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The primary purpose of this study was to identify the competencies needed to perform effectively as a long-term care administrator. An original list of competency statements was generated from the literature and from persons active in the field of long-term care administration. This list of 53 statements was placed into questionnaire form and submitted to a panel of 20 national experts. These experts were identified by their contributions to the field and by recommendations of organizations involved in long-term care. This research used a modification to the Delphi technique to solicit the opinions of the experts concerning each of the competency statements.

Findings

Forty-two competency statements, arranged in five job function categories, met the mean standard for acceptance and were included in a final list of long-term care administrator competencies. The five job function categories were the following: Patient Care; Personnel Relations; Budgeting and Financing; Management and Supervision; and Legal Problems and Government Regulations.

The category of Legal Problems and Government Regulations experienced the highest level of agreement among the expert panelists,

followed by the categories of Personnel Relations, Management and Supervision, Budgeting and Financing, and Patient Care, respectively. The high level of disagreement experienced in the Patient Care category was attributed to the trend of increased separation of administrative responsibilities and direct patient care.

The trend in long-term care administration, as indicated by these experts, is moving in the direction of principles associated, historically, with the general field of administration. These principles concern management of personnel and reflect less direct interaction with clientele.

THE IDENTIFICATION OF LONG-TERM CARE ADMINISTRATOR COMPETENCIES

by

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IDENTIFICATION OF LONG-TERM CARE ADMINISTRATOR COMPETENCIES

I. INTRODUCTION

The long-term care administrator is the chief executive officer of facilities which provide extended care to individuals, usually aged, who require some level of health care (Buttaro, 1977; Kahl, 1976). The competence of this chief executive directly affects the quality of health care that is provided to the clients in long-term care facilities (USDHEW, 1975). Therefore, if clients needing the services provided by long-term care facilities are to receive quality health care, it is then necessary to determine specifically what these administrative competencies are and to design educational programs capable of producing these competencies in its graduates.

Administrative thought, in general, was not formally conceptualized and seriously studied as a discipline prior to the late 1800's. The increased complexity of economic, social, and political structures that developed following the industrial revolution influenced the concern for greater efficiency within organizations and advanced the study of how people and organizations function together. The origin of administration and its genesis as a discipline worthy of study is embedded in the products industry. As the social matrix became more complex, the organization which provided services also became more complex. Traditionally, persons functioning as administrators in these organizations were either the owners or a person recognized for excellence in a particular discipline (e.g. medicine, nursing, etc.).

This evolutionary pattern is typical of the field of long-term care administration. These administrative positions were held primarily by persons with little or no background in the theoretical aspects of administration. Public criticism of the quality of care being provided in long-term care administration provided the impetus for federal legislation (Medicare and Medicaid) which specified that licensing procedures for long-term care administrators be enacted in states receiving federal funds under the Medicare and Medicaid amendments (Mass, 1977; USDHEW, 1975; Vladeck, 1980, Yokie, 1977). The response in the field of long-term care administration to these policy mandates has, during the past one and a half decades, focused on compliance. The field of long-term care administration has spent minimal time and effort on introspection to determine the body of knowledge, skills, and competencies needed to be an effective administrator. The rapid growth in the service industry and the increasing complexity of the entire health care delivery system have required the preoccupation of the efforts of personnel in this field.

This study is intended to focus attention on administrative activity in the field of long-term care administration by identifying the competencies deemed necessary to function as an effective long-term care administrator. The product of this process will enhance the understanding of the theory of administration in the field of long-term care administration at this point in time.

Origins of the Problem

The Social Security Act of 1935 attempted to reduce the financial

burdens on the aged population of the United States by providing a system of fiscal support for individuals not housed in public institutions. The effect of this legislation was an increase in the number of for-profit boarding homes which eventually added nurses to their staff and became known as "nursing homes" (Moss, 1977). These homes, in general, were developed from the conversion of private family dwellings into facilities with relatively few beds that provided extended care to elderly clients. The persons operating these small extended-care facilities lacked educational and experiential backgrounds in the field of administration; thus the lack of administrative experience has persisted in this field. According to research conducted by the United States Division of Health Resources Statistics in 1969, sixty-five percent of nursing home administrators surveyed had no previous experience in any type of administration prior to their current position (Brown, 1973).

With the eventual acceptance of the nursing home as an integral part of the health care delivery system and concomitant social and economic changes, rapid growth in the numbers of nursing homes in the United States occurred. This growth was given further impetus by the 1954 amendments to the Hill-Burton legislation (United States Public Health Services, 1971), which authorized funds for the construction of nursing homes providing skilled care. Subsequently, nursing homes increased 1400 percent during the years 1960 to 1970 alone (United States Congress, 1974).

This increased demand for long-term care is expected to continue. To meet long-term care facility needs, the United States Department

of Housing and Urban Development (HUD) (1972) made the following estimates:

1) add an estimated 140,000 new skilled nursing home beds each year to meet the increase in "65 and over" population,

2) replace and upgrade approximately 240,000 beds in facilities which are below established standards, and

3) help bring these health care services to the financially disadvantaged.

The Congressional Budget Office (1977) also estimated that client demand for long-term care in the next ten years is expected to increase 34.5 percent, or almost two million persons per year. These projections emphasize the continued, and even escalated, importance of the role of the long-term care administrator in the health care delivery system in the United States.

The event that has influenced the role of the long-term care administrator more than any other single phenomenon was the passing of the 1967 Title XIX (Medicaid) amendments to the Social Security Act. This amendment required states receiving Title XIX money to have some process for licensing of long-term care administrators (Gustafson, 1977). The objective of this legislation was to insure at least a minimum level of administrative skill in order to enhance the quality of administrative practice and, thus, quality of patient care. Participation by states in Title XVIII (Medicare) programs was also included in the legislation concerning licensing of long-term care administrators and further standards, or conditions of participation, were written (Federal Register, January 17, 1974).

Legislatively-mandated licensure regulations have not been

effective. These regulations establish only minimum requirements and consequently each state interprets these requirements and develops its own regulations. As a result, little uniformity exists among the states in their educational or inservice requirements for licensing of long-term care administrators (American College of Nursing Home Administration, 1976). Additionally, the type of educational background required for licensure varies from state to state. For example, in Oregon the education and experience requirements for licensure of long-term care administrators is varied and can be met in the following ways: 1) high school degree or General Equivalency Diploma (GED) plus three years of experience out of the last five years with administrative responsibilities in planning, organizing and directing the operation of a licensed long-term care facility after having reached age 18; 2) registered nurse (RN) in Oregon plus one year of experience out of the last five; 3) licensed practical nurse (LPN) licensed in Oregon plus two years of experience out of the last five; 4) completed two years of college and is working continually toward a four-year bachelor's degree plus two years of experience out of the last five years; 5) hospital administrator for five years plus one year of experience out of the last five years; 6) physician or osteopath licensed in Oregon plus six months of experience; 7) a four year college degree plus six months experience out of the last five years; 8) a master's degree in nursing home administration plus internship; or 9) has had three years of experience out of the last five years and within the last year has attended workshops, seminars or training opportunities in long-term care

(Oregon State Health Division, 1979).

Bellande (1977), an administrator for a nursing home corporation, commented that it is difficult to recruit qualified health care administrators, and that there is a lack of universal standards for the development of educational programs to train health care administrators. Kleppick (1975) urged that studies needed to be undertaken to identify the dimensions of the job so that educational institutions could more effectively develop their programs in this field. Norris (1973) added that "we must face the fact that, to date, there has been no significant supply of prepared students coming from the academic community to assume the position of long-term care administrator" (p.7).

In essence, then, the problem of identification of competencies of long-term care administrators originated in the late 1960's when federal legislation was put into effect and mandated regulation and control of persons entering this field.

The overall purposes of this study were to generate new information, vis-a-vis the competencies of this position that would be useful to educational institutions, official agencies and the professionals involved in the improvement for the long-term care clients.

Need for the Study

The need to identify long-term care administrator competencies originates with the increased complexity of the position during the past decade and with the need to identify and validate information which would be helpful in making decisions concerning education and

licensure of long-term care administators. Burmeister (1977) and Yokie (1975) both point out the meagerness of information in the literature regarding long-term care administration and Kahl (1976) addresses the need specifically in her statement that "the body of knowledge and preparation needed by nursing home administrators is not clearly defined and people with many different types of backgrounds enter the field" (p.36). The need to identify the "body of knowledge and preparation needed by nursing home administrators" was also suggested in the introductory report of the Long-Term Care Facility Improvement Study conducted in 1975 by the United States Department of Health, Education and Welfare.

In 1974, the Foundation of the American College of Nursing Home Administrators undertook a national study to develop a profile of, certification procedure for, and a continuing educational model for long-term care administrators (Burmeister, 1977; Yokie, 1977). A recommendation of this study was that further "studies should be pursued toward establishing that most important relationship between the credentialing process and competent job performance" (Burmeister, 1977, p.44). Through the identification of competencies of long-term care administrators and the development of a valid set of statements, future comparative studies, as suggested by Burmeister, could be pursued.

The increasing internal and external complexity of the health care delivery system, in general, suggests a concomitant increase in the complexity of the long-term care administrator's job and the need for educational institutions to consider these aspects when developing their curricula in this field. Kleppick (1975) suggested

that studies need to be undertaken to identify requirements of long-term care administrators so that educational institutions can more effectively develop training programs in this field. Concerning the relationship between education of the long-term care administrator and its effect on the delivery of services, Dickler (1974) lists five a priori assumptions:

1) That administration determines the quality of care provided by an organization.

2) That the better the administration, the better the quality of care.

3) That administration is determined and controlled by the administrators (not the owners).

4) That minimum standards for administrators will insure that we have better administrators.

5) That the most important factor in fulfilling standards and developing administrators is education.

The extent to which this study would contribute to a more concise description of the body of knowledge of long-term care administration and a clearer definition of the educational needs for training long-term care administrators was the measure of the need for this study.

Statement of the Problem

The primary purpose of this study was to identify the competencies deemed necessary to perform effectively in the provision of quality care to residents in long-term care institutions.

A secondary objective of this study was to develop an instrument which could be used in future comparative studies in the field of long-term care administration.

The identification of such competencies, and the formulation of an instrument for future comparative studies would be useful in the following ways:

1) as a basis for curriculum development in undergraduate and graduate colleges and universities;

2) as a basis for developing in-service programs for long-term care administration practitioners;

3) as a basis for determining educational requirements for long-term care administrator licensure; and

4) the final instrument could be used for future comparative studies on a local, regional, or national basis.

Approach to the Problem

As a basis for formulating and compiling long-term care administrator competencies a thorough search of the literature in the field of long-term care administration was completed. These competencies were arranged in five categories suggested by Burmeister (1977).

The competency statements were then placed into a questionnaire format with six levels of response ranging from strongly disagree to strongly agree. The questionnaire was pretested by a sample of eight experts in long-term care administration in Oregon. The pretest results suggested minor changes to improve clairty of writing, understanding of the statements, but no new statements were added.

The next phase in this research involved the identification of a group of people, on a national basis, to serve on an expert Delphi panel. The experts were identified by their contributions to the literature in the field of long-term care administration and from suggestions by persons representing practitioners, official agencies

(federal and state), educational institutions, and professional associations for long-term care administration.

Sixty persons were identified as national experts in this field. Excluding three persons who were included in the pre-test, the remaining 57 individuals were contacted by mail and requested to participate in this research; 20 accepted.

The questionnaire instrument was sent to each of the expert panelists for their response. Following the return of the questionnaire from all 20 participants, the responses were statistically analyzed. The expert panel generated three new competency statements which were added to the questionnaire instrument which, along with a summary of questionnaire #1, was sent to each of the panel members.

Nineteen of the expert panelists completed round two, the final round, of this process. Questionnaire #2 was statistically analyzed and each statement was evaluated to determine if it, at least quantitatively, fell within the agree category. This identification was determined by evaluating the mean levels to determine if the mean of all responses on each statement realized a mean level of 4.80 or better. Those statements failing to meet this standard of acceptance were deleted from the final list of competency statements.

Limitations of this Study

This study is limited:

1) In that long-term care facilities may provide both Medicare and Medicaid designated Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) beds. This study will not attempt to distinguish between administrative competencies required within each designation.

2) To the extent of the usefulness of the Delphi technique as a method of eliciting expert opinion.

3) By the judgments of the participants of this study.

4) By the paucity of research in the field of long-term care administration.

5) In that competencies of long-term care administrators may vary by size of institution. This study will not attempt to distinguish administrative competencies required in different-sized institutions.

Basic Assumptions of This Study

The basic assumptions of this study were as follows:

1) Specific competencies of long-term care administrators could be identified.

2) Experts in the field of long-term care administration would be identified who would be willing to participate in this study and whose judgments would be considered valid.

3) The judgments of the expert jurrors would be representative of the general field of long-term care administration.

4) A modified Delphi technique would be an effective process for determining long-term care administrator competencies.

Definition of Terms

Specific terms important to this study are defined as follows:

1) Board of Examiners of Nursing Home Administrators: A board of nine persons appointed by the Governor of Oregon to serve three year terms of appointment with the charge of implementing the responsibilities outlined in Oregon Revised Statute 678.820, Duties and Powers of the Board. In general, this board is responsible for licensing nursing home administrators in Oregon.

2) Competency: The maintenance of adequate, current knowledge of the techniques and principles of the professions, including efficient work habits, effective organization of work, professional responsibility and self-discipline (Blockstein, 1966).

3) Delphi Panel Expert Panel): A group of individuals, recognized for their contribution to the field of long-term care administration as determined by their peers, publications, professional offices held, or administrative position in a professional organization.

4) Delphi Technique: A research procedure developed by the Rand Corporation to obtain consensus of opinion without bringing the experts together in a face-to-face confrontation.

5) Health Care Administration: Planning, organizing, directing, controlling, and evaluating the resources and procedures by which needs and demands for health and medical care and a healthful environment are fulfilled by the provision of specified services to individualized clients, organizations, and communities (The Commission on Education for Health Administration, 1975).

6) Intermediate Care Patient: A patient who, in the judgment of the attending physician, is not a skilled patient but who requires preventive care with less than continuous licensed nursing care observation (OAR 33-23-700, 1980).

7) Long-Term Care Administrator: A person who is licensed by the officially recognized body, who is under the overall direction and control of and is responsible to the governing body, and who is responsible for planning, organizing, directing, and controlling the operation of a nursing home (long-term care facility) (OAR 333-23-700, 1980).

8) Long-Term Care Facility: Permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Division (of Health), to provide treatment for two or more unrelated patients (OAR 33-23-700, 1980).

9) Skilled Care Patient: A patient who, in the judgment of the attending physician, requires rehabilitative service and/or continuous daily licensed nursing care and/or observation (OAR 333-23-700, 1980).

10) Generic Administration: "The guidance, leadership, and control of the efforts of a group of individuals toward some common goal," (Newman in Wren, 1979; p.44). The elements of administration include planning, organizing, directing, staffing and controlling.

II. REVIEW OF RELATED LITERATURE

There is a paucity of literature in the field of long-term care administration at this point in time. Several factors which contribute to this meagerness of writing activity are: 1) historically the background of long-term care administrators has been experiencial rather than academically oriented; 2) long-term care administration is an emerging profession with a relatively short history; 3) little scientific research has been accomplished with a focus on long-term care administration; and 4) increased educational requirements for entrance into the profession were mandated by federal law within the last 15 years.

This review focused on literature directly concerned with long-term care administration and attempted to identify the trends in administrative thought in this field. The genesis of long-term care administration was not spontaneous but was part of an evolutionary process that resulted from the convergence of what people were already doing as long-term care administrators with the theoretical notions that were being formulated through the scientific process by persons in the product industry. To say that the convergence of theory and practice in long-term care administration has been achieved would be erroneous. The degree of accomplishment of this phenomenon will be decided in the future.

