekeeping Executive to make sure that every employee in the department is familiar with the facility's absenteeism policy. Strict enforcement of regulations is imperative and vital in reducing absenteeism. Up-to-date records must be maintained and available in the housekeeping department as well as in the personnel office.

The Housekeeping Attendance Report (Figure 3) will allow the Executive Housekeeper to easily calculate the department's absenteeism rate for each week, month, and year. A formula to determine the absenteeism rate:

$$\frac{\text{Days Lost} \times 100}{\text{Total Days Available}} = \text{Absenteeism Rate}$$

The formula is simple to use and will quickly reveal the absentee rate in any department of the health care facility. For example, during one month, eight out of 20 service workers were absent for a combined total of 19 days. Multiply the 22 working days in the month by the 20 service workers, which will result in 440 working days available to the department. Divide 19 days lost by 440 working days available and multiply the result by 100, which will determine the absenteeism rate for one month. The answer to this example is 4 percent. An absentee rate of more than 2.5 percent in a health care facility is considered excessive.

Reducing Accident Costs

Reducing accidents in the housekeeping department and in the health care facility at large is the third cost containment measure in which the Housekeeping Ex-

ecutive can reduce unnecessary expenditures.

Accidents can be reduced through evaluation programs in the health care facility. Potential risk hazards can be identified, with corrective action initiated by the housekeeping and maintenance department to reduce the possibility of injury or loss of life. Figure 4 provides a safety checklist to determine potential hazards.

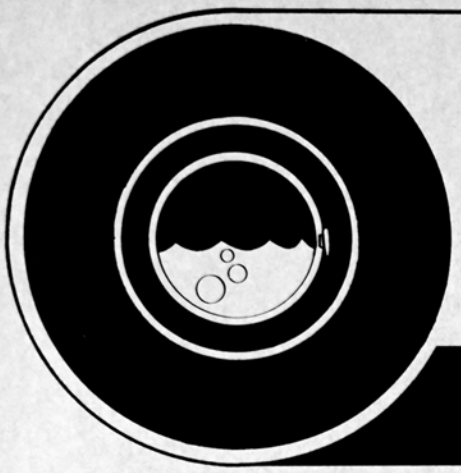
Accidents can result from unsafe working conditions and improper use of equipment. A "safety conscious" Housekeeping Executive can reduce most of the accidents in the department by taking these steps:

FIGURE 4
Safety Checklist

_____ Are electric cords and plugs, lamps, heating pads in good condition?
_____ Are overhead lighting units in good condition? (sufficient lighting; shades clean)
_____ Are acoustical ceilings in corridors made of noncombustible material?
_____ Are dry areas or aisles left for persons to walk on by cleaning a small surface at a time?
_____ Are wet areas blocked off and a sign posted to warn persons approaching?
_____ Are "non-skid" waxes or polishes used?
_____ If lightweight rugs or throw rugs are used, do they have rubber backings?
_____ Are floors kept clean and free of litter at all times?
_____ Are warning signs used when equipment and cleaning articles are placed in aisles or on stairs while cleaning?
_____ Is your institution inspected periodically for safety hazards?
_____ Are drinking fountains, showers, and lavatories checked daily for cleanliness?
_____ Are drives clear and pavement in good condition? Walks in good repair and unobstructed?
_____ Are personnel required to list all furnishings and equipment in residents' rooms in need of repair?
_____ Are all stepladders in safe condition? Do portable ladders have safety feet?
_____ Are the proper tools used when opening containers?
_____ Are protruding nails, metal strappings and wires from all boxes, barrels, and crates removed before handling?
_____ Are oils, waxes, sweeping compounds, and all inflammable supplies and materials properly stored?
_____ Is storage on ledges, in corners, tops of cabinets, tops of lockers, radiators, etc., eliminated? Is storage properly arranged for materials? For grouping similar things together? Discourage floor storage. Is obsolete or unused equipment, etc., taking up space?

1. Departmental meetings and in-service training programs can be effectively utilized to convince the staff that safety is in their best interest.
2. Departmental supervisors must practice "good safety habits" daily in order to set a strong example.
3. Make it clear to all workers that "good safety habits" are critical in determining job performance and, ultimately, performance appraisals.
4. Periodic safety meetings should be scheduled to review recent accidents in the department, focusing on the cause and cost in terms of lost productivity and wages. Finally, steps to be taken to reduce similar accidents could be discussed among the individuals attending the meeting.

Training in correct techniques for handling equipment and supplies and increasing the staff's awareness of the importance of safety will reduce on-the-job injuries. A low percentage of accidents means lower premiums for workers compensation. ■



Laundry Infection Control: An Ounce of Protection

Tim Menees

by Herbert P. Weiss and J.P. Long

Stopping the spread of microorganisms in the long-term care facility is no easy task. It requires teamwork, putting knowledge to use, and good technique.