The review of related literature was directed at identifying those factors which have had impact on the formation of competencies deemed necessary to be an effective long-term care administrator.

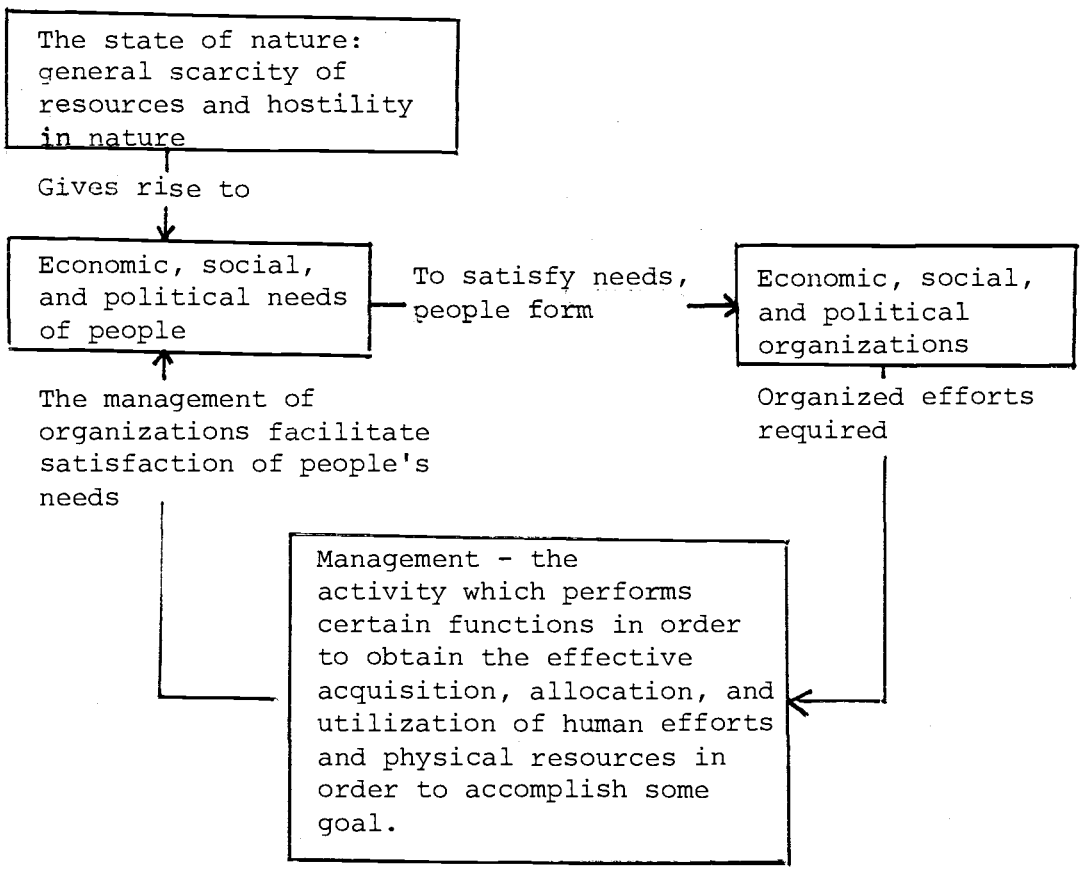
This review of related literature will start with a brief examination of the generic field of administration from which administrative theories have evolved and which historically has been product oriented. The second perspective examined will be administrative responsibilities in a service industry (health care) as opposed to a product industry. Finally the literature dealing specifically with long-term care administration will be presented from both historical and current perspectives.

Influences on Long-Term Care Administration

The evolution of administrative theory began when people first gathered in common places and assumed differentiated roles that helped accomplish some common goal. This cooperative effort was manifested to increase the working capacity and thus the production of the group. The cooperation effort led to a stratification of tasks and the development of a crude hierarchy and the establishment of a leader based on a valued trait such as strength, wisdom, age, etc. (Wren, 1979).

Wren's (1979) model of the Cultural Environment provides a succinct description of the logic in the development of management (administration) and organizations.

THE CULTURAL ENVIRONMENT



(Wren; 1979; p.10)

As civilization became more complex increased administrative roles, were assumed, vis-a-vis government, churches, military, etc. The concern, however, in this evolutionary process focused on outcomes and not on the theory and principles by which these outcomes were achieved. The industrial revolution provided the impetus for change in focus and advanced the development of administrative theory. The literature in the field of administration cites several individuals whose works provided the foundation for administrative

thought. Included in these citations are the works of Andrew Ure, Charles Dupin, Robert Owen, Charles Babbage, Henry Fayol, and Max Weber who first advanced administrative thought in the industrial setting in England and Europe (Wren, 1979). In the United States, early administrative theory was developed through the efforts of Fredrick Taylor, Luther Gulick, Lyndall Urwick, Mary Follett and Chester Barnard to name only a few of the prominent theorists (Austin, 1975; Bennis, 1966; Gross, 1964; Gulick and Urwick, 1937, Wren, 1979).

Taylor is generally recognized as the father of scientific management. He scientifically and systematically evaluated production efforts to establish processes that would bring about greater efficiency in production. During the early 1900's Taylor's theory served as the focal point for the advancement of administrative thought. The field of psychology also contribured to this stage of development and gave rise to the branch of psychology known as industrial psychology (Wren, 1979).

Gulick (1937) identified the functions of the chief executive in his famous acronym POSDCORB. The initials stand for planning, organizing, staffing, directing, coordinating, reporting, and budgeting. Gulick developed his functional model from Fayol's earlier elements of management which included planning, organizing, commanding, coordination, and control. The principles identified and expanded by Fayol and Gulick remain in contemporary literature in the field of administration.

The next phase in the evolution of administrative thought

focused on the human element within the context of organizations. Major contributors included Mary Follet, Elton Mayo, Chester Bernard, Fritz Roethlisberger, and Herbert Simon (Bennis, 1966; Etzioni, 1964; Gross, 1964; Wren, 1979). Researchers began observing and researching human behavior in relation to the success of social and organizational goals. The fields of sociology, psychology, and anthropology played major roles in the emergence of theories of people in organizations. It is interesting to note that this historical era was initiated in the 1930's and the 1940's (Gross, 1964; Wren, 1979).

The "Modern Era" of administration began in the 1950's with the work of William H. Newman who described administration as "the guidance, leadership, and control of the efforts of a group of individuals toward some common goal" (Newman, 1951; p. 1; Wren, 1979). Again, Fayol's and Gulick's ideas remain in the works of the modern writers and are fundamental to Newman's views.

The modern era experienced a proliferation of ideas and approaches to management (administration) and prompted Koontz (in Wren, 1979) to identify six major groups of management thought:

1) The management process school "perceives management as a process of getting things done through and with people operating in organized groups."
2) The empirical school identified management as "the study of experience"...
3) The human behavior school, variously called the human relations, leadership, or behaviorial science approach.
4) The social system school saw management as a system of cultural interrelationships in which various groups interacted and cooperated.
5) The decision theory school concentrated on analyzing and understanding who made decisions, how they were made, and the entire process of a selection of a course of action from among various alternatives.

6) The mathematical school viewed management as a "system of mathematical models and processes" (Wren, 1979; pp. 455-456).

Although referred to as schools, Loontz suggested that these six groups were management tools and that each provided insight into a better understanding of management theory in general.

Further evolution of administrative thought in the 1960's brought about "general systems theory" and "comparative administration" (Wren, 1979). Systems theory focused on the interrelationship of the parts of an organization while comparative administration was "the attempt to analyze and integrate administrative concepts from cross-cultural, cross-institutional, and cross-disciplinary points of view" (Wren, 1979; p. 464). With the approach of the 1980's focus on systems theory and comparative administration dimmed; and the notion of situational or contingency theory surfaced. The basis of contingency theory, as developed by Fiedler (in Longnecker, (1977), suggests that effectiveness of leadership may vary depending upon the situation or circumstances in which leadership is exercised.

Wren (1979) summarizes the status of management (administrative) theory in his statement:

> The search continues for unity in theory, harmony in organizations, and orderliness in problem solving and goal attainment. It is this search that makes the study of management most worthy of intellectual and practical exercise. Management is one of the most dynamic of all disciplines; as technology, institutions, and people change, our ideas of management evolve in order to cope with our oldest problem - the allocation and utilization of scarce resources to meet the manifold desires of human society. Today is not like yesterday, nor will tomorrow be like today; yet today is a synergism of all our yesterdays, and tomorrow will the the same (p.561).

The field of administration was also influenced by professionals in other fields, such as social science, political science, psychology, anthropology, economics, history, philosophy, and natural science. The expansion of ideas presented by these specialized fields raise the question of the degree to which the principles of general administration can be effective in a variety of specialized settings.

Health Care Administration

Austin (1975) pointed out that the major management theories first developed and articulated by Taylor, Fayol, Gulick, Simon, Mayo, Follett, McGregor, and Bernard focused on inward organizational structure, as opposed to recent theories advanced by Gouldner, Parson, Etzioni, Blau, Scott, and Bennis, which focused on external organizational relations. Applied to the health care field, both perspectives are essential. Concentration on the inward organizational structure is necessary to fulfill the operational tasks of the facility in the process of meeting the immediate needs of the clients, and external organizations, and groups that contribute to the delivery of services in one particular setting.

Richardson (1975), in a paper prepared for the Commission on Education for Health Administration, stated that both generic administrative knowledge and knowledge peculiar to the health field should be part of the health administrator's background. He suggested that generic administrative knowledge includes knowledge of social organizations, human behavior, economic relationships,

political processes, planning, budgeting, accounting, and quantitative methods. Under health knowledge, Richardson includes knowledge of health programs, agencies and institutions; an understanding of methods of organization, financing, and control of person and community health services; and a knowledge of social organizations, economic and political processes dealing with the health field.

Weaver (1975) suggested that the complexity of the health care delivery system, as it interfaces with bureaucratic and ancillary organizations, has given impetus to the development of the professional health administrator. The Commission on Education for Health Administration (Austin, 1975) stated that health administrators must demonstrate a level of competency that compares favorably with other providers of direct health services and defines health administation as:

> Planning, organizing, directing, controlling, and evaluating the resources and procedures by which needs and demands for health and medical care and a healthful environment are fulfilled by the provision of specified services to individualized clients, organizations and communities (p. 149).

This definition includes four of the five dimensions most often listed in the literature as generic administrative functions: planning, organizing, directing, and controlling. The fifth element usually included is staffing and is implied in this definition in the statement concerning "the provision of specified services."

Austin (1975) defined health administration in terms of actions, and states:

> In simple terms administration in the health delivery system can be viewed as the process of converting a set of inputs

> (needs, demands, resources, and others) into a set of outputs (services rendered to clients, plans for new services and others) with success and/or failure at the outstage influencing future input through positive and negative feedback (p. 143).

In this definition, input includes the need and demand for health services, community values, formal regulations imposed by external authorities, and power inputs which are largely determined by the political process. Austin specified three dimensions of outputs; services received by the client and the outcome of these services; evaluation of services provided, and planning of new or modified services; and the explicit and implicit communications to the community and clientele by the providers of health care. Input, conversion, and output are affected by socio-economic, political and technological factors which contribute to, or distract from, the provision of health services, although the director has no control over these factors.

The question that arises concerning health care administration is: is health care administration different from generic administration? Austin (1975) identified several qualities of the health care system that require unique administrative competencies: (1) the services of the health care industry must be individualized and cannot be mass produced; (2) persons that work in the health care industry are the most professionally credentialed among all industries; and (3) the health care industry is extremely complex, having a pluralistic base with which all facets of the system interface with each other as well as with agencies outside of the system.

Richardson (1975) also supports the position that health care

administrators perform unique administrative functions and ascribes this uniqueness to the fact that the health care administrator's role involves the physical, mental, and social well being of his/her clients.

The principles upon which health care administration is based can be traced to the fundamental principles of generic administration; however, the individualized nature and the comprehensiveness of the services provided support the contention of some health care professionals that health care administration is unique. It was even argued by Weaver (1975) that during the next decade administrative roles within each category of health care (i.e. acute care facilities, long-term facilities, etc.) will become more distinctive.

Long-Term Care Administration

Historical Development

To understand the role, responsibilities, and competencies needed by long-term care administrators requires an understanding of the historical development of long-term care facilities themselves.

The evolution of the long-term care facility reflects social, political, and technological changes that have occurred during the last two centuries. In that time, members of societies have increasingly acknowledged a responsibility to the aged and/or suffering within their societies. Many factors have helped focus and sharpen this understanding. The first such attempt at caring for those less privileged where the "almhouses" begun during the renaissance in Europe. Almhouses were developed as a means for housing social

outcasts of the times (Schneeweiss, 1974). Although crude by any standard, the lack of humane conditions in these institutions is thought to have been central in developing the social fear against a lack of financial planning and subsequent dependence upon society for subsistence (Moss, 1977; Schneeweiss, 1974). In turn, much attention was drawn to ways that a society could care for its less fortunate members. With increased organization, various institutions and facilities evolved to care for those isolated from the mainstream of society. Flop houses in city slums housed alcoholics as well as the poor; urban hotels, apartments, and multiple family dwellings became crude precursors to the long-term care facility of today (Moss, 1977; Rogers, 1974).

Among many other factors, the industrial revolution and advancement in technology promoted population mobility. This movement weakened traditional family support networks and increased the likelihood of social provision of care for the elderly and infirmed (Moss, 1977).

During the twentieth century advances in medical technology influenced the demographic characteristics of the population. The percentage and numbers of the aged population has increased measurably. In 1900, four percent (approximately three million people) of the population of the United States was over the age of sixty-five. Today, that figure approaches ten percent or 20 million people (Brotman, 1974; Moss, 1977).

Collectively, the above-mentioned forces, among others, signaled the need for facilities which provided more than just a place to

reside (Rogers, 1976). As a result, facilities that provide nursing care were established by fraternal organizations, churches, and private individuals converting family residences into "mom and pop" types of shelters (Report on Joint Legislative Task Force on Nursing Homes, 1978).

The Social Security Act of 1935 represented a significant change in the direction of long-term care facility development. The 1935 act introduced the influence of the federal government directly into the health care delivery system of the United States. In general, this legislation attempted to provide supplemental financial assistance to the aged and encouraged them to live in their own homes or in private facilities. In effect, this act caused the rapid development of "for-profit" boarding facilities which eventually added nursing services and became known as "nursing homes" (Moss, 1976).

Coupled with this original Social Security legislation, the increase in the proportion of the population in the aged category, the inability of adult offspring to accomodate their parents, and the absence of the other types of facilities have been cited as reasons for the increased number of nursing homes in the United States during the past 25 years (Winston, 1977). The period 1960 to 1975 highlights this phenomenal growth. The number of nursing homes increased 140 percent with the majority (approximately eight percent) operated on a "for-profit" basis and approximately one-third of these are supported through the federal programs of Medicare and Medicaid (Moss, 1977).

Garlin (1973) points out that through the 1965 Medicare and

Medicaid legislation (amendments of the original Social Security Act of 1935) public responsibility for nursing home care for the aged has been substantially increased. As federal involvement has been expanded, standards for performance within these institutions have also been established. This represents the government's initial entry into standards for providers of health care (Garlin, 1973).

Such federal standards have also influenced the trend in ownership by large chain operation, primarily because small family-owned operations have difficulty meeting compliance standards (Townsend, 1977). With these changes in ownership, administrative trends also have been influenced. The "owner-operator" facility is increasingly being replaced by the professionally trained and licensed administrator hired by "for-profit" corporations (Rogers, 1976).

In summary, the movement toward today's modern, long-term care facility, staffed by trained and often licensed professionals, is the product of a variety of influences from social and legislative forces. Once a small cottage industry, the current demands of this complex setting require broad-based skill and advanced professional training.

The Long-term Care Setting

The long-term care setting in which any administrator functions determines the role he/she will be required to fulfill, and the competencies needed to complete the tasks of this role (Coggeshall, 1973).

To date, the most comprehensive study describing the long-term care setting is the National Nursing Home Survey conducted and

reported by the National Center for Health Statistics (Series 13 and 17). This study conducted between August 1973 and April 1974 involved a random stratified sample of the 15,700 nursing homes in the United States. The general findings of this survey are outlined below: (Vital and Health Statistics, Series 14, Number 17).

a) Seventy percent of all existing nursing homes were constructed for that purpose.

b) Approximately eighteen percent of current facilities were originally constructed as private dwellings.

c) Ninety-three percent of the nursing homes have a minimum age requirement (Three-fourths listed twenty-one or younger as the minimum age.)

d) Seventy-four percent of the nursing homes are certified under federal legislation (Medicare or Medicaid) as extended care facilities, skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

e) Non-certified nursing homes housed thirteen percent of all nursing home patients.

f) Sixty-eight percent of non-certified facilities have bed capacities of under fifty.

g) In eighty percent of all certified nursing homes, Registered Nurses (RN's) are in charge of one or more shifts, compared with forty percent in non-certified homes.

h) Resident costs were lower in the smaller facilities with an average of $479. Sixty percent of this money was directly provided by public funds, forty-eight percent using Medicaid as the primary source.

i) Seventy-one percent of the residents received care from private physicians, twenty-three percent by physicians on staff at the home or as contracted employees for the home.

j) In a majority of homes (fifty-six percent), an RN was responsible for the daily supervision of all clinical services with an additional seven percent being assumed by administrators who were also Registered Nurses.

k) Sixty-nine percent of nursing homes provided some form of rehabilitative service by a professional therapist or counselor. The survey also indicated that the larger the home the greater the possibility of rehabilitative services being supplied.

l) Seventy-two percent of the homes maintained waiting lists with the greatest percentage (fifty-five percent) having between one and ten persons on the list. Larger homes tended to have the largest number of people on their waiting list.

m) Approximately two-thirds of the nursing homes had only one or two beds in seventy-five percent of their rooms.

n) The average bed capacity in a nursing home was seventy-five. Relative to certification, the non-certified homes averaged forty-five beds while the Medicare/Medicaid certified homes averaged one-hundred-five beds.

Burmeister (1977) reported that the typical facility was a 74 bed, proprietary facility receiving some portion of their revenue from Medicaid and the remainder from direct patient payments. Additionally, the smaller, non-profit, and government facilities employed a higher proportion on non-clinical employees (housekeeper, maintenance, clerical, etc.) than other types of facilities.

Clearly, the difficulty in providing strong effective leadership for long-term care facilities is directly related to the unique multi-faceted nature of the facilities and their daily operation.

Administrators and Quality of Care

The long-term care administrator position is one of several administrative positions in the health care delivery system that directly affects the quality of health care provided to patients (Goldblatt, 1977; Buttaro, 1977; Weaver, 1975; Pursley, 1976).

In recent years a great deal has been written about the quality of care in nursing homes. Testimony before the Senate Subcommittee

on Long-Term Care was heard over a seven year period. The results of these hearings led the committee to conclude that fifty percent of the nursing homes in the United States are substandard (Moss, 1977; United States Congress, 1976). To a large extent this failure seems to come from inadequate administrative leadership. For example, Moss (1977) contends that "of paramount importance to the quality of care is the administrator's ability to inspire his staff, to create the kind of harmony, unity of purpose, and spirit which makes a great symphony orchestra..." (p. 202).

A study of long-term care facilities conducted by the Department of Health Education and Welfare supports Moss' position on the impact of the administrator on the quality of care by the statement that "the administrator and/or director of nursing set the climate and working tone in most of the homes, affecting significantly the level and quality of patient-care" (Long-Term Care Facility Improvement Study: Introductory Report, 1975). The problem remains, however, that states often license persons who are ineffective administrators who do not carry out their responsibilities. A specific recommendation is that additional studies be undertaken to determine the body of knowledge and preparation needed by nursing home administrators.

Goldblatt (1977) stated that "the selection of the administrator, nursing director, and activity director is the single most crucial factor in differentiating homes of high quality from those which are merely adequate or worse" (p.78). Schneeweiss (1974) also writes that the administrator is the team leader and his actions directly affect the quality of patient care. Charles Miller, former chief,

Health Facilities Services, Oregon State Health Division, stated that where there is incompetence in either the administrator or the director of nursing services, the facility will be ranked as borderline or poor. This observation is based upon the number of demerits received in nursing home inspections.

Attempting to address the problem of improved leadership, the Multhomah County Oregon's Nursing Home Assessment Project (1977) determined that quality of care in nursing homes involved five general areas: administration, staffing, medical and nursing care, sanitation and safety, and psychological care. Listed under the heading of administration are sub-categories on administrator competence, licensing and regulations attitudes toward staff and residents, and management skills. This study recommended that administrators be accountable for the quality of care provided to the patients to the same degree they are accountable for the solvency of the institution.

In general, it appears that nursing home administrator competence is considered to directly affect the quality of care provided to patients residing in long-term care facilities.

Education of the Long-Term Care Administrator

Historically, the field of long-term care administration has placed less emphasis on educational degrees and training than have other sectors of health care (Weaver, 1975). As a result, prior to 1965, a large percentage of long-term care administrators had not received any formal college education and were not held in high

esteem as administrators in the delivery of health services (Schneeweiss, 1974).

Education in the field of long-term care administration was recently stimulated through the 1967 Social Security Amendments (PL 90-248 Section 1908A) which required that states participating in Medicaid programs implement a licensure program based on education and experience (Connor, 1978; Kleppick, 1975). The educational requirement was to consider both entry-level and inservice education.

Currently all 50 states license long-term care administrators and require various levels of education, ranging from a high school diploma or its equivalent to a baccalaureate degree. Indications are that educational requirements will continue to increase and that by 1985 several states may require a master's degree as a prerequisite for licensure (Connor, 1978). The value of increased educational requirements is suggested by Miller (1979), who states that a direct relationship exists between the training of the long-term care administrator and the quality of care received by the patient.

Wasmuth (1978) comments that within nursing homes there is currently a shifting of emphasis from the previous medical model, with its concentration on diagnosis and treatment, to the social model, emphasizing assessment of human needs. This change implies the need for change in administrative preparation, which Wasmuth states should be directed towards educational experience which enhance the individual's ability to empathize with the patient, since factual knowledge alone will not insure a high quality of patient care.

The office of Long-Term Care of the Association of University Programs in Health Administration (AUPHA) identified 72 colleges in the United States offering programs in long-term care administration, with 48 of these institutions granting associate, baccalaureate, and master's degrees (Connor, 1978; Cahall, 1976). Twelve of these institutions had accredited graduate programs in health services administration. Analysis of the above survey indicates that a consistency exists between the curricula offered in the institutions and the requirements established by state licensure boards for nursing home administrators (Cahill, 1976). Still, when compared with administrators in other areas of the health care delivery system long-term care administrators have achieved fewer baccalaureate and graduate degrees (Education of Health Administration, 1975). Long-term care administrators rank lowest in education among health care administrators with only six percent holding earned bachelor degrees (Burmeister, 1977). Many of these degrees are in fields other than health care administration, such as nursing. Health administration was the academic major of approximately ten percent of the long-term care administrators. Hospital administrators, as groups, all have higher educational credentials than do long-term care administrators. Also, in long-term care administration there is usually only one administrator, as opposed to a host of assistant administrators in hospitals and other health care delivery systems.

If, as Miller (1979) suggests, a direct relationship exists between educational level and quality care of patients, then the above statements reflect the quality of care provided to patients in

various areas of the health care delivery system. This would also suggest that a need exists to increase educational requirements for long-term care administrators and subsequently require expansion in existing educational programs with curricula based on validated data.

Roles of Long-Term Administrators

Allison, Dowling, and Munson (1975) developed a Taxonomy of Organizational Activities and implemented a study to identify roles or activities that were "crucial", or essential, within four administrator positions in the health care delivery system. The four areas included the following: hospitals, long-term care facilities, clinics, and health maintenance organizations. The authors of this study drew on previous studies to develop a list of 46 organizational activities, divided into five sub-system categories:

1) adaptive activities: external (market research, product research, long-range planning, etc.)

2) supportive activities: public relations, lobbying, long-term capital, recruiting, etc.

3) production activities: decisions concerning nursing care, diet, treatment, records, etc.

4. maintenance activities: reward systems, personal problems, etc.

5. managerial activities: control, coordination, organizational relations, etc.

The results of this study indicate that the long-term care administrator role was unique among the four compared roles. This determination was based on the findings that long-term care administrator activities designated as "crucial" were the fewest among the common core identified by three other administrator positions.

Further differences were indicated by the reliance of the long-term care facilities on federal funds or external forces which formed guidelines by which the administrator functioned. Additionally, the long term care administrator experienced greater interaction with the family of persons admitted to their institution and also with the "consuming public".

The above study also found that long-term care administrators were more involved than other types of administrators in activities that were concerned with the personnel of the various departments within the organization. These activities included salary decisions; work procedures for professionals; promoting and rewarding professionals and managers; employee and management development and training; disciplining professionals and managerial employees; decisions regarding maintaining building and equipment; motivating and directing immediate subordinates and delaing with personal and interpersonal problems.

The long-term care administrator was found to be the exception when comparing managerial activities as well. Differences were attributed to the "monolithic power struggle and lack of an organized medical staff" in the long-term care facilities. Physicians provided services to patients in these facilities, but the control of the facility and the relationship with the physician was determined by the owner, or his representative.

Austin (1975) and Richardson (1975) also take the position that the long-term care administrator performs unique roles when compared

with other administrator positions in the health care delivery system.

Weaver (1975) studied 46 health care facilities in a metropolitan region of Southern California and identified administrator function, frequent problems encountered by convalescent hospital administrators, and administrative patterns unique to long-term care administrators. He found that long-term care administrators spend a greater portion of their time directly involved with patients, and the family of patients, then other health care administrators. He also points out that long-term care facilities have less elaborate heirarchies and employ smaller staffs.

In the same study, it was also found that long-term care administrators spend substantially more time interacting with organizations and persons outside of their own institution that did short-term care facility administrators. This study identified the comprehensive role of the office of health care administrator as the "principle means for the exchange of resources between the organization and its environment." Further findings confirm that the administrator must provide for the coordination of patient care with other organizations within the health care delivery system. In general, Weaver found that among all health care administrators studied, the largest percentage of work time was involved with the decisions of work assignments or problems associated with personnel. Weaver concluded that as institutions continue to become more complex in the services they provide, the functions of the administrator will become more distinctive.

Buttaro (1977) points out that the long-term care facility is

only one facet of the health care delivery system and must operate in concert with other organizations and facilities in the community. He suggests that the administrator must be involved in local, state, and national health organizations to gain and maintain a familiarization with trends and functions within this broad system. Rogers (1976) also recognizes the long-term care facility as a social organization operating within the context of the greater community and states that the long-term care administrator must be aware of relationships between the facility and professional groups, community groups and the patient.

Emphasis is placed on the importance of the long-term care administrator's ability to work with people in a team effort to accomplish the goals of the facility. Schneeweiss (1974) summarizes the role of the long-term care administrator in the following statement:

> Good administration can be defined as the accomplishment of clearly established goals and objectives by a team of individuals working in a health--care environment conducive to the achievement of maximum results. This means the primary role of the administrator of the nursing home is to get people representing various disciplines to carry out what they have been hired to do in the most effective manner possible (p. 17).

Clearly, the role of the long-term care administrator is one that requires working cooperatively with persons, and agencies, within and outside of long-term care proper. Additionally, this role became more complex because it changes as the size of the facilities change, always creating new and unique responsibilities when compared to more traditional forms of administrative practice.

Given the historical background of long-term care administration, the direct relationship between long-term care administration practice and quality of care and the critical, complex role of long-term care administrators, it is not surprising to find that the development of "competency statements" for this field has been disappointing. Most discussion of the areas of knowledge and skill necessary to administer such facilities is vague or global in nature.

As members of the health professions, long-term administrators have been subject to credentialing processes similar to those addressing physicians, nurses, therapists and similar human service professionals. The distinct difference between long-term care professionals mentioned is that entry level credentialing occurred prior to the identification of a foundation of skills and knowledge necessary to establish a baseline of competence.

Competence in a field implies that the individual has adequate knowledge of the "technical and principles" of the field and has the ability to function effectively in the performance of responsibilities (Blockstein, 1976).

As mentioned previously, attempts to identify the competencies of long-term care administrators is, at best, in its infancy. To date, three notable attempts have been made to provide a framework and/or listing of such competencies.

Kahl (1976), writing in the Occupational Outlook Quarterly, presented a list of general skill series necessary to function as a nursing home administrator. These skill areas were:

1) knowledge of personnel management

2) financial management including bookkeeping, cost accounting, purchasing, and inventory control

3) health care institution management skills

4) knowledge of legal components of long-term facilities

5) familiarity with health care delivery systems in general

6) knowledge of physiological and psychological aspects of aging

7) knowledge of rehabilitative health care

8) understanding of phychosocial and medical aspects of illness

9) personal communication skills

10) must like people and be able to deal with them effectively

11) sympathetic but decisive

12) at ease with ill people

A brief review of this listing indicates that many of the items are not, in fact, skills but are more general areas of interest, empathy, or understanding.

A second attempt at specifying long-term care administrator competencies was done by the commission on Education for Health Administration (1975). The Commission stated that health administrators must develop a competence in their field that places them as peers to providers of services in the health care and delivery system.

The Commission went on to list three areas of knowledge and skill that should be required of administrators of health care facilities. They were health and disease and organization for medical care; management skills; and knowledge of behavioral sciences as

applied to human services agencies.

The most recent comprehensive study in the field of long-term care administration was conducted under the auspices of the American College of Nursing Home Administrators. Directed by Burmeister (1977) and using data collected from 1441 facilities distributed throughout the United States, "The Practice, Certification and Education of Long-Term Care Administrators" project had three specific purposes: 1) to develop a national profile on long-term care administration; 2) to construct a professional certification program based on profile findings; and 3) to develop model continuing education programs.

The profile of long-term care administrators included demographic, biographical, education, professional, and facility data. Additionally, this study asked participating administrators to list five important aspects of long-term care administration. The data generated from this portion of the study were categorized into the following five areas:

1) Patient care (motivation of residents towards rehabilitation, maintaining good patient care, awareness of patient needs and fulfillment of needs, making a "home" for residents "away from home", provide highest quality care at least possible cost)

2) Personnel relations (attitude and performance of employees towards residents and patients, motivating people, hiring, training and returning competent staff, providing good working conditions to acheive a high standard of personnel, improve employee training program)

3) Department management and supervision (develop procedures, coordinate work of all departments in the institution, policy review and implementation, public relations in the community to educate the public on changes and advancement in nursing homes, cleanliness of home and grounds)

4) Budgeting and financing (efficient operation of the business, operating within an acceptable cost, preparation of budgets and cost allocations, keeping the beds filled, fiscal accountability, budget and control of revenues and expenditures)

5) Legal problems and government regulations (documentation of activities and services, maintain facility in compliance with current regulations, keep current with all rules and regulations, paper work)

These categories of activities are listed in order of perceived importance by the respondents in the study and provide a profile of what active long-term care administrators do in the performance of their job. The data generated from the "Practice Certification, and Education of the Long-Term Care Administrator" study will be used in the future to develop educational programs and a certification process under the auspices of the Foundation of the American College of Nursing Home Administrators, Inc.

III. METHOD OF INVESTIGATION

Data for this study were obtained from a select national panel of 20 experts in the field of long-term care administration. Panel members were located in thirteen states and eight of the ten U.S. Department of Health and Human Services regions of the United States. Panelists represented several different aspects of long-term care administration including long-term care administrators, federal authorities, state authorities, physicians, educators, controllers, gerontologists, and officers in professional organizations.