Over 100 years ago, articles of clothing might have been taken down to the local stream to be washed and then dried by direct sunlight. After this laundering process, the individual had clean but contaminated clothes. Obviously, over the years, more sophisticated techniques based on sound scientific principles have been developed with the intent of reducing the incidence of contamination. When developing laundering techniques in the long-term care facility, one must take into account the different types of linens and fabrics, and finally, the chemicals and machines utilized by the laundry department.

The laundry department is in the forefront of the continual effort to reduce contamination in the long-term care facility. Soiled linens can harbor microorganisms which can cause nosocomial infections in the facility's patient population. Therefore, it is extremely important for the laundry manager to marshal all of the know-how and facility resources at his disposal to reduce the spread of pathogenic microorganisms.

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The Cornerstone

The "infection control committee" in the long-term care facility should be considered the cornerstone of an effective infection control program. The laundry manager can play a key role on this committee in the development and implementation of viable and realistic policies and procedures to reduce contamination due to improper laundering. Coordination of all departments in the facility to implement an infection control program should be a goal of this committee. Infection control should be an on-going program and not just another instance of "paper compliance."

The infection control program could consist of the following components:

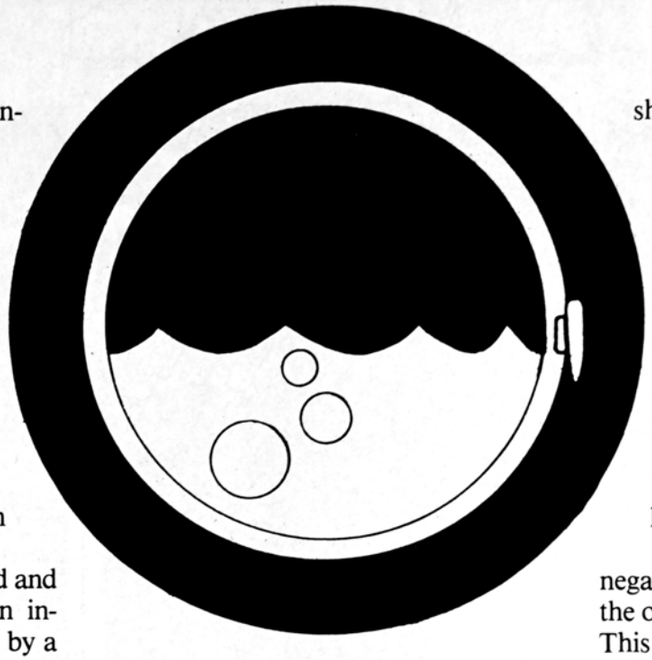
1. Specific written policies and procedures to be utilized as the "Bible'" for this program, whose contents focus on Asepsis (techniques to prevent pathogenic microorganisms). Policies and procedures incorporated into this program should include, but not be limited to:

- The handling of clean and soiled laundry. Isolation procedures on the proper handling, transportation, storage, and laundering should be developed and implemented when required.
- The utilization of proper washing procedures to reduce contamination in various types of textiles, which might include linens, towels, wash cloths, diapers (if applicable), residents' personal clothing, and wash and wear items.

2. The implementation of on-going employee orientation and inservice training programs which describe nosocomial infections, their effects on the patient population, and finally, techniques for the prevention of contamination by pathogenic microorganisms.

Due to economy of scale, it may be more economically viable for an administrator to utilize a commercial laundry and/or linen service than to depend upon in-house laundering.

Policies and procedures developed and implemented for a facility with an in-house laundry can be easily utilized by a facility that uses a commercial laundry.



Adequate provisions must be made in the long-term care facility's physical design to ensure the proper storage of clean and soiled linens is possible. Space for a central holding area should be allocated, to consist of a clean linen room (linen is taken from this room to be distributed to the floors) and a soiled linen room (linen is stored in this room and transported to either an in-house laundry or a commercial laundry).

A small linen room on each floor allows for brief storage of clean linens and better facilitates issuance to the nursing staff for distribution to patient areas. Linens stored in these rooms should be rotated. The first linens placed into storage should be the first taken out for distribution.

Ventilated closets on each floor or wing are ideal for storing soiled linens before their movement to the soiled linen room in the central holding area. Finally, appropriate storage is needed for trucks and carts used to transport soiled linen.

Washing Procedure

There is more to effective infection control than placing linens in the facility washing machine and adding a cup of extra-strength detergent. The laundry department must ensure that the washing procedure will effectively destroy pathogenic organisms to reduce the probability of the spread of infection to the patient population.

Information pertinent to proper washing procedures:

- Six or more changes in wash water should occur during the course of a standard wash cycle formula. These changes can reduce by dilution the number of microorganisms even without the addition of chemicals.
- Detergents and alkalines dislodge germ-carrying soil and expedite its removal, greatly reducing microorganisms in the wash load. About 95 percent of microorganisms are removed from the wash load during the suds operation.
- The utilization of heat during various stages of the laundering procedure will destroy microorganisms remaining on the linen. This heat can either be applied during the wash cycle (hot water); the drying process (hot air); or by surface heat (ironing). Temperatures of over 180 degrees Farenheit will destroy microorganisms.
- Chlorine bleach is extremely effective in the destruction of microorganisms. During the bleach operation, 125 to 195 parts per million available chlorine at pH 10.2 to 10.8 in water temperatures of 150 to 160 degrees Farenheit can reduce microorganisms.
- During the later phase of the washing procedure, the linen is soured by an acid fluoride that lowers the pH count in the wash. This high degree of acidity also destroys microorganisms.

After the washing procedure, it is important to minimize the danger of contamination by airborne microorganisms. All clean linen should be covered as soon as possible after laundering to prevent contamination. It is important that the linens be completely dry. Make certain that linens are being transported properly to the central holding area from soiled linen rooms located on the floors.

Isolation linen should be handled separately and double-bagged in water-soluble, colored bags. These bags should be taken directly to the central holding area or placed in a cool, closed-off area until transportation to the central holding area is possible. Bags or other types of containers should be utilized efficiently to seal-up soiled linens. This linen should be transported in well-covered, easily identifiable carts used exclusively for this purpose. The cart liners should be cleaned with a disinfectant cleaner or laundered often.

The sorting area should be under negative air pressure and ventilated to the outside, with no recirculation of air. This area should be scrubbed down and disinfected daily with a solution of disinfectant detergent. All pipes, vents, and laundry machines in the laundry room should be cleaned daily.

Laundry chutes should be cleaned with a germicidal cleaner as often as twice a week. They can also be cleaned with a hot spray. Clean linen, as it leaves the central holding area, should be well-covered to protect it from recontamination. Trucks that transport linens to floors should be thoroughly cleaned and disinfected as well.

One point that must be made clear to employees is that they should not, under any circumstances, carry linens into a patient room that are not to remain there. In other words, employees must not fall into the trap of grabbing linens for several different patient rooms and carrying that stack from room to room. Linens must be taken, one set at a time, into the rooms where they belong to avoid unnecessary contamination. Nursing home surveyors are known to watch for such violations of infection control standards.

No Easy Task

It is no easy task to provide a totally "germ-free" environment in a long-term care facility, but the laundry manager can plan an effective campaign to reduce the contamination of textiles in the facility by following specific policies and procedures.

Finally, there must be an on-going inservice program to educate the staff on the importance of infection control. One ounce of prevention can protect patients in the long-term care facility from unnecessary nosocomial infections. CA

MANAGING RISKS, SAVING DOLLARS

Organizing nursing home personnel and establishing an ongoing risk management program can reduce accidents . . . and save dollars at an appreciable pace.

by John R. Hopkins and Herbert P. Weiss

Jim Osborn

It is no secret that work-related injuries have a negative impact on the operating budget and efficiency of services provided in the long-term care facility. A high incidence of accidents in a facility can drastically increase the number of workers compensation claims filed, while additional expenditures for training replacements for the injured employees, unanticipated overtime, and damage to property will quickly drain the facility's fiscal resources.

According to the National Safety Council publication, *Accident Facts-1983 Edition*, work-related accidents (wage loss, medical expenditures, insurance administration costs, and fire loss) cost the nation $31.4 billion each year. In 1980, the national figures for national workers compensation for all workers covered by such laws stood at about $13.3 billion. Breaking this statistic down further, of the total amount, $3.8 billion covered medical/hospital costs and $9.5 billion went to wage compensation.

These figures reveal that work-related accidents have a tremendously detrimental impact on both the national economy and the long-term care industry. One method of addressing this problem in the nursing home is through the development of an ongoing risk management program supported by top management, mid-level managers, and the employees at the "grass roots" level.

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A Case Study

Meridian Healthcare is a proprietary nursing home corporation located in Towson, Maryland. In 1978, a risk management program was implemented in 16 long-term care facilities located in four states due to workers compensation losses of over $500,000. These losses disturbed top management because the compensation claims from fiscal year 1976 to 1978 had increased 125 percent with the opening of only two additional facilities (a 15 percent addition to the total workforce). If the compensation claims could not be reduced, the corporation's profit on an annual basis could be significantly reduced.