The methods and procedures used to identify the competencies required to be an effective long-term care administrator were as follows: 1) the development of a list of competency statements based on opinions of experts in Oregon and a search of the literature in the field of long-term care administration; 2) the development of a questionnaire instrument; 3) the selection of a national panel of experts; 4) the implementation of a modified Delphi technique applying two rounds of the questionnaire instrument; and 5) the statistical treatment and analysis of the data.

The Delphi Technique

The Delphi Technique is a heuristic process which leads experts toward a convergence of opinions or group consensus through several iterations or "rounds" of questionnaire completion without face-to-face confrontation. A panel of experts is selected to participate in responding to several iterations of a questionnaire (usually between two and four) which the director analyzes statistically and returns

to the panel for further response until consensus is determined to have been achieved.

The conventional Delphi as interpreted by the Rand Corporation included the following characteristics (Sackman, 1974):

a) The format is typically, but not always, a paper-and-pencil questionnaire; it may be administered by mail, in a personal interview, or at an interactive, online computer console. The basic date collection technique is the structured, formal questionnaire in each case.

b) The questionnaire consists of a series of items using similar or different scales, quantitative or qualitative, concerned with study objectives.

c) The questionnaire items may be generated by the director, participants, or both.

d) The questionnaire is accompanied by some set of instructions, guidelines, and ground rules.

e) The questionnaire is administered to the participants for two or more rounds; participants respond to scaled objective items; they may or may not respond to open-end verbal requests.

f) Each iteration is accompanied by some form of statistical feedback which usually involves a measure of central tendency, some measure of dispersion, or perhaps the entire frequency distribution of responses for each item.

g) Each iteration may or may not be accompanied by selected verbal feedback from some participants with the types and amounts of feedback determined by the director.

h) Individual responses to items are kept anonymous for all iterations. However, the director may list participants by name and affiliation as part of the study.

i) Outliers (i.e., upper and lower quartile responses) may be asked by the director to provide written justification for their responses.

j) Iteration with the above types of feedback is continued until convergence of opinion or "consensus" reaches some point of diminishing returns, as determined by the director.

k) Participants do not meet or discuss issues face-to-face, and they may be geographically remote from one another. (pp.7-8)

The Delphi Technique has been used by a number of researchers in the process of gathering data in several fields of investigation (Dalkey, 1969; Uhl, 1970; Dunham, 1971; Massie, 1973; Syhlman, 1973; Travis, 1973; Lindemen, 1975; Brown, 1978). Brown (1978) developed an instrument for identifying competencies of nurse-supervisors in small hospitals using a modified Delphi Technique and determined that this tool was appropriate in gaining expert opinion.

The modification of the Delphi Technique used in this study was similar to those suggested by Brown (1978), Travis (1973), and Gaeta (1980). Travis (1973) suggested a need for limiting the administration of the questionnaire to two rounds and Brown (1978) completed her study using two rounds to gain consensus regarding competencies for nurse-supervisors. In addition, Gaeta (1980) suggested that solicitation of reasons for agreeing to each statement were not consistent with the purposes of this type of study and increases the time and energy required of the expert panel.

The modifications to the Delphi Process appropriate to this study included:

1) The initial list of competency statements and categorical arrangements were provided to the panel of experts. As Uhl (1970) points out, this approach saves time and simplifies the expert panel's task.

2) Experts were not required to reach agreement nor was an attempt made to persuade their opinion in a specific direction.

3) The panel of experts was asked to modify statements and suggest additional competency statements.

4) The procedures used in this study were limited to two rounds, or iterations, or solicited judgments from the panel of experts.

5) Reasons for agreeing were not solicited because of the added burden this would have placed on the members of the national panel who were considered to be extremely busy people.

The modifications of the Delphi technique used in this study reflect the changes in application of this procedure since its inception during the late 1940's by the Rand Corporation (Sackman, 1974). This procedure is being used with greater frequency to do research in education and business in an attempt to increase the quality of decisions by using groups of experts (Gibson, Ivancevich, and Donnelly, 1979).

Development of Competency Statements

Sources for Development of Competency Statements

Sources utilized for the development of initial competency statements included:

1) Professional literature directly related to long-term care administration, general administration, and health care administration.

2) Interviews with practicing long-term care administrators.

3) Interviews with persons in professional associations concerned with long-term care administration.

4) Information concerning roles, characteristics and functions of long-term care administrators from national associations and accrediting bodies (e.g. American College of Nursing Home Administrators, American Health Care Association, Federal Council on Aging, and others).

Categories of Competency Statements

For organizational and analytic purposes, competency statements were arranged categorically by general job function. Several categorical arrangements were considered, including the National Advisory

Council on Nursing Home Administration's Core of Knowledge arrangement and the arrangement developed in the Foundation of The American College of Nursing Home Administrators, Inc. study titled, "Practice Certification and Education of the Long-Term Care Administrators" (Burmeister, 1977). Common categories are included in both documents; however, the more inclusive arrangement found in the latter document was determined to be more appropriate for this study. This was based primarily on the fact that the National Advisory Council's document is limited to knowledge areas, while the Foundation document includes both knowledge and on the job skills. Further, The American College of Nursing Home Administrators' study reflects a broader range of the long-term care administrator's job and, therefore, the competencies of that job. The five categories were: 1) patient care; 2) personnel relations; 3) departmental management and supervision; 4) budgeting and financing; and 5) legal problems and government relations.

Category I. Patient Care. This category concerned the long-term care administrator's actions that directly involve the client or the client's family. This included: the evaluation of client needs; the direct care provided the client; the environment provided the client; and policies which govern the client's entrance into and exit from the long-term care facility.

Category II. Personnel Relations. This category included those competencies that deal with actions of the long-term care administrator's recruiting of employees; motivation, education, and evaluation of employees; and general policies which govern the employees of the facility.

Category III. Management and Supervision. Competencies in this category included: an understanding of generic management principles; the development of procedures and policies for operation of departments; methods of evaluating the institution; and community relations.

Category IV. Budgeting and Financing. This category included competency statements concerning: annual budgets; salary policies; facility resources; investments; and payments.

Category V. Legal Problems and Government Relations. Competencies in this category included: knowledge of government licensing and certification procedures; complicance regulations; legislative trends; labor laws; patient right; and Medicare, Medicaid regulations.

The Expert Panel

Criteria for Selection of Panel

Selection of the expert panel was a difficult task. As mentioned previously, the field of long-term care administration is a relatively new professional entity. Consequently, the emergence of professional leadership in this area is also a new phenomenon. To assist in the selection of a panel at least one of the following criteria was considered:

1. The individual should be actively contributing to the field of knowledge of long-term care administration through teaching, research, and/or publications.
2. The individual should be acknowledged as a leader in the field of long-term care administration as determined by past professional responsibilities, professional affiliation, research, and publications.

3. The individual should have professional interest or experience in the field of long-term care administration and be available for the time period required to complete this study.

Procedures for Selection on Expert Panel

The following procedures were used to select the members of the expert panel:

1. Potential panel members were identified first through a review of literature related to long-term care administration. Those persons whose names were most frequently presented as authors or cited as experts in the literature were placed on a list of potential participants.

2. Professional organizations concerned with long-term administration were contacted and requested to supply a list of names of prospective panel members that meet the established criteria. (See Appendix F for a listing of organizations which contributed names of experts).

3. A final list of 60 potential panel members were identified from the above procedures.

4. A letter requesting participation was sent to each of the potential panelists inviting him/her to participate in this study. The letter included a brief explanation of the study and was accompanied by a response sheet and a stamped, self-addressed envelope (see Appendix C). A two-week response time was requested during which time 20 persons responded affirmatively. This group became the expert panel.

Jones (1973) stated that as few as ten to twelve carefully selected individuals were sufficient to explore a problem and reach consensus. Both Brown (1978) and Gaeta (1980) used 16 professional experts to comprise Delphi panels in their research in the health care field.

Preparation and Distribution of Questionnaire #1

Competency statements and categories identified through a thorough search of the literature and interviews with experts located

in Oregon formed Questionnaire #1 (see Appendix I). A six point voting scale was used to record the judgment of each expert panelist on each competency statement. The rating scale with assigned weights was as follows:

1) Strongly Disagree (SD).....1
2) Disagree (D).....2
3) Disagree with Reservation (DR).....3
4) Agree with Reservation (AR).....4
5) Agree (A).....5
6) Strongly Agree (SA).....6

In addition, panelists were instructed to provide reasons for disagreeing, to alter wording of statements in the questionnaire, and, if they chose, to submit additional competency statements.

Pre-Testing of Questionnaire #1

Prior to being sent to the national expert panel, the questionnaire was submitted to a panel of seven local professionals actively involved in the field of long-term care administration (see Appendix B). This pre-test panel was selected from persons not engaged in the data collection phase of this study and included representatives from: The Oregon State Board of Examiners of Nursing Home Administrators; the Oregon State Health Division, the Oregon Health Care Association; Oregon State University Health Care Administration Program; and practicing long-term care administrators.

The pre-test panel was contacted by telephone and letter to solicit their participation in the pre-test process. They were asked to determine if both the instructions and the competency statements were clear and concise. The local panel was also asked to complete the questionnaire and suggest additions, deletions, or changes which would improve the meaning, content, clarity, and organization of the

questionnaire. They were also asked to record the time necessary to complete the questionnaire so that the national expert panel could be apprised of the approximate time that would be required if they elected to participate. The time ranged from 30 to 60 minutes for completion of the questionnaire.

The pre-test was executed to improve the reliability of the questionnaire. Nunnally (1967), stated that several factors should be addressed to insure a minimum of measure error and include: 1) writing items clearly; 2) making test instructions easily understood; 3) adhering closely to prescribed conditions for administering the instrument; and 4) by having explicit scoring instructions.

These factors were adhered to in the administration and rewriting of the pre-tested questionnaire. Minor changes suggested by the pre-test panel were made to improve the clarity of the items. No comments were made on the instructions for filling out the questionnaire and since the questionnaire was completed correctly, it was assumed the instructions were understood. Procedures used to administer the test were effective and, therefore, no changes were considered for the administration to the national panel.

Distribution of Questionnaire #1

Questionnaire #1 was sent to each of the expert panelists accompanied by cover letters, a set of instructions and a stamped, self-addressed envelope (See Appendices G, H, and I). The cover letters explained the purpose of the study and assured each member of the panel of experts that summarized results would be used, and that their specific responses and comments would remain confidential.

Panelists were informed of the approximate time required to fill out the questionnaire and were instructed to return Questionnaire #1 within fourteen days after it was received.

Follow Up of Unreturned Questionnaire #1

Two pannelists had not returned Questionnaire #1 within fourteen days after the mailing. Each was contacted by telephone and encouraged to complete the task and both complied.

Analysis of Questionnaire #1

When Questionnaire #1 was received from all 20 expert panelists the mean, standard deviation, median and interquartile range (IQR) were calculated for each item. These descriptive statistics were computed to provide indications of the distribution of the responses on each item to the researcher, as well as to provide feedback to the expert panelists. The interquartile range (the interval containing the middle 50 percent of the responses) is used in the Delphi technique to determine consensus (Dalkey, 1967).

Preparation of Questionnaire #2

The items and their order in Questionnaire #2 were identical to Questionnaire #1 with the exception of three additional items that were recommended by the expert panelists. The three items were placed in the appropriate categories and identified as new items and distinguished by an alpha subtitle vis-a-vis I.13a, II.28a, and II.28b (See Appendix M).

Distribution of Questionnaire #2

The procedures for the distribution of Questionnaire #2 were identical to those for Questionnaire #1. Included in the second mailing were a cover letter (See Appendix L), a Summary Report of Questionnaire #1, (See Appendix J), and an Expert Panelist - Data Sheet (See Appendix N).

Panelists were asked to return Questionnaire #2 within five days. Three panelists were dunned by telephone calls and one panelist, who was unable to be reached by telephone, was sent a second complete set of materials and a dunning letter.

Analysis of Questionnaire #2

Descriptive statistics including the mean, median, standard deviation, range, and interquartile range were computed on each item. The mean and standard deviation were also computed on each category.

Statistical Comparisons of Questionnaires #1 and #2

The means of identical items on both questionnaires were compared using a t-test. The null hypothesis was that no significant differences existed between the means of Questionnaire #1 and Questionnaire #2. The alternate hypothesis was that a significant difference existed between the means on the two questionnaires. A rejection of the null hypothesis at the .05 level of significance would indicate a significant change of opinion on a particular item. No items were rejected at the .05 or .01 level of probability.

IV. RESULTS AND ANALYSIS

In order to generate and validate the competencies necessary to be an effective long-term care administrator, two rounds of a questionnaire instrument were submitted to a panel of nationally recognized experts in the field of long-term care administration. The expert panel was asked to consider and evaluate 53 competency statements that were extrapolated from the literature in the field of long-term care administration and directly from professionals in long-term care. The Delphi technique was designed by the Rand Corporation as a research process to identify group opinion without face to face confrontation by the participants. Controlled feedback to the participant is used to provide different perspectives on an issue. In this study, reasons for disagreeing with a specific statement were used as the form of feedback. The rationale for this decision was based on the premise that the national experts involved in this study have extremely busy time schedules and professional commitments which might discourage them from participating in a study that required a great deal of their time. The results of this process will be presented and discussed as follows: results and analysis of Questionnaire #2; comparisons between Questionnaire #1 and Questionnaire #2; and a final list of statements which meet the standards of acceptance identified for this study.

Results and Analysis of Questionnaire #1

The results of Questionnaire #1 will be discussed within the context of the five categories of competency statements vis-a-vis

TABLE 1

SUMMARY RESULTS OF QUESTIONNAIRE #1

Category	Statement Number	Mean	Standard Deviation	Median	Interquartile Range
Patient Care	1	4.35	1.461	4.333	4-6 (AR-SA)
	2	3.90	1.518	4.071	3-5 (DR-A)
	3	5.35	0.745	5.400	5 (A)
	4	5.10	0.968	5.300	4-6 (AR-SA)
	5	4.75	1.209	5.000	4-6 (AR-SA)
	6	4.35	1.226	4.357	4-5 (AR-A)
	7	5.75	0.444	5.833	6 (SA)
	8	5.65	0.745	5.833	6 (SA)
	9	4.10	0.968	4.125	4-5 (AR-A)
	10	4.80	1.056	4.929	4-6 (AR-SA)
	11	4.95	0.999	5.071	4-6 (AR-SA)
	12	4.90	0.968	5.000	4-6 (AR-SA)
	13	5.00	0.918	5.071	4-6 (AR-SA
Personnel Relations	14	5.05	1.276	5.667	4-6 (AR-SA)
	15	5.60	0.598	5.731	5-6 (A-SA)
	16	5.45	0.887	5.786	5-6 (A-SA)
	17	5.80	0.410	5.875	6 (SA)
	18	5.40	0.883	5.731	5-6 (A-SA)
	19	5.95	0.224	5.974	6 (SA)
	20	5.45	0.945	5.786	5-6 (A-SA)
	21	5.95	0.224	5.974	6 (SA)
	22	5.65	0.671	5.833	6 (SA)
	23	5.90	0.308	5.944	6 (SA)
	24	5.85	0.366	5.912	6 (SA)
	25	5.55	0.759	5.786	5-6 (A-SA)
	26	6.00	0.000	6.000	6 (SA)
	27	5.90	0.308	5.944	6 (SA)
	28	5.75	0.444	5.833	6 (SA)

TABLE 1 (cont.)