A safety program to reduce accidents was developed with the input of the company's brokerage group and their loss control services company. Information obtained from contacting nursing home chains of similar size about their risk management programs, and from seminars sponsored by the National Safety Council, the American Hospital Association, and the American Management Association, were incorporated into the development of the program.

The following seven components were incorporated into Meridian Healthcare's safety program in 1978:

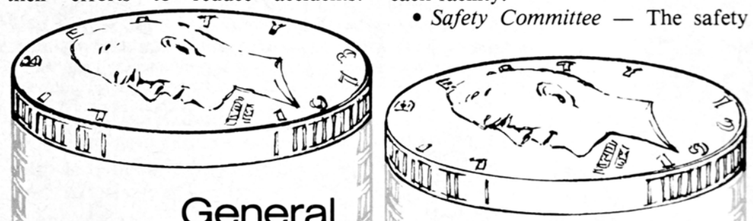
• *Reporting, Selection and Audit Procedures* — This component consisted of a loss and reporting system which was built on an improved employee selection system. These procedures enabled department heads and the administrator to examine the workers compensation loss history of the applicant through the utilization of reference checks. Physical aspects of the job and what precautions would be necessary to limit injury were made extremely clear to the applicant. Finally, a revised physical program was developed to emphasize the ability to perform the job thoroughly and safely. The administrator was actively involved in the investigation of accidents in the facilities through the examination of the supervisor's investigation reports and the development of corrective measures. The process of employee selection, investigation of accidents, and finally, the initiation of corrective measures were monitored by the central office through an internal examination and audit of each facility report.

• *Incentive Program* — An incentive program was implemented to monetarily reward the administrator and department heads in each facility if the central office audit revealed that policies and procedures were being followed with deviations being corrected promptly. Monies were also allocated for the control of the workers compensation claims dollars within specific prescribed limits. This incentive program was well received by both administrators and department heads because it recognized their efforts to reduce accidents. Management of each facility began to feel a greater responsibility to their employees in reducing accidents through the on-going maintenance of a safe work environment.

• *Safety Consultant* — Safety consultants increased their involvement in Meridian Healthcare's risk management program through increased inspections of equipment in the facilities; the implementation of an increased number of fire safety seminars; and the development of training materials on accident reduction which were utilized during in-house training programs.

• *Fiscal Resources Allotted To Materials* — Monies allocated to the safety budget were authorized with input from the administrators. Budgeted items included: training materials and employee handouts pertaining to on- and off-the-job safety; audio-visual cartridges on accident and fire prevention; safety committee recognition awards; and resource books and periodicals which were distributed in each facility.

• *Safety Committee* — The safety



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committee in each facility was given the ultimate responsibility by central office to educate all new and existing employees in their respective facilities as to the importance of performing their jobs in a safe manner. The committee chairman at the initiation of this safety program was the administrator. However, this responsibility over time was delegated to an individual interested in accident prevention and safety. All departments and shifts were represented on the committee. These individuals inspected all departments to locate unsafe work environments. Finally, each facility had a "safety bulletin board" which the committee utilized to promote safety awareness.

• *Staffing Resources* — The safety committee, part-time inservice trainer, the administrator, and region director monitored training programs within the facility. The director of risk management and a loss control consultant could be utilized if requested by an administrator to provide expertise on accident prevention. Audio visual programs on accident prevention were obtained from state and national associations to supplement the corporations own training materials.

• *On-site Visits* — The director of risk management and the regional director visited each facility three times a year to initiate an on-site evaluation of the effectiveness of the safety program. Information obtained from these visits combined with audited reports determined the monetary awards allocated in the incentive program.

The safety program described above promoted a unified effort between the 16 facilities and the central office to reduce accidents. On-site visits and the evaluation and internal central office audit of facility accident reports provided data to evaluate the effectiveness of each facility's program.

Results . . . Reductions

Due to the support of top management, middle management, and the employee at the "grass roots" level, there has been a large reduction of workers compensation claims. In fiscal year 1978, when the program was initiated, workers compensation claims were reduced by 50 percent from $500,000 to $250,000, and were maintained at that level for the following fiscal year. By the end of fiscal year 1983, claims were under $200,000, a 60 percent reduction. Even more dramatic is computing what the fiscal year 1978 expense would have been had no effort been initiated to reduce accidents. The projected claims would probably have exceeded $1 million over the actual loss.

Through the close monitoring and evaluation of the safety program, Meridian Healthcare has compiled five years of data specific to long-term care facilities. This data base is important because data specific to the long-term care industry and pertaining to work accident costs is nonexistent. Associations such as the National Safety Council that keep such important statistics do not have a category specifically for long-term care data.