Category	Statement Number	Mean	Standard Deviation	Median	Interquartile Range
Budgeting	29	5.40	0.940	5.731	5-6 (A-SA)
and	30	5.25	1.070	5.591	5-6 (A-SA)
Financing	31	5.30	0.733	5.375	5-6 (A-SA)
	32	5.45	0.759	5.667	5-6 (A-SA)
	33	5.05	1.050	5.214	5-6 (A-SA)
	34	4.65	1.089	4.667	4-6 (AR-SA)
	35	4.85	1.424	5.500	4-6 (AR-SA)
Management	36	5.90	0.308	5.944	6 (SA)
and	37	5.70	0.571	5.833	6 (SA)
Supervision	38	5.85	0.366	5.912	6 (SA)
	39	5.40	0.821	5.667	5-6 (A-SA)
	40	5.85	0.366	5.912	6 (SA)
	41	5.65	0.671	5.833	6 (SA)
	42	5.05	0.887	5.100	4-6 (AR-SA)
	43	5.50	0.688	5.667	5-6 (A-SA)
	44	5.60	0.681	5.786	5-6 (A-SA)
	45	3.65	1.461	3.875	3-4 (DR-AR)
	46	4.25	1.118	4.600	4-5 (AR-A)
	47	5.85	0.366	5.912	6 (SA)
Legal Problems	48	5.80	0.410	5.875	6 (SA)
and	49	5.85	0.366	5.912	6 (SA)
Government	50	5.65	0.489	5.731	5-6 (A-SA)
Regulations	51	5.65	0.587	5.786	5-6 (A-SA)
	52	5.95	0.224	5.974	6 (SA)
	53	5.65	0.587	5.786	5-6 (A-SA)

Patient Care, Personnel Relations, Budgeting and Financing, Management and Supervision, and Legal Problems and Government Relations. The quantitative and qualitative standards described as the interquartile range (IQR) and the mean were utilized to provide indication of levels of agreement or disagreement between the panel of experts. The IQR alone indicates only the position on the six point scale where consensus is reached, but does not describe a standard for accepting or rejecting specific competency statements. The value of 4.80 or better was used to establish a quantitative point of acceptability for the means of specific competency statements. This standard places the level of acceptance at least at the "agree" level.

Table 1 presents the mean, standard deviation, median and interquartile range for all responses in each category in Questionnaire #1. Fifty-one (96%) of the statements had an IQR totally within the agree range (agree with reservations to strongly agree) and 46 (87%) statements had mean values equal to or greater than 4.80. These statistics indicate the high level of acceptance by the expert panelists of the statements generated from the literature and early interviews with long-term care administrators. Narrative responses listed in the Summary Report of Delphi Questionnaire #1 (see Appendix J) also suggest that higher ratings would have been made if competency statements would have been stated in terms of development of policies rather than direct services.

Categorical Summaries

Table 2 provides statistics computed on each category. These

statistics were computed on the collective means of all statements in each category and provides a composite analysis between each category. These data reveal that Category I (Patient Care) had the lowest level of general agreement with a collective mean of 4.842 and Category V (Legal and Government Relations) had the highest level of agreement with a collective mean of 5.711. The difference in agreement levels between these two categories clearly suggests a specific direction in perceived competencies necessary to be an effective long-term care administrator. Statements in Category I deal with direct patient services and the relationship between the administrator and the patient and their families. Category V deals with the long-term care administrator's knowledge of government rules and regulations. The level of agreement expressed by this panel of experts relative to regulations is consistent with the increased amount of regulatory activity in long-term care that was experienced during the 1970's.

It is also interesting to note that in Connor and Siebler's (1981) study, providers of long-term care suggested that regulatory paperwork interfered with patient care. The question that arises then concerns the expert panel's agreement that long-term care administrators should be competent in the knowledge of regulations, but had a much lower level of agreement about the administrator's involvement in patient care activities. It has been suggested in the literature (Goldblatt 1977; Moss 1977) that the quality of patient care is directly related to the competence of the administra-

tors. The level at which the administrator impacts on the quality of patient care then is suggested to be at the policy level rather than at the level of direct services.

Both Categories II (Personnel Relations) and V (Legal Problems and Government Relations) had collective mean values approaching the "strongly agree" position on the response scale. All of the statements in both categories had mean values about the 4.80 level. The remaining three categories, I (Patient Care), III (Budgeting and Finance), and IV (Management and Supervision), had at least one statement that failed to meet the mean standard of 4.80.

Category I. Patient Care

In Category I, five competency statements (1,2,5,6, and 9) did not achieve mean ratings equal to, or greater than, the designated acceptance level of 4.80 (See Table 1). Two of these statements (2 and 5) concerned the provision of direct patient services; two statements (1 and 6) dealt with working with the director of nursing services (D.N.S.) in the supervision and evaluation of patient services; and one statement (9) concerned a knowledge of competency in the areas of anatomy and physiology.

Responses on Statement 2 (meet with and motivate patients toward rehabilitation) indicated a lack of agreement that administrators should be competent to provide direct patient services in the form of motivation. It was pointed out that in large institutions, this procedure would be impossible and that basically it is a competency that is expected of care givers in the long-term setting.

Although several respondents indicated agreement with Statement 5 (work directly with the patient's family) (see Appendix J), the mean value of 4.75 was below the standard of acceptance. The experts who disagreed with this statement explained that the administrator would become involved with the patient's family when problems could not be resolved at another administrative level (e.g. D.N.S., etc.).

The low mean rating of 4.35 computed on Statement 1 is explained by the expert panelists as disagreeing with the idea that an administrator needs competence in the determination of patient needs. Formulation of policies and evaluation of effectiveness at the departmental level were listed as administrator roles concerning patient care.

Statement 6 dealt with the realtionship of the administrator and the D.N.S. The respondents indicated that separate competencies are required by administrators and directors of nursing services. Hall (1981) stated that the D.N.S. is responsible for direct patient care and this territory should be avoided by the long-term care administrator.

Responses to Statement 9 (understand anatomical and physiological principles of patient care) suggest that an understanding of these principles might be helpful, but should not be a required competency of a long-term care administrator. Again the respondents point out that this knowledge base is associated with direct patient care and requires additional technical training.

It is interesting to note that the responses to each of the statements (9, 10, 11 and 12) concerning knowledge of principles associated with patient care were near or below the acceptable mean value. The Occupational Outlook Quarterly (Kahl, 1976),a publication which describes the preparation needed in a wide array of occupations, lists each of these knowledge areas as necessary to perform as a long-term care administrator. This discrepancy demonstrates the inconsistency in competencies that are expected of long-term care administrators.

The responses to Category I clearly identify the respondents' positions concerning the division of competencies required for long-term care administrators and providers of direct patient services. The respondents pointed out that the administrator's competence is associated with the development of policies associated with patient care and that the development of procedures and the implementations of these procedures is accomplished by other personnel.

The question that does arise, however, concerns how much knowledge is necessary to develop policy in a given area. It would appear to lack logic to expect a person to establish policy statements in areas where they lack the theoretical base of understanding in that area. For example, if the administrator lacked an understanding ot the sociological principles of patient care, it would seem a near impossible task to establish policies that accounted for the social needs of patients in long-term care settings. It would also appear to contradict the opinions of authors who have recently

stressed the importance of establishing a "social model" (Connor and Siebler, 1981). Much has been written in the past decade about the lack of humane treatment experienced by older people in long-term care facilities. Whether this treatment can be directly attributed to a lack of social understanding or just the insensitive action of a few administrators can only be conjecture at this point.

Category II. Personnel Problems

Category II had the second highest group mean rating among all categories (see Table 2). All of the competency statements in this category met the minimum mean standard (4.80) for acceptance.

Statement 14 experienced the lowest mean rating (5.05) within this group; however, the median calculation of 5.667 (see Table 1) more accurately indicates the strength of acceptance of this statement. Twelve respondents (see Appendix J) rated this statement in the "strongly agree" column. Those respondents disagreeing with this statement did so taking the position that this job would be done at the department level. The assumption of this statement is that department heads would be included for consideration as professional employees, and, therefore, subject to recruitment and discharge.

On the other end of the spectrum, Statement 26, "delegate responsibility appropriately," was the only statement in Questionnaire #1 where all respondents checked "strongly agree." This response emphasizes the concept of division of labor and that the competence of an administrator in a long-term care setting is associated with delegation of direct patient services to other personnel.

In addition, nine statements (17, 19, 21, 22, 23, 24, 26, 27

and 28) experienced IQR's totally within the "strongly agree" response category. These statements dealt with competency that applied to the administrators own professional growth (Statement 19); competence to work with governing boards (Statement 24) or competency in working with department heads (Statements 17, 18, 21, 22, 23, and 26).

In general, Category II dealt with generic administrator competencies. The process of implementation of these competencies within the long-term care setting would distinguish the unique characteristics between this setting and other bureaucratic settings. The existence of classical bureaucracies in health care delivery for the aged, however, is questionable and possibly inappropriate (Connor and Siebler, 1981). Connor and Siebler (1981) state that "the issue then partially becomes one of how best to conceptualize and design long-term care facilities." (p.46)

Category III. Budgeting and Financing

Six of the seven competency statements in Category III reached an acceptable mean level of 4.80 or better. Statement 34 concerning understanding of the principles of investment had a mean value of 4.65 (see Table 1); therefore, this statement did not reach the acceptable standard in the first round of the questionnaire. The rationale stated for rejection of this statement was that most long-term care administrators do not have investment responsibilities.

Although six of the seven statements in this category reached an acceptable mean level, there was not unanimous agreement on each of these six statements. In general, persons who disagreed stated that

a particular competency went beyond the requirements of a long-term care administrator. It should be recognized, however, that total agreement on a specific set of competencies in any professional field would probably not be feasible; long-term care is not an exception.

Category IV. Management and Supervision

In Category IV two competency statements did not meet the acceptable mean standard; statements 45 and 46 (see Table 1). Statement 45 dealt with whether or not an administrator needed to be competent in the supervision of purchasing of supplies and managing of an inventory. The rationale for disagreeing with this statement was that this was a function of a purchasing department and that another person (i.e., department head) would be responsible for this action. Again, the respondents iterated that the administrator's competence involved formulation of policies and development of systems (see Appendix J).

Statement 46 which deals with competency of being able to determine procedural policies concerning medical records also did not reach the standard of acceptance. Reasons for disagreeing generally suggested that procedural policies concerning medical records was a function of medical and nursing departments and thus the responsibility of department heads.

Six of the 12 competency statements in this category had an IQR totally within the "strongly agree" response column. Generally, these statements concerned the development of policies and procedures on an institutional wide basis (e.g., supervision of department heads). This response pattern is in line with basic principles of management when describing the competencies required of top manage-

ment (or chief executive officers) positions as opposed to middle-management and supervisory-management position (Longenecker, 1977). Longnecker (1977) describes management as "those activities that are necessary to secure the contributions of individuals and to regulate these contributions to achieve the organization's goal" (p.10).

Category V. Legal Problems and Government Relations

The high level of agreement in this category reflects the degree of involvement of external agencies, especially the federal government, in the activities of long-term care facilities. The financial reimbursement processes carried out through Medicare and Medicaid programs place extensive regulations on the operation of long-term care facilities as well as requiring the certification of administrators of these facilities. As pointed out in a two-year study of regulation impact on long-term care facilities, regulations of the federal, state and private level have substantially increased during the past decade (Conner and Siebler, 1981). The panel of national experts in this study are apparently sensitive to the above trend by their expression of agreement that competence in this area is necessary.

TABLE 2

Categorical Summary of Results of Questionnaire #1

Category	Mean	Standard Deviation	Median
I	4.842	.570	4.923
II	5.683	.222	5.633
III	5.136	.769	5.500
IV	5.354	.358	5.354
V	5.758	.327	5.917

Results and Analysis of Questionnaire #2

The process of identifying any one set of principles or competencies upon which an entire professional field is based is a most difficult task. The Delphi technique, which establishes a forum and opportunity for experts in a given field to express their opinion, appeared to be the most efficient process for identifying the competencies necessary to be an effective long-term care administrator. The efficacy of this process is promoted through controlled feedback which provides, to the expert, the opinions of other experts in the field (in this study, nineteen) without a face-to-face confrontation. The strength of this process then concerns the equal weighing of each expert's opinion which may or may not be persuaded by the opinions of other experts during the feedback process. This procedure avoids the pitfall of intimidation that could be encountered in a face-to-face confrontation.

Categorical Data

The overall mean values in each category in Questionnaire #2 were nearly identical to Questionnaire #1 (Table 4). No changes were experienced in the numerical ranking of each category based on group means between Q 1 and Q 2. Category I (Patient Care) continued as the category with the lowest level of agreement and the group mean of 4.677 was below the acceptable mean standard of 4.80 used for evaluating individual statements.

Category I. Patient Care

Category I continued to experience a high level of disagreement

with a total of nine of the fourteen statements failing to reach the acceptable mean level of 4.80 (Table 1). The general response pattern and statements of reasons for disagreeing identify perceived competency parameters for long-term care administrators. Although the response range is wide (e.g., Statements 1 and 2 experienced responses at all six levels of agreement), the qualitative interpretation of responses, as indicated by the mean standards, reflects a somewhat consistent theme in Category I. This theme suggests that the competency of long-term care administrators in the area of patient care relates only to principles of managing personnel who, in turn, deliver direct patient care.

The failure of nine of the competency statements to achieve mean levels of 4.80 or better in Category I suggests a change in the perceptions by experts in the professional field of long-term care administration as to the competencies necessary to be an effective administrator. The list of skills necessary to function as a nursing home administrator presented in the 1976 Occupational Outlook Quarterly (see page 37 of this study) included most of the competencies that were rejected in Category I of this study (Table 4). Differences also exist between these perceptions of job competencies and the administrative activities generated through Burmeister's (1977) study (see page 39 of this study). These differences concern two main aspects of administration: direct contact with the patient or the patient's family; and cognitive awareness relative to the mental physicial and social characteristics of patients in long-term care facilities. The responses of the expert panel in this study appear to suggest that the principles associated with generic administra-

tion are indeed those that ought to receive concentration in preparing administrators in this field, as opposed to a thorough understanding of the patients themselves.

The question that surfaces, then, is to what degree does an administrator's knowledge of patient needs affect the quality of care provided to the patients in long-term care facilities? If, as suggested by some of the expert panelists, the information can be "helpful but not mandatory," then it appears that the administrator's competence should concentrate in the area of managing middle management (i.e., Director of Nursing Services) personnel and not on understanding of the patient. Since this study did not differentiate the competencies needed in facilites of various sizes, it would be conjecture to state that direct interaction between the administrator and the patients or their families would increase with the decrease in the size of the facility and number of personnel employed.

The range of responses of the panelists (see Appendix O) indicated the differences in expectations at even the expert level and represents the dissonance in perceived expectations of long-term care administrators by people in the field itself. Kahl's (1976) statement that "the body of knowledge and preparation needed by nursing home administrators is not clearly defined" is supported by the wide range of responses made by the expert panelists.

The low mean scores on Statements 1, 2, 4, 5, and 6 (see Table 3) clearly distinguish the performance domains between the administrator and the medical staff, especially the Director of Nursing Services (DNS). Hall (1981) emphasized that the DNS deals directly with the

patient and the patient's family and the details surrounding their care, whereas, the administrator is more responsible for the global activities of the long-term care facility. Hall stressed the importance of good communication between the DNS and the long-term care administrator in the process of operation of a succesful long-term care facility.

The expert panelists suggested one additional statement in Category I during round one of the Delphi process. This statement, I.13A, was added to Questionnaire #2 (see Table 3) and concerned the relationship between the facility and the general public. The majority of panelists agreed with this competency statement indicated by the mean response of 5.526 (see Table 4).

An issue that surfaces in this study concerns the relationship between the competencies that involve performance of some administrative task and the understanding of principles associated with patient care vis-a-vis anatomical, physiological, sociological, psychological, and therapeutic and supportive principles. Although not addressed specifically in this study, it is difficult to perceive that administrative decisions concerning the quality of care of a patient in a long-term care facility can be made without an understanding of the basic principles associated with the fundamental services provided by that institution. Specifically, long-term care facilities must account for the comprehensive array of patient needs over an extended period of time. Without an understanding of the sociological principles of patient care, it is difficult to comprehend how the administrative priorities of the institution could be established and yet

account for patient needs. This argument could be extended to all the competency statements in the Patient Care category dealing with a level of understanding of principles of psychology, anatomy, physiology, therapy, and support, all of which were rejected (Statements 9, 10, 11, and 12).