A national forum is needed to exchange ideas pertaining to risk management in long-term care, and dialogue is needed to explore new and innovative ways of developing risk management programs specifically geared to the needs of long-term care. CA

Editor's Note: The authors of this article invite anyone interested in attending a national forum on risk management in long-term care to contact them. Write Herbert P. Weiss, Health Facilities Association of Maryland, 10400 Connecticut Avenue, Suite 300, Kensington, Maryland 20795.

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MAKING MEDICAID WORK:

The Creation of Maryland's Innovative Reimbursement System

by Roger C. Lipitz and Herbert P. Weiss

Editor's Note: *This is the first installment in a two-part story about the Maryland Medicaid reimbursement system. This system is now being heralded as one of the most ingenious and practical reimbursement systems ever developed. In a day and age when such systems tend to be constant sources of irritation for providers, it is refreshing to hear about one which has met with such unbridled success. Roger Lipitz played an important role in the development and implementation of this system. In this month's article, he details, along with Herbert Weiss, the events and coming together of forces that culminated in this system's inception. In the February 1985 issue, Lipitz and Weiss will explain the inner workings of the system — why it is, in the opinion of many health care professionals, the system of the future.*

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The recently enacted Maryland Medicaid reimbursement system is recognized widely as the most innovative and progressive system of its kind in the country. This recognition is attributable to the incentives and benefits it provides to all parties affected, specifically the patient, the provider, and the state itself.

The development of this system did not happen in a vacuum. Many factors and individuals came together in the development process. It is indeed a newsworthy story that the system is in place and that it works, but it is equally important to understand the dynamics that led to the development and subsequent implementation of this reimbursement program.

How It All Started

In 1969, the State of Maryland implemented a retrospective reimbursement system with an arbitrarily established ceiling on maximum payments. The nursing home was allowed to keep an efficiency payment if its allowable costs remained below the established ceiling.

At one point, the efficiency ceiling was as high as $1.80. In the mid-1970s, the maximum efficiency payment was lowered to $1.40. With the advent of Section 249 of Public Law 92-607, which called for "reasonable cost-related reimbursement" under Medicaid programs, the State of Maryland developed a formula to determine the ceiling.

The ceiling was set at the 75th percentile of weighted Medicaid patient day costs of all facilities (facilities' costs were trended forward by the consumer price index to establish the prospective ceiling). Any facility with costs above the 75th percentile was obligated to absorb these costs.

The inadequacies of such a system were glaringly obvious to the provider community, resulting in a hearty desire to attract private pay residents. This was due, of course, to the substantial difference that generally occurs between private pay rates and Medicaid rates. In addition, accepting easy-to-care for patients helped assure that costs would remain below the state-established ceiling.

The Maryland legislators were well aware of their constituency problems relative to the lack of access to nursing home beds by Medical Assistance patients. Several bills were introduced to limit the nursing homes' right to discriminate against Medical Assistance recipients. The long-term care industry argued that it was an inadequate reimbursement system that created the problem of access for Medicaid patients.

Social workers in acute care facilities who functioned as discharge planners were suddenly under great pressure from their hospital administrators to discharge Medical Assistance patients to nursing homes. But these nursing homes would not take Medicaid patients — especially the heavy care patients — due to "inadequate reimbursement."

The resulting "pile-up" of heavy care patients in acute care facilities created fiscal problems for both the hospitals and the State Medical Assistance Agency.

The State Medical Assistance Program was paying over $200 per day for Medical Assistance patients receiving care in acute care facilities. Placement in a nursing home would have lowered their reimbursement to less than $40 per day. Therefore, lack of access to Medicaid beds was having a detrimental impact on the State's Medicaid budget.

The Catalyst

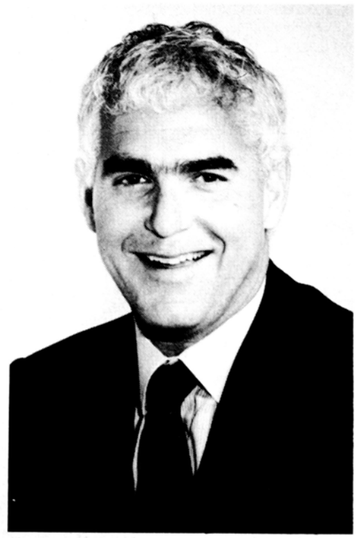
While all of these issues and concerns were discussed at many levels of the state bureaucracy, and some effort was made to alleviate some of the issues, the problem of Medicaid reimbursement had never been a major priority of the State. Not until six non-profit, principally hospital-based (for the most part, special hospitals for chronic care, and not acute care, beds) nursing homes went to the then-Acting Governor Blair Lee and key leaders of the Maryland General Assembly.

Representatives of these facilities lobbied for additional funding to make up the deficits their institutions were experiencing from the inadequate Medicaid reimbursement system.

Though the reimbursement system has always been inadequate in covering these facilities' costs, it was the constant increase in the number of Medicaid patients as a percentage of total patients that created their critical financial problems. These facilities justified the need for a special additional payment to them based on the following arguments:

Lack of access to Medicaid beds was having a detrimental impact on the state's Medicaid budget.

- They took more difficult-to-care-for patients who were seriously ill.
- They had higher staffing expenditures due to the utilization of in-house staffing (medical director, social workers, physical therapists, etc.).



Roger Liptiz played an active role in the development of the Maryland Medicaid system.

- They were distinct parts of acute care facilities or were licensed as chronic care hospitals, which further increased their operating expenditures.

During the 1979 legislative session, intensive lobbying by representatives of these facilities prompted Governor Lee to approve a line item in the state budget that provided the facilities with a "one-time grant" of $4.2 million. It was this single event more than any other that created the environment that allowed the development of the current Maryland Medicaid reimbursement system.

When this budget item was reviewed by the Senate Budget and Taxation Committee and the House Appropriations Subcommittee, it was severely criticized. One major reason for this criticism was the obvious fact that as a special payment, none of these funds were reimbursable by the federal government under the Medicaid program. The other reason was that if the executive branch of the government felt the need for a special grant, they were conceding that the reimbursement system was inadequate. It was also an admission of sorts that the Department of Health and Mental Hygiene (DHMH) had a responsibility to develop a new and more adequate reimbursement system.

The Health Facilities Association of Maryland (HFAM), representing most of the proprietary facilities in the state, as well as a significant number of non-proprietary homes, was the major provider "spokesman" during all of the deliberations regarding this issue for all other nursing homes.

The True Beginning

Even though the state political leadership had accepted the political reality of this special grant to hospital-based nursing homes, HFAM, working through its Annapolis lobbyist and legislative contacts, convinced the House Appropriations and State Budget and Taxation Committees to insert additional budget language into the fiscal year 1980 budget ordering DHMH to develop and implement a new reimbursement system which would be fair to the entire industry.

The legislation restricted the use of $1,685,988 in the Medicaid budget. This was intended to be a strong

signal to DHMH that the General Assembly would not tolerate a long delay in the Department coming to terms with the issue of access of Medical Assistance patients to nursing homes and the adequacy of reimbursement to long-term care providers.

The language included statements that the newly developed reimbursement system should assure:

- Accessibility for all Medicaid patients.
- Accessibility for the Medicaid patients who were more difficult to care for.
- A fair return to providers based on the fair value of their assets utilized in the provision of health care. (The fair return language included in this passage was the result of Maryland having a rate-setting commission which set rates for all hospital patients. This legislation included fair return language since the Attorney General of Maryland had ruled that the legislation made hospitals effectively public utilities.)

A Nursing Home Task Force on Reimbursement was created by the Department in May 1979 as a response to this legislation. The task force included representatives of HFAM, the Maryland Association of Homes for the Aged (representing many non-proprietary facilities who were not already members of HFAM), and the Maryland Hospital Association (representing hospital-based nursing homes).

By August 1979, Secretary Charles Buck of DHMH came before a joint hearing in Annapolis of the Senate Budget and Taxation Committee and the House Appropriations Committee and presented his findings. These findings included some recommendations from the Nursing Home Task Force on Reimbursement. The report identified many of the weaknesses of the reimbursement system which were expressed in the 1979 legislative session and made some striking recommendations.

1. The Medical Assistance reimbursement in Maryland should be modified and improved to minimize or eliminate the weaknesses (identified by the task force).

2. The Department of Health and Mental Hygiene should use the West Virginia nursing home reimbursement system with appropriate modifications as the starting point in the development of a reimbursement system designed to meet the specific needs of the Maryland Medical Assistance Program.

3. The Department of Health and Mental Hygiene should initiate action at the earliest possible opportunity to hire additional outside resources to develop a reimbursement system in accordance with Recommendation 2.

No new hospital-based facilities would be eligible for the special rate.

4. The Task Force should continue to advise the Secretary during the development of the new system on major policy decisions affecting it.

5. Nursing homes attached to acute care or chronic hospitals should be reimbursed under the methodology established by the Health Services Cost Review Commission (HSCRC), become part of the Medicare experiment, and remain under the system for the duration of the experiment.

HFAM generally accepted the Task Force's recommendations but expressed concern over Recommendation 5, which placed the hospital-based nursing homes under the reimbursement methodology established by the Health Services Cost Review Commission (the Hospital Rate Setting Commission). This, in effect, would raise the Medicaid reimbursement for those facilities by more than $15 per patient day over that being paid to freestanding facilities.