Although there was not unanimous disagreement with the statements concerning knowledge of specific principles of patient care, the low overall rating of these statements indicate the lack of agreement in the field of long-term care administration itself in regard to what competencies are needed to provide quality patient care.

Category II. Personnel Relations

The total group mean of 5.697 represents the position that most panelists strongly agreed with the competency statements in this category. Only two statements, 14 and 20, had responses at some level of disagreement. The disagreement responses on Question 14, concerning the hiring and discharge of employees, are rationalized by suggestions that this is a job of department heads and supervisors and not the administrator of the facility. The intent of the statement was to include the recruitment and discharge of department heads and supervisors, and, apparently, the majority of the respondents interpreted the statement correctly.

Two panelists also disagreed with the idea that the administrator should be able to establish the philosophy and goals of the institution. It was suggested that this competency was the responsibility of the board and/or the sponsoring group. Perhaps the verb "establish" used in this statement was inappropriate, and a stronger level of

agreement would have been achieved if "establish" would have been changed to either "write" or "interpret." The latter would be more appropriate as an action of competence rather than the establishment of philosophy and goals of the facility. In either of these statements, the majority of panelists were able to perceive the implicit meaning of the statement.

Two additional statements were generated from the panelists during the first round of the questionnaire and were included in Questionnaire #2. Statement 28a indicates a specific action implied more generally in Statement 14. The importance of the statement, however, was interpeted to be the reference to the connection between personnel and the provision of quality care to patients. The assumption is that the administrator's competence includes the ability to identify quality patient care and, administratively, account for this by employing nurses that will deliver quality patient care.

Statement 28b refers to the competence of the administrator to identify standards in the field of long-term care administration. This statement suggests that the administrator should participate in professional activities and maintain awareness of trends of management in long-term care facilities.

The strength of agreement in this category is indicated not only by the high group mean of 5.697 but also by the fact that all 19 (100%) respondents marked "strongly agree" on two of the statements (19 and 21) and 18 of the 19 respondents marked strongly agree on four additional statements (22, 24, 26, and 27).

In general, the expert panel appears to view the competencies of

the long-term care administrator in the area of personnel relations in terms of traditional bureaucratic organization. Bureaucracy is described as a formal organization with a "pyramid of officials who direct and coordinate the work of specialists by use of formal procedures" (Longnecker, 1977, p.194). Conner and Siebler (1981) state that traditional bureaucratic form is not appropriate in the health care delivery system and especially in the delivery of health care to the aged. These authors also opined that new conceptual forms of organization must be developed before constructive change in the long-term care setting will occur.

Category III. Budgeting and Financing

Two of the statements in Category III (34 and 35) did not achieve mean levels acceptable within the standards selected in this study. Statement 34 dealt with the understanding of the principles of investment. The respondents stated that this was not a job of the administrator.

Statement 35 concerned the competency for billing and collecting payments. The expert panelists opined that this was the job of a business manager or subordinate; therefore, the administrator need not have this competency. One panelist, however, did point out that a small facility may not have a business manager. This latter statement suggests, once again, that competency differences may be required depending on the size of the institution. Additionally, minority opinions expressed through responses in the disagree categories (see Appendix J) indicate that competency variations may be associated with differences in the sizes of facilities involved.

In summary, the administrator's competence in the areas of budgeting and financing suggests an understanding of these processes is necessary, but may not require the technical competence to compute the details of these operations.

Category IV. Management and Supervision

All of the statements dealing with the development of policies which govern the organization achieved mean levels greater than the 4.80 standard of acceptance. Two statements (45 and 46) concerning supervisory and specific procedural activities, however, did not achieve acceptable mean levels (see Table 3) and reinforce the perceived differences in competencies required of top management, middle management, and supervisory management (Longnecker, 1977).

The responses in this category appear to support the contention that administrators have distinctive competencies that are different from personnel that deliver care to patients. The practice of promoting personnel based upon their proficiency and effort in a technical area is questioned by theorists in the field of administration (Longnecker, 1977). Competencies which contribute to a person's ability to deliver medical care or keep records on inventory are quite different than competencies necessary to write policy statements, deal with a board of directors, or understand the principles basic to management processes.

Category V. Legal Problems and Government Relations

Category V had the highest calculated mean value (5.711) among the five categories. This high rating possibly reflects the degree to which long-term care administrators interact with government and

TABLE 3

SUMMARY RESULTS OF QUESTIONNAIRE #2

Category	Statement Number	Mean	Standard Deviation	Median	Interquartile Range
Patient Care	1	4.316	1.204	4.222	3-5 (DR-A)
	2	3.579	1.539	3.600	2-5 (D-A)
	3	5.105	0.875	5.200	4-6 (AR-SA)
	4	4.421	0.268	4.417	3-5 (DR-A)
	5	4.316	1.336	4.750	3-5 (DR-A)
	6	3.895	1.286	4.000	3-5 (DR-A)
	7	5.789	0.419	5.867	6 (SA)
	8	5.737	0.562	5.867	6 (SA)
	9	3.684	1.250	3.750	3-5 (DR-A)
	10	4.684	1.157	4.857	4-6 (AR-SA)
	11	4.632	1.116	4.813	4-5 (AR-A)
	12	4.789	0.249	4.938	4-6 (AR-SA)
	13	5.000	1.247	5.400	4-6 (AR-SA)
	13A	5.526	0.612	5.636	5-6 (A-SA)
Personnel Relations	14	5.211	1.084	5.636	4-6 (AR-SA)
	15	5.684	0.478	5.769	5-6 (A-SA)
	16	5.421	0.769	5.636	5-6 (A-SA)
	17	5.632	0.597	5.769	5-6 (A-SA)
	18	5.526	0.697	5.708	5-6 (A-SA)
	19	6.000	0.000	6.000	6 (SA)
	20	5.263	1.327	5.708	5-6 (A-SA)
	21	6.000	0.000	6.000	6 (SA)
	22	5.947	0.053	5.972	6 (SA)
	23	5.789	0.535	5.906	6 (SA)
	24	5.947	0.053	5.972	6 (SA)
	25	5.684	0.582	5.821	5-6 (A-SA)
	26	5.947	0.053	5.972	6 (SA)
	27	5.947	0.053	5.972	6 (SA)

TABLE 3 (cont.)

Category	Statement Number	Mean	Standard Deviation	Median	Interquartile Range
Personnel Relations (cont.)	28	5.895	0.053	5.972	6 (SA)
	28A	5.316	0.820	5.550	5-6 (A-SA)
	28B	5.632	0.597	5.769	5-6 (A-SA)
Budgeting and Financing	29	5.316	0.946	5.636	5-6 (A-SA)
	30	5.263	1.240	5.636	5-6 (A-SA)
	31	5.368	0.684	5.438	5-6 (A-SA)
	32	5.316	0.749	5.429	5-6 (A-SA)
	33	5.263	0.274	5.708	5-6 (A-SA)
	34	4.632	1.165	4.750	4-6 (AR-SA)
	35	4.579	1.387	4.857	4-6 (AR-SA)
Management and Supervision	36	5.947	0.229	5.972	6 (SA)
	37	5.632	0.597	5.769	5-6 (A-SA)
	38	5.526	0.697	5.708	5-6 (A-SA)
	39	5.579	0.607	5.708	5-6 (A-SA)
	40	5.947	0.229	5.972	6 (SA)
	41	5.632	0.684	5.821	5-6 (A-SA)
	42	5.211	0.918	5.417	5-6 (A-SA)
	43	5.579	0.607	5.708	5-6 (A-SA)
	44	5.842	0.375	5.906	6 (SA)
	45	3.684	1.293	3.857	3-4 (DR-A)
	46	3.947	0.970	3.938	3-4 (DR-A)
	47	5.895	0.315	5.941	6 (SA)
Legal Problems and Government Regulations	48	5.842	0.375	5.906	6 (SA)
	49	5.789	0.419	5.867	6 (SA)
	50	5.632	0.496	5.708	5-6 (A-SA)
	51	5.579	0.692	5.769	5-6 (A-SA)
	52	5.842	0.375	5.906	6 (SA)
	53	5.579	0.607	5.708	5-6 (A-SA)

other formal organizations. An elaboration of this interaction and a measure of the impact of regulations on long-term care facilities is explored in depth by Connor and Siebler (1981) who studied this relationship over a two-year time span. These authors studied the impact of regulations on several aspects of the long-term care facility as perceived by three groups associated with long-term care: regulators, advocates, and providers. This study specifically focused on cost-benefit ratios of regulations; the intent of regulations; the impact of paperwork; and regulatory reduction.

The fact that this study was perceived as necessary is indicative of the concern that long-term care administrators have with legal problems and government regulations.

TABLE 4

Categorical Summary Results of Questionnaire #2

Category	Mean	Standard Deviation	Median
I	4.677	.688	4.571
II	5.697	.275	5.784
III	5.105	.812	5.286
IV	5.368	.338	5.396
V	5.711	.384	5.889

Comparison of Competency Statement Means Of Questionnaires #1 and #2

The Delphi technique was used in this study to gain the opinions of experts in a manner which would allow them to receive input from each other and thus increase the strength of the decisions they made on each statement. The decisions concerned the level of agree-

ment or disagreement with each competency statement in the questionnaires. In addition to the mean standard for accepting or rejecting statements, t-tests were calculated on the 53 original statements to determine if significant changes of opinion occurred. As can be seen in Table 5, no significant changes occurred between the responses on each statement of Questionnaires #1 and #2 at the .05 or .01 level of probability.

When applying the mean standard of acceptability of 4.80, ten statements in Questionnaire #1 were rejected: and these same ten, plus three additional statements, were rejected in Questionnaire #2 (see Table 5). The three additional statements that were rejected were all listed in the Patient Care category and indicate the lack of agreement by the expert panel as to the competencies that are required in this dimension of the job. The disagreement with statement 4 appears to relate to job role, as indicated by the response that the administrator's realm of responsibility would be to require that such policies exist, but that the administrator need not have the competency to write such policies.

Statements 11 and 12 were rejected in Questionnaire #2, but were not rejected in Questionnaire #1. Both of these competency statements concern the understanding of specific principles of patient care, vis-a-vis therapeutic and supportive care, and sociological principles of patient care (see Appendix M). The lack of support for these two statements, as well as statement 10, was somewhat confusing. Since all three statements concern the understanding of principles associated with the patients and their relationship to

the long-term care facilities, it is difficult to reason how qualitative improvement in patient care could be accomplished without these competencies. These responses also appear to contradict the theme which runs through comtemporary literature, which suggests that long-term care facilities should concern themselves with providing an environment that accounts for the basic emotional and sociological needs of persons who are institutionalized. Connor and Siebler(1981) suggest, in the summary of their study, that new organizational designs for the delivery of long-term care must be conceptualized within the social model of care. This suggestion implies that qualitative growth in the long-term care field relates to social issues and not advancements in medical technology.

The remaining four categories (40 statements) experienced no changes in the acceptance or rejection of competency statements between Questionnaire #1 and Questionnaire #2. The rejection of statements 34 and 35 on both questionnaires indicates the agreement by the expert panel that principles of investment, and billing and collecting procedures are competencies to be assumed by persons in long-term care facilities other than the administrator. Likewise, the rejection of statements 45 and 46 (supervise the purchasing of supplies and manage the inventory; and determine procedural policies concerning medical records, respectfully) indicate that these statements are also better assumed by other personnel in the long-term care facility.

TABLE 5

COMPARISON OF COMPETENCY STATEMENT MEANS
OF QUESTIONNAIRES #1 AND #2

Category	Statement Number	Mean Quest. #1	Mean Quest. #2	t Value	Degree of Freedom	2-Tailed Probability
Patient Care	1	* 4.2632	** 4.3158	-.17	18	.867
	2	* 3.8421	** 3.5789	1.32	18	.205
	3	5.3684	5.1053	1.05	18	.310
	4	5.0526	** 4.4211	2.05	18	.055
	5	* 4.7368	** 4.3158	1.91	18	.072
	6	* 4.3158	** 3.8947	1.22	18	.238
	7	5.7368	5.7895	-.57	18	.578
	8	5.6316	5.7368	-.49	18	.630
	9	* 4.0526	** 3.6842	1.68	18	.110
	10	* 4.7895	** 4.6842	.62	18	.542
	11	4.9474	** 4.6316	1.84	18	.083
	12	4.8947	** 4.7895	.62	18	.542
	13	4.9474	5.000	.19	18	.848
Personnel Relations	14	5.000	5.2105	-.75	18	.465
	15	5.5789	5.6842	-.70	18	.494
	16	5.4211	5.4211	0	18	1.000
	17	5.7895	5.6316	1.37	18	.187
	18	5.3684	5.5263	-.77	18	.454
	19	5.9474	6.000	-1.00	18	.331
	20	5.4737	5.2632	1.17	18	.259
	21	5.9474	6.000	-1.00	18	.331
	22	5.6842	5.9474	-1.76	18	.096
	23	5.8947	5.7895	.81	18	.429
	24	5.8947	5.9474	-.57	18	.578
	25	5.5263	5.6842	-1.14	18	.268
	26	6.000	5.9474	1.00	18	.331
	27	5.9474	5.9474	0	18	1.000
	28	5.7368	5.8947	-1.84	18	.083

TABLE 5 (cont.)

Category	Statement Number	Mean Quest. #1	Mean Quest. #2	t Value	Degree of Freedom	2-Tailed Probability
Budgeting	29	5.3684	5.3158	.44	18	.667
and	30	5.2105	5.2632	-.33	18	.749
Financing	31	5.2632	5.3684	-.70	18	.494
	32	5.4211	5.3158	.81	18	.429
	33	5.0526	5.2632	-1.00	18	.331
	34	* 4.6316	** 4.6316	0	18	1.000
	35	* 4.7895	** 4.5789	1.17	18	.259
Management	36	5.9474	5.9474	0	18	1.000
and	37	5.6842	5.6316	.29	18	.772
Supervision	38	5.8421	5.5263	2.05	18	.055
	39	5.4000	5.5789	-1.14	18	.268
	40	5.8947	5.9474	-.57	18	.578
	41	5.6316	5.6316	0	18	1.000
	42	5.0526	5.2105	-.72	18	.482
	43	5.5263	5.5789	-.33	18	.749
	44	5.6316	5.8421	-1.17	18	.259
	45	* 3.5263	** 3.6842	-.83	18	.420
	46	* 4.2105	** 3.9474	1.32	18	.205
	47	5.8421	5.8947	-.44	18	.667
Legal Problems	48	5.7895	5.8421	-.57	18	.578
and	49	5.8421	5.7895	.57	18	.578
Government	50	5.8949	5.6316	1.76	18	.096
Regulations	51	5.6316	5.5789	.33	18	.749
	52	5.9474	5.8421	1.46	18	.163
	53	5.6316	5.5789	.44	18	.667

* statements in Questionnaire #1 failing to meet the minimum acceptable mean value of 4.80

** statements in Questionnaire #2 failing to meet the minimum acceptable mean Value of 4.80.

Final List of Competency Statements

The final list of competency statements represents those competencies which a panel of national experts in the field of long-term care administration agree are necessary for a person to possess in order to be an effective long-term care administrator. It is important to point out that this study, and consequently the final list of competency statements, does not reflect variations in competencies needed that may be affected by variables such as size of institution, community values, economic backgrounds of the clients, etc. The attempt to develop a unified statement representing the field of long-term care administration is difficult and as Wren (1979) points out concerning management, "Unity in theory has not come; perhaps it never will" (p.470).