Things Start to Happen

After much discussion and negotiation, the legislature approved the following provisions:

- Pay full cost of six hospital-based nursing homes, effective July 1, 1980, with rates set by HSCRC. Should the HSCRC payment methodology be unacceptable to the federal government, these six facilities would receive outright subsidy grants as they received in fiscal year 1980.
- Appropriate approximately $100,000 to hire a consultant to develop a reimbursement system with a target date of July 1981 for implementation.

HB1726, which required the Medical Assistance Agency to reimburse three acute care and three chronic hospital-based nursing homes at the rates established by the Nursing Home Rate-Setting Commission, was introduced to implement Secretary Buck's recommendations, but was limited to only those six facilities. No new hospital-based facilities would be eligible for this special rate.

The fiscal year 1981 budget contained an allocation of $111,000 for a consultant contract to develop a new reimbursement system for freestanding nursing homes. This contractor would attempt to correct the weaknesses of the current system by developing a system to ensure accessibility for the Medical Assistance patients, with emphasis on the more difficult-to-care-for patients, and finally, to provide a reasonable rate of return to the nursing home provider.

The 1980 legislative session ended with $1.6 million from the Medical Assistance Budget still being restricted by the Maryland General Assembly. DHMH would have to accomplish the mandate to develop and implement a new reimbursement system before the funding restriction would be lifted.

During the summer of 1980, DHMH opened up the bidding process and obtained the services of a consultant. The consulting firm of Applied Management Sciences Inc. of Silver Spring, Maryland, was awarded the contract. They began their work on September 2, 1980.

The Applied Management Sciences report which was subsequently issued contained basically all of the components of an excellent reimbursement system. Specifically, it provided an efficiency payment in two cost centers if the providers kept their costs below certain specific levels. It encouraged nursing homes to take more difficult patients by paying substantially higher nursing rates for those types of patients. Lastly, it paid a fair rate of return for the use of the nursing home property to all providers based on the appraised value of the nursing home assets.

HFAM spent considerable time attempting to negotiate the various levels at which the reimbursement payment would be set. Specifically, they negotiated for higher ceilings in the cost centers where ceilings were employed and greater efficiency payment, along with a higher rate of return for the property payment (HFAM utilized the services of an economic consultant during the negotiations and to testify before the Maryland legislature).

Separate reimbursement ceilings were set for the cost centers based on geographic location and size.

DHMH was generally not willing to change much of the methodology to meet the concerns of the provider community. This deadlock was broken by the House leadership in the Maryland General Assembly, which stated that the consultant's recommendations would not be accepted until all efforts to resolve the differences were exhausted. Secretary Buck and key members of the Health Department and legislature met with representatives of the provider community, and the differences were "ironed out." The new reimbursement system now had the support of the legislature, DHMH, and the provider community. Implementation of the system would become a reality.

Finally . . . Implementation

The new reimbursement payment for freestanding nursing homes was implemented on January 1, 1983. Under this methodology, separate reimbursement ceilings were set for the cost centers based on geographic location and size of each nursing facility. Finally, the cost centers were:

- Administrative and Routine
- Direct Nursing Services
- Other Patient Care
- Capital Facility Investment

Patient payment for nursing care is based on the level of care required by each patient.

Many events came together to create the environment that developed the new Maryland Medicaid Reimbursement system. One such event was the incident in which the hospital-based nursing homes demanded relief from a reimbursement system that paid them far below their cost. This forced the Maryland legislature to make a decision regarding what priority should be given to improving the nursing home reimbursement system.

Once the legislature established the priority for the development of such a system, it maintained an oversight role over the Department of Health to assure that such a system would be developed which was fair to the providers. Because Maryland already had in place a rate setting commission that called for fair rates of return, both the Maryland legislature and the Department of Health felt obligated to include that policy in its new reimbursement system.

Lastly, and in some respects, most importantly, there was mutual respect on the part of all of the individuals involved in the development of the new system, including the leadership of the Maryland legislature, the Department of Health, the provider community, and the consultants who developed the new system. CA

LONG-TERM CARE INSURANCE:

Public- and Private-Sector Responses

By Herbert P. Weiss, M.A., N.H.A.

Over 20 years ago, on July 30, 1965, President Lyndon Johnson signed legislation to enact Title 18 of the Social Security Amendments of 1965. This legislation, known as Medicare, provided financing for a large portion of both hospital and physician expenses for those over 65. The elderly were now protected from fiscal bankruptcy due to acute illness.

Today, however, more and more long-term care services are needed by an older population with increased chronic disabilities; such services are not covered by Medicare. This lack of coverage and the resulting drain on the elderly's budget can clearly be seen in the results of a 1986 study financed by the National Center for Health Service Research. In this study, "it was found that 42% of the elderly's total out-of-pocket expenses are for nursing home care and that for those aged who spent more than $2,000 out-of-pocket, 81% of their additional expenses were for nursing home care" (Statement of the Health Insurance Association of America 1986).

Both the Reagan administration and Congress are acutely aware of the issue of financing long-term care. But public policymakers find themselves in a "Catch-22" situation. They see an increasing Medicaid enrollment that will exponentially increase their limited budget, but recognize the importance of promoting access to needed nursing home care. Currently, long-term care insurance purchased through the private sector is being seen as a way to protect both the financial stability of the elderly and state Medicaid budgets.

President Ronald Reagan placed the issue of catastrophic insurance on the administration's policy agenda during his February 1986 State of the Union address. In his speech, he directed Otis Bowen, M.D., secretary of the Department of Health and Human Services, to recommend ways of providing affordable long-term care insurance to the elderly, whose life savings would be threatened by catastrophic illness.

Committee Recommendations

In response, Secretary Bowen formed the Private/Public Sector Advisory Committee on Catastrophic Illness, composed of representatives of Congress, consumer groups, third-party payers, and provider associations. On August 19, 1986, the committee presented its recommendations to Secretary Bowen. In the area of catastrophic long-term health care expenses, the committee's report noted that the following options deserved careful consideration: educating the public about long-term care protection, with state and local governments taking a major role in this education; encouraging the development of private insurance policies for long-term care at skilled- and intermediate-care facilities; promoting tax-preferential IRAs and other savings arrangements to stimulate the purchase of long-term care insurance; improving data on the cost and utilization of long-term care services; encouraging practical research and demonstration projects; removing legislative barriers preventing employers from providing long-term care insurance; and expanding the scope of skilled-nursing and home health services under Medicare to include a broader range of nursing and other health services (Report to the Secretary of Health and Human Services 1986). The report made one point very clear, however—Bowen's committee was not willing to propose massive changes to the current method of financing long-term care.

Congressional Efforts

Congress, in its efforts to find a viable way to finance long-term care, established a task force to study the issue and introduced related legislation. In April of 1986, under Section 9601 of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Task Force on Long-Term Health Care Policies was created to evaluate current issues relating to private long-term care insurance. The task force report and its recommendations will be released in October of 1987 to Secretary Bowen, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Labor and Human Resources of the Senate.

Many bills were introduced during the 99th Congress (1985–86)

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UPDATE

to provide the elderly with assistance in financing long-term care, or to promote dialogue on the subject. These bills offered such options as home equity conversion; medical-expense deductions; special tax credits, deductions, and exemptions for care givers; individual health savings accounts; coordination of the Medicare and Medicaid programs; Medicare and Medicaid demonstration projects; Medicare coverage expansion; and the establishment of research, training, information, and support programs. No legislation to finance long-term care, however, was enacted during the 99th Congress.

Geza Kadar, assistant Washington counsel of the Health Insurance Association of America, provides his perception of Congress's failure to act on this issue: "The House Ways and Means Committee and the Senate Finance Committee, which have jurisdiction over changes in Medicare, did not look seriously at any bill that would have added nursing home care to the Medicare benefit structure. If anything, they were struggling desperately to try to find ways that would be politically acceptable to reduce existing promises and benefits for Medicare."

Future Trends

During the 100th Congress, more attention will be directed to the issue of financing long-term care. Political forces operating under the influence of Gramm-Rudman, however, will continue to seek reductions in Medicare benefits rather than expand the program. The Task Force on Long-Term Care Policies will have presented its report to Secretary Bowen, and this will be a major influence shaping the administration's response to financing long-term care. The administration's belief that the only realistic way to confront costly catastrophic care is through long-term care insurance offered by private companies will in all probability find its way into the task force report.

Several legislative staffers on Capitol Hill have expressed their concern, however, that the long-term care policies currently on the market can only be afforded by a small percentage of the population, leaving both the lower and middle class with no protection. They strongly believe that federal programs will become a necessity to plug the gap left by private long-term care insurance policies.

In summary, the financing of long-term care insurance is still considered by most in the insurance industry to be a new frontier. The American public, especially its younger members, will have to be educated about the fact that with old age comes a high probability of being inflicted with chronic diseases, which increases the need for costly long-term care services. Marketing long-term care insurance to corporations as a new employee benefit, and to a younger age group, may be the only realistic way to lower the current high premiums.

Once the insurance industry has had a chance to further develop, refine, and market long-term care insurance, public policymakers will be able to assess realistically who will and who will not be able to afford it. In the era of Gramm-Rudman, it still may be necessary for the government to develop, fund, and legislate programs to finance long-term care services.

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