The original list of competency statements was gleaned from the literature in the field of long-term care administration and from persons in Oregon recognized as experts in this field. The fact that the national expert panel did not reach a level of agreement of support for 13 of the original statements and added only three new statements reflects the lack of unity of thought of persons who are active in this field. This study, however, contributes to the identification of the trend of thought in long-term care administration. The value of this process then is that "management thought is the mirror reflection of managerial activity. Management thought brings form to function and philosophy to practice" (Wren, 1979; p.560).

Final List of Long-Term Care Administrator Competencies

Category I. Patient Care

The long-term care administrator should be able to:

1. work with the director of nursing services to develop policies for determining and improving nursing;
2. provide an environment that is attractive and conducive for good patient morale and care;
3. develop policies that insure standards of environmental health and safety and comply with official regulations;
4. develop procedures for patient admission and discharge to and from the institution;
5. establish and be involved in an on-going community public regulations program.

Category II. Personnel Relations

The long-term care administrator should be able to:

6. recruit competent and discharge incompetent professional employees;
7. motivate all staff to accomplish tasks that fulfill the goals of the institution;
8. deal with personnel problems;
9. make available in-service training opportunities for employees.
10. develop procedures for employee evaluation.
11. improve own professional knowledge and skill.
12. establish philosophy and goals of the organization;
13. establish administrative lines of authority;
14. develop and communicate policies and procedures to department heads;
15. conduct meetings effectively;
16. plan and implement long and short range objectives of the facility;
17. delegate responsibility appropriately;
18. interpret governing board's philosophy and goals;
19. establish management policies and procedures;
20. employ a nursing staff that is capable of providing good quality of care;
21. identify the standards in the field of long-term care administration.

Category III. Budgeting and Financing.

The long-term care administrator should be able to:

22. develop a sound annual budget;
23. develop financial policies and establish financial controls;
24. develop policies that determine employee salary and fringe benefits;
25. understand procedures of third party payment organizations;
26. secure adequate resources to accomplish goals of the institution.

Category IV. Management and Supervision.

The long-term care administrator should be able to:

27. understand the principles of the management process (planning, organizing, directing, controlling, and coordinating);
28. develop procedures to inform community about the institution;
29. establish policies of operation;
30. formulate goals and objectives of the institution;
31. deal with the governing board of the institution;
32. develop systems of control for patient care and general functions of the institution;
33. develop policies for maintenance and improvement of the physical plant;
34. develop policies and procedures for operations between departments;
35. develop procedures for measuring the accomplishments of the institution with the goals of the institution;
36. supervise department heads.

Category V. Legal Problems and Government Regulations.

The long-term care administrator should be able to:

37. know government licensing and certification procedures;
38. know how to bring institution into compliance with official regulations;
39. interpret legislative trends that effect long-term care institutions;
40. know labor laws and develop policies to comply with these regulations;
41. know patient rights;
42. understand the regulations of Titles XVIII and XIX of the Social Security Act.

The final list of competency statements will be discussed by both category and specific statement.

Category I. Patient Care

The failure of nine of the original fourteen statements to achieve an acceptable level of agreement in the Patient Care category was somewhat surprising; but is indicative of a trend in thought that suggests that long-term care administrators are moving closer to administrative patterns found in other business organizations. Historically, the long-term care administrator assumed a greater range of responsibilities that brought him/her into direct contact with the patient or the patient's family. The small census in these facilities, as well as the lack of administrative theory in the administrator's background, may have influenced the promotion of this direct contact. As the health care delivery system became more complex due to federal and state intervention, both on an economical and regulatory basis, the size of long-term care institutions increased; thus affecting the role and the competencies required of the long-term care administrator. These changes have resulted in a greater separation of the administrator from the patient and a more intense interaction between the administrator and the middle managers (supervisors) that are responsible for the delivery of direct services. For example, the director of nursing services supervises the delivery of direct care that is provided patients and has the major responsiblity for developing policies and procedures for nursing care. The competency required in this example, then, concerns working with

the director of nursing services in the determination and development of policies which govern nursing care.

Statement 1. The long-term care administrator should be able to work with the director of nursing services to develop policies for determining and improving nursing. Oregon Rules Governing the Long-Term Care Facility (1981) specify that the long-term care administrator, in conjunction with at least one physician and one registered nurse (RN), must participate in the preparation, adoption and implementation of written patient care policies. Oregon "Rules" further state that these written policies must include the following components:

> 1) admission, including patients not accepted, fees charged, services provided; 2) transfer; 3) discharge planning; 4) discharge; 5) physician services; 6) nursing services; 7) dietary services; 8) rehabilitative services; 9) pharmaceutical services; 10) care of patients in an emergency, during a communicable disease episode and when critically ill or mentally disturbed; 11) patient activities; 12) social services; 13) medical records; infection control; 14) diagnostic services; and 15) review of professional practices of facility for the purpose of reducing morbidity and mortality for the improvement of patient care (Oregon Administrative Rules, 1980).

The technical nursing expertise (competency) in this relationship is provided by the director of nursing services and a physician, while the administrator needs to have competency in the formation of policies. It is obvious that no single dimension of an organization that provides comprehensive human services can operate in isolation. The administrator brings this comprehensive perspective into the decision making process dealing with patient care.

The effectiveness of this process relies on the competence of

the director of nursing services and emphasizes the confidence that must exist between the director of nursing services and the long-term care administrator. Hall (1981), a director of nursing services, stated that patient care and patient care policies are the result of a team approach and suggests that a "good marriage" must exist between the director of nursing services and the long-term care administrator.

Statement 2. The long-term care administrator should be able to provide an environment that is attractive and conducive for good patient morale and care. Oregon statutes specifically address three environmental areas of compliance for long-term care facilities: patient environment (e.g. beds, mattresses, tables, call systems, personal care items, wheel chairs, etc.); physical environment (e.g. building codes, rugs, doors, lights, laundry, dining facilities, etc.); and sanitary environment (e.g. water supply, sewage disposal, insecticide and rodenticide labelling and storage, etc.). Each of these three components is linked with other departments and with the provision of a safe environment. The long-term care administrator must understand this relationship and be capable of identifying potential interaction hazards. An example of this interaction effect would be the link between the housekeeping department and the dietary department. The provision of a non-contaminated dietary service would rely upon a housekeeping service that insures no possibility of cross-contamination between the dietary preparation and service areas and the patient-living areas.

Statement 3. The long-term care administrator should be able to develop policies that insure standards of environmental health and safety and comply with official regulations. Rogers (1976) stated "Safety should become a way of life for the staff of the nursing home. It is an obligation to make the facility safe for the patient, to practice safe work habits, and to continue to upgrade safety" (p.179). State regulatory agencies, as well as logic, address the issue of safety in long-term care facilities. Additionally, long-term care facilities are regularly evaluated by outside agencies to determine compliance with these regulations.

Currently, the federal government is emphasizing the deregulation of many industries; and these suggestions include the long-term care field. However, Richard S. Schweiker, Secretary of the Department of Health and Human Services (DHHS), stated his support for a "strong federal role" concerning the safety of long-term patients (Pear, 1982). Schweiker stated that "The current rules have brought about significant improvements in the long-term care of nursing home residents" (in Pear, 1982; p.A10)

The long-term care administrator must be competent in the knowledge of federal, state, and local environmental health and safety regulations and must be capable of developing policies in this area.

Statement 4. The long-term care administrator should be able to develop procedures for patient admission and discharge to and from the institution. This competency is more complex than it appears. The administrator is required to develop policy statements for admis-

sion, transfer, and discharge in compliance with Medicare, Medicaid, state and local standards. These standards require specific agreements between health care institutions (e.g. acute care hospitals and long-term care facilities) and specifications of physician referral.

This competency area requires the long-term care administrator to understand the pluralistic base of the health care delivery system and how the many facets interface with one another. This requires policies that consider the physical aspects of the patient; the interchange of medical information necessary for care and treatment; and the determination of whether or not the patient's needs can be met by a particular facility. The long-term care administrator must also be able to respond to the appropriate regulatory standards which may vary depending on whether the patient needs skilled or intermediate nursing care.

Statement 5. The long-term care administrator should be able to establish and be involved in an on-going community public relations program. Long-term care facilities should be perceived as an integral part of the community. Isolation of the elderly in long-term care facilities has been a national social concern. By establishing a favorable public image, the long-term care facility enhances the prospect of social contact between the community at large and the long-term care facility.

A favorable image of the facility also serves as a positive marketing influence. Without appropriate public relation efforts and the creation of a positive image, the financial success of the

facility is placed in jeopardy.

Category II. Personnel Relations

With the increase in the number of beds in long-term care facilities and concomitantly, the increase in number of personnel required to provide support services to patients, the need for competence in personnel relations has increased. During the "Scientific Era" of management development, personnel management, as a specific discipline emerged. The origins of this discipline are suggested to be from two separate, and often conflicting, beginnings (Wren, 1979). One position held that personnel work was approached from a paternalistic or "welfare" perspective and the other was based on scientific management and the principles of efficiency. The conflict between these two perspectives concerns the one position that attempts to enhance productivity through better worker conditions and the other position which attempts to produce efficiency through scientific process of job matching.

The early attempts to understand personnel in the work place were undertaken to increase efficiency and productivity. Industrial psychology evolved to provide a systematic and scientific method of selecting and placing personnel. The increase in union membership and activity in the 1930's expanded personnel functions and forced administrators to recognize the role of unions in the determination of working conditions. The increased participation of health personnel, vis-a-vis nurses, in union activities in recent years is beginning to have an impact on the health care delivery system. The future will reveal the total effect of this action and the impact it will have on

personnel functions in the long-term care setting.

The personnel component of administration has increased in sophistication over time and is currently referred to as "human resource administration" (Wren, 1979). The increase in employment legislation has imposed increased demands on the administrator's competence in labor laws, equal opportunity, affirmative action, retirement, providing for health and safety in the work environment, and a myriad of other personnel related controls.

The presence of a relatively high personnel turnover rate further complicates the job of the long-term care administrator. To counteract this circumstance, one study (Milles, et al., 1979) suggested that job satisfaction was enhanced through appreciation of co-workers, direct patient contact, opportunities for growth and development, reduction of transportation problems, and housing provision for dietary assistants and porters. This study also suggested that a reduction in turnover rate was related to "fewer part time personnel, more females, and an increased number of married employees and an older starting age" (p.136).

The final list of competency statements in this study included 16 statements in the Personnel Relations Category. This number was the highest among all five categories.

Statement 6. The long-term care administrator should be able to recruit competent and discharge incompetent professional employees. The key to any successful human service organization concerns the quality of the staff that must assume the responsibility for super-

vising the delivery of direct services. The long-term care facility is no exception. The delivery of 24 hour patient care requires that several professional persons must assume managerial responsibilities within the facility. It is the administrator's responsibility to recruit and employ competent departmental managers that are capable of providing good quality patient care.

Competence in recruiting and employing qualified staff involves an awareness of labor laws and regulations stipulated by federal and state agencies. This competence also requires communication and human relations skills to interview and evaluate the applicant's capacity for working in a particular setting.

Additionally, the long-term care administrator must be competent in evaluation skills to be able to measure the contribution of professional staff and be capable of following through to discharge staff that are not fulfilling the obligations of their job description.

Statement 7. The long-term care administrator should be able to motivate all staff to accomplish tasks that fulfill the goals of the institution. Staff motivation is subsumed under the administrative element of leading. There are many leadership patterns which may be classified in a variety of ways, including, autocratic, democratic, and laissez-faire (Longenecker, 1977). Rensis Likert (1976), a contemporary researcher in the field of management and organizations, suggests that leadership is the most important management task. Likert developed a model for describing leadership styles as follows: System 1, exploitive; System 2, benevolent authoritative; System 3, consultative; and System 4, participative.

Although much research has been accomplished to determine the most effective leadership style, it becomes clear that there may be no one leadership style that is most effective. Fiedler (1967) described the contingency model of leadership in terms of situations in which the leader was most effective. Fiedler further developed a procedure for identifying leadership styles which could be matched with situations which had the greatest possibility of success.

The contingency model of leadership would appear to have a high degree of compatibility with the long-term care field. The unique qualities of each long-term care facility, as influenced by factors such as size, cost, and clientele, could benefit from a leadership base that provided for flexiblity and adjustment to the situation. In order to be successful, however, the competence of the administrator must include the knowledge and skills of a variety of leadership styles. In addition, the administrator must be competent in self-evaluation in order to determine his/her effectiveness and to recognize that a style of leadership in one setting may not be effective in another setting.

Statement 8. The long-term care administrator should be able to deal with personnel problems. "For any organization to perform effectively, interdependent individuals and groups must work out their relations across organizational boundaries, between individuals, and among groups" (Gibson, et al., 1979, p.162). The responsibility of the administrator is to recognize conflict and determine whether the conflict is functional or dysfunctional. If the conflict is dysfunctional, then the administrator should be competent to determine

some form of acceptable resolution. Resolution may involve any one of several behaviors which the administrator should be familiar with. Gibson (1979) lists several conflict resolution techniques that can be useful to the administrator: 1) problem solving (face to face confrontation); 2) superordinate goals (establishing common goals); 3) expansion of resources; 4) avoidance (short term); 5) smoothing (deemphasize differences, emphasize common issues); 6) compromise; 7) authoritative; 8) altering human variable; 9) altering the structural variables; and 10) identifying a common enemy.

The quality of patient care in the long-term setting depends on the providers and their ability to concentrate on the goals of the organization. Dysfunctional conflict would result in diminishment of quality patient care.

Statement 9. The long-term care administrator should be able to make available in-service opportunities for employees. The fundamental principle underlying employee in-service is that "the best trained and the best informed employee is the most likely to be the most efficient, most productive and most motivated" (Demisay, 1976, p. 43). The process of in-service education is not simple and requires assessment skills on the part of the administrator to determine the content of the in-service program and then be able to measure the effect following implementation.

Demisay (1976) points out that participation by the employee that will be directly involved in the in-service program can provide valuable input into the planning process and promote a higher degree of motivation and understanding on the part of the employee.

Statement 10. The long-term care administrator should be able to develop procedures for employee evaluation. Employee evaluation is one facet of a larger component of administration known as controlling. Controlling is based upon a measurement of the degree to which organizational goals and objectives are met. Longnecker (1977) identified four steps in the process of establishing control: "1) establishment of a standard; 2) measurement of performance; 3) comparison of performance with the standard; and 4) corrective action, when needed, to bring performance into line" (p.468).

The competencies required of the long-term care administrator in establishing control includes goal setting skills; an awareness of the standards of the industry and those expected by the community; the skill to measure performance; and the ability to translate the results of these measurements into expected behaviors. The ultimate goal of control efforts is to determine the degree to which organizational goals are met while delivering a high quality of patient care.

Statement 11. The long-term care administrator should be able to improve his/her own professional knowledge and skill. The health care industry in general, and the long-term care industry in particular have experienced rapid growth both in size and complexity during the past two decades. Government participation in financing of long-term care (Medicare, Medicaid) brought with it mandates for the licensing of long-term care administrators. In the majority of states a relicensing process requires some form of continuing education experience (Hanson, et al., 1976). The long-term care admini-

strator license renewal laws in Oregon, for example, require 30 classroom hours of continuing education within the 12 month period prior to the renewal request.

The purpose behind the improvement of the administrator's knowledge and skill concerns the relationship this experience has on the ability of the person to provide a higher quality of patient care. Several writers suggest that the long-term care administrator is in a position to have the greatest impact on the delivery of high quality patient care (Buttaro, 1977; Goldblatt, 1977; Weaver, 1979). Rogers (1976) goes as far as to say that "any administrator who does not devote time daily to reading and digesting the proliferation of printed materials...is likely to find himself out of the profession" (p.vi).

Statement 12. The long-term care administrator should be able to establish philosophy and goals of the organization. Organizations exist as a result of someone's actions to accomplish a particular purpose or goal. The administrator of a long-term care facility may or may not have been the person involved in the original development of the facility, however, he/she does represent the board of directors and, therefore, is instrumental in the establishment of the philosophy and goals of the facility. This aspect of the administrator's responsibilities is most important because it represents the standard upon which the entire facility can be evaluated. Evaluation, whether of individuals or organizations, is based on the degree to which the goals are accomplished.

The skill of the long-term administrator concerning goals,

relates to the translation of organizational goals into behavioral goals for the employees of the long-term care facility. The general philosophy and goals of the organization should enter into the administrator's decision concerning whether or not he/she will accept the position. If the administrator cannot, in good conscience, implement the goals and philosophy of the organization and genuinely promote them through the staff, then the administrator should search for a more compatible situation.

Statement 13. The long-term care administrator should be able to establish administrative lines of authority. This competency is an integral part of the administrative component of organizing. Organizing involves defining the objectives of the organization through functions which can be described as departments and further subdivided into individual jobs (Longnecker, 1977). Historically patterns of organization were conceptualized in hierarchial pyramids, with power increasing in concentration at the top of the pyramid. Although this structure is still used today, the degree to which personnel at all levels of the pyramid are included in the decision making process has increased. In the modern era of administration, administrators have become more sensitive to the value of employee participation in the decision making process. Further, different configurations exist for how organizations can be conceptually designed.

In general, organizational trends indicate some form of decentralization. Decentralization concerns the expansion of decision authority beyond just the administrative level and involves greater

autonomy in the decision process for departmental supervisors (Gibson, et al., 1979).

The competence of long-term care administrators should encompass the knowledge of the variety of organizational configurations that exist and the ability to evaluate which pattern would be most effective in a particular setting. Evaluation would be based on the effectiveness of the organization in meeting both the goals of the long-term care facility, as well as the goals of the employees. Without consideration of the employees in the organizing process, the probability of success is diminished.

Statement 14. The long-term care administrator should be able to develop and communicate policies and procedures to department heads. Even though the administrator is ultimately responsible to develop and communicate policies and procedures, this process should not exclude participation by the department heads or other appropriate personnel in the long-term care facility. This process should promote and emphasize the team concept in the delivery of services. Policies and procedures outline the process by which organizational goals are to be achieved. The inability to write clear and concise policies and procedures and the failure to adequately communicate them to all personnel who would be affected, would reduce the potential for a smooth running organization.

Organizational effectiveness is dependent upon the communication process. The intensity of words in long-term care facilities, intensifies the need for good communication channels, both horizontally and vertically within the organization. Communication breaks in

receiving and sending messages can severely limit organizational effectiveness (Wofford, 1982).

Statement 15. The long-term care administrator should be able to conduct meetings effectively. As Wofford (1982) points out "Groups are of increasing importance in organizational life. The increase in complexity and in the rate of change in organizations, along with the spread of the participative and team-centered managerial approaches, has markedly heightened the significance of organizational groups" (pp. 298-299). The complexity of long-term care facilities necessitates the gathering of groups of personnel to discuss and communicate how their responsibilities interface with other facets of the long-term care organization.

The administrator must possess the skills to conduct and lead effective meetings. The administrator must know how groups function, how to maximize individual input, and the effect of group size on group interaction. Decisions in the long-term care facility cannot be made and executed independently. The interaction among departments and the impact that decisions in one area have on all other departments emphasizes the group process skills needed by the administrator.

Statement 16. The long-term care administrator should be able to plan and implement long and short range objectives of the facility. Gulich (1937) described planning as "working out in broad outline the things that need to be done and the methods for doing them to accomplish the purpose set for the enterprise" (p. 13). This definition appears to accurately describe the planning component of administration as it exists today. With the growth in computer utilization

and the increased sophistication of management information systems, the planning process has evolved to a much higher technical level than Gulich could have ever imagined in 1937.

The planning process is a continuous activity of the long-term care administrator that is directed toward the accomplishment of the organization's goals and objectives. Plans are usually formulated into a time framework. Short range planning may be a yearly plan that accomplishes specific goals, while long range planning may outline more general objective to be achieved over a five or even a ten year period of time.

Planning attempts to anticipate and account for changes (social, governmental, financial) that might occur and have a significant influence on long-term care facilities. For example, administrators must constantly be aware of legislative trends that pertain to the health of the elderly. Changes in Medicare or Medicaid legislation could drastically alter the long-term care industry.

Planning is not limited to the chief executive officer but also involves plans at the departmental, and at times, the individual level. The combination of plans at all levels forms the comprehensive plan of the organization and should reflect the short and long range objectives of the facility.

Statement 17. The long-term care administrator should be able to delegate responsibilities appropriately. Delegation involves the conveying of the responsibility and authority of a superior to a subordinate (Longnecker, 1977). The long-term care administrator must realize, however, that the ultimate responsibility for the

achievement of goals of the institution remain with the administrator and cannot be delegated. Patterns in delegation of authority range from superficial delegation where the person being delegated a particular responsibility is really not given the power to make decisions to the opposite end of the spectrum where the administrator places the total burden of responsibility on a subordinate. Somewhere in between these two extremes lies the range of appropriate delegation of responsibility.

The advantages of delegation of responsibility are numerous, but the major advantage involves the relieving of the administrator of specific time consuming work that is more appropriately completed by another person. For example, the director of nursing services should be delegated the responsibility of supervising the department of nursing. Reluctance on the part of the administrator to delegate this responsibility could interfere with the administrator completing his/her own administrative responsibilities, as well as, having a negative effect on the morale of the person who should assume the responsibility. Additionally, the delegation process creates an obligation between the administrator and the subordinate to establish a good working relationship.

Statement 18. The long-term care administrator should be able to interpret the governing board's philosophy and goals. The translation of the governing board's philosophy and goals, at first, should be a major consideration of the administrator prior to accepting the position. The administrator must be able to interpret the nuances behind philosophy and goal statements and be capable of translating

these statements into actions through the personnel of the facility.

An understanding of the larger organizational structure and the philosophy and goals of the organization contributes to the satisfaction of personnel at all levels. If the housekeepers can conceptualize their role beyond just making beds or sweeping floors and understand their role in contamination control, they may experience a higher level of satisfaction and thus be more productive over an extended period of time.

Statement 19. The long-term care administrator should be able to establish management policies and procedures. Management, as a process, is comprised of "activities in decision making, coordination of group effort, and general leadership" (Longnecker, 1977; p. 10). Management policies and procedures concerning personnel relations involve an understanding of how decisions will be made in the long-term care organization. If the procedures are clear and concise, and are implemented through consistent policies, personnel will be more inclined to have greater confidence in the process and accept decisions that are made. Breakdowns in recognized management procedures can lead to a breakdown in the morale of personnel and reduce the effectiveness of the leadership.

Statement 20. The long-term care administrator should be able to employ a nursing staff that is capable of providing good quality care. The major function of long-term care facilities is the provision of nursing care to the patients. Only recently has this field deleted nursing from its legal name. This action should not be perceived as a reduction in the emphasizes of nursing in these facilities,

but rather as a conceptual expansion that more accurately describes the comprehensiveness of the services that are provided to patients.

Nurses in the long-term care facility are the first line of delivery of medical care to patients and, therefore, may be the most important employee in the patient care team. The administrator must be able to provide an environment and develop a relationship that will be attractive to competent nurses.

Statement 21. The long-term care administrator should be able to identify the standards in the field of long-term care administration. Implied in this statement is the notion that long-term care administrators possess the knowledge of where professional standards are stated and has the capacity to interpret these standards into personal behaviors. Participation in professional organizations brings the administrator into physical contact with his/her peers. This exchange should enhance the awareness level of long-term care administrators concerning the standards that are expected in this field. The description of long-term care administration as an emerging profession emphasizes the importance of participation of the administrator in professional activities.

Category III. Budgeting and Financing

Budgeting and financing are aspects of administrative control. In large institutions, the accounting process is such a major part of managerial control the accounting executive is often called the controller (Longnecker, 1977). Even though the long-term care administrator is not the business manager, nor the accountant, he/

she must understand the financial system of the organization and be able to make informed decisions within the financial process.

The profit objective is an important consideration in all classifications of long-term care facilities, whether they are profit or non-profit organizations. Even the non-profit organization must make a profit in order to exist, even though the profit margin may be smaller than in a profit organization. Although only one aspect of administrative evaluation, the profit figure does enter into the measurement of the administrator's success or failure. This aspect in itself should be sufficient motivation for the long-term care administrator to gain as much competence as possible in the areas of financing and budgeting.

The long-term care administrator must be competent to interpret financial information in order to determine where attention must be focused within the organization. A decision to invest dollars into facility expansion may reduce the working capital temporarily in order to realize a larger return in the future. This process emphasizes the degree to which the administrator must work in harmony with the business manager to determine the financial system that will be appropriate for a particular facility.

Statement 22. The long-term care administrator should be able to develop a sound annual budget. "Budgeting makes use of past experiences to forecast future expenditures" (Rogers, 1977; p. 356). Long-term care facilities are businesses and consequently must incorporate into their operations procedures which demonstrate fiscal responsibility. From both planning and controlling perspectives

the budget represents one of the major concerns of the long-term care administrator.

Budget preparation in a long-term care facility does not have the luxury of dealing totally with fixed-cost items. Projections must be made on variable-cost items, as well as income projections based on the history of the institution. The final budget is based on specific data from all components of the long-term care facility. The competence of the administrator involves being able to acquire all the necessary data on which to base budget decisions. The inability to establish a sound annual budget would certainly diminish the effectiveness of the administrator and the facility.

Statement 23. The long-term care administrator should be able to develop financial policies and establish financial controls. The responsibility of the long-term care administrator in relationship to the finances of the organization involves two primary functions; "recording, monitoring, and controlling of financial consequences of past and current operations; and acquiring funds to meet current and future needs" (Spiro, 1977; p.1). Theories of economics and accounting data systems are used by the administrator to establish financial policies and controls of the long-term care facilities. Since the financial health of the organization is ultimately the responsibility of the administrator, a better understanding of the functions of finance increase the understanding of how the total organization operates.

The provision of patient services is tied directly to the finances of the institution. The administrator must be able to

evaluate circumstances and determine the tradeoffs that will result from all financial decisions. Subsequently, financial decisions must be communicated to all personnel to increase their understanding and appreciation of the total process.

Statement 24. The long-term care administrator should be able to develop policies that determine employee salary and fringe benefits. Critical to any service industry is the ability of the organization to attract and maintain personnel that are capable of providing good quality service to their clientele. Factors that enter into this attraction are salary and fringe benefits. A delicate balance exists in the long-term care organization between the expenditures for salaries and fringe benefits and income generated from patients who may select a facility based on cost. This balance includes the dimension of morale, as well as the fiscal soundness of the organization.

Statement 25. The long-term care administrator should be able to understand procedures of third party payment organizations. Third party payment procedures are complex and require constant attention. The federal government's entrance into long-term care through Medicare (Title XVIII) and Medicaid (Title XIX) ushered in an entirely new set of controls for long-term care facilities and their personnel. The administrator must be familiar with these legislative amendments as they currently exist and as they may evolve from a macroeconomic perspective.

The administrator must also understand the policies and procedures of private insurance companies and be capable of interpreting

this information to the patients of the facility.

Statement 26. The long-term care administrator should be able to secure adequate resources to accomplish the goals of the institution. The type of organization (profit, non-profit, corporate chain, etc.) will determine, to some extent, the degree of participation and competence required of the long-term care administrator in the process of acquiring adequate resources. In a corporate chain, for instance, the administrator may have minimal responsibilities in this area, while in a small non-profit organization, the administrator may have the major responsibility to raise capital by subscription.

Exclusive of the type of facility in which the administrator is employed, he/she should be sufficiently versed in resource allocation that they understand the principles of this process and the relationship it has to planning the operation of the facility.

Category IV. Management and Supervision

Management in long-term care facilities appears to be following the historical patterns experienced by other organizational enterprises. Historically, small, local, owner-managed businesses characterized the economic picture in the United States (Longnecker, 1977). These businesses were owner managed and the business was passed on to the heirs. Increases in market potential led to expansion of production and requirements for capital beyond the resources of the individual owner-manager. As a result of this phenomenon, public sale of stocks was used and the ownership diffused

among many investors. Consequently, professional managers (administrators) were employed to manage the organizations.

With the rapid growth of long-term care facilities in the United States during the last few decades the owner-manager trend in long-term care is following a similar pattern of development as did general business. The current trend in long-term care is toward growth of larger institutions and corporate chains. The need for professional administrators to meet the needs of this trend is obvious.

A theory of management began to take form in the late 1800's and early 1900's with the works of Fredrick W. Taylor (Wren, 1979). Taylor developed a system of scientific management based on time studies that determined the most efficient way to accomplish a specific task. At approximately the same time, Henri Fayol was studying the management process in France and developed the "first theory of administration" (Wren, 1979). Fayol identified 14 principles of management which formed the foundation of the theory of administration. He further described the elements of management which remain in the literature today: planning, organizing, commanding, coordinating, and controlling. Gulick (1937) expanded on the works of Fayol and developed his famous acronym POSDCORB. These initials stood for planning, organizing, staffing, developing, coordinating, reveiwing, and budgeting.

Statement 27. The long-term care administrator should be able to understand the principles of the management process (planning, organizing, directing, controlling, and coordinating). The principles

of generic management, as described originally by Taylor, Gulick and others, remain as integral conceptual components of the management process today. Differences exist within each component as they are applied to modern organizations. As Wren (1979) points out "The planning activity has evolved from a highly intuitive, command-oriented concept to one enriched by modern technology, by sophisticated aids, and by a broader understanding of people-machine interactions in a broader system" (p.533). Long-term care administrators need to be competent in the knowledge of modern technological processes in order to be capable of sound planning procedures.

The area of organizing may be the most unstable component of the management process. The formal heirarchy that formed the bureaucratic makeup of organizations is changing in response to changes in social values. Connor and Seibler (1981) suggest that improvements in quality of care in long-term care facilities will require creative thinking concerning the organizational designs that will respond to the social needs of the long-term care patient.

Directing (leading) in organizations has been studied extensively to determine how best to motivate employees and meet both the goals of the organization and the individual. Successful administration requires the motivation of employees to accomplish tasks effectively and efficiently. No one best way has been developed for successful leadership, but many principles of human behavior within organizations have been developed. The competent administrator should be familiar with these principles.

Controlling and coordinating, similar to organizing, have been influenced measurably by the increases in technology and sophistication of the processes that provide data upon which standards of operation can be measured. The speed and capacity of contemporary computers allows the impact of projected decisions to be measured prior to their implementation.

Statement 28. The long-term care administrator should be able to develop procedures to inform the community about the institution. Long-term care facilities are one component of the larger health care delivery system. The administrator should possess an understanding of the basic principles of public relations and be able to identify those factors which determine the image of the long-term care facility. Skills to communicate to and through the media (newspaper, television, radio, etc.) are essential to the administrator.

Information procedures should be viewed as marketing processes. The decision to select one facility over another is often based on the attitude the decision makers have concerning these institutions.

Statement 29. The long-term care administrator should be able to establish policies of operation. Establishment of policies is one facet of the total planning process and is defined as a "basic statement serving as a guide for administrative action" (Longenecker, 1977; p. 121). The key word in this statement is "guide", which implies that policies are not written for specificity but rather to establish guidelines for administrative behavior.

Policy statement provide conceptual directions for administrators

within the context of a broad issue. This provides the administrator with a certain degree of latitude in the process of accomplishing a specified goal. This helps avoid getting bogged down in the detail of an issue.

Statement 30. The long-term care administrator should be able to formulate goals and objectives of the institution. Institutional goals and objectives are operative in nature and identify a future end result to be achieved by the organization (Wofford, 1982). Goals and objectives are most specifically part of both the planning and controlling segments of administration but tangentially are part of all phases of administration.

Within the context of planning, goals and objectives specify "time and target"; i.e., what will be achieved by when (Wofford, 1982). Drucker (1954) suggested eight areas in which goals should be used in organizations: market standing, innovation and improvement, physical and financial resources, profitability, manager performance and development, worker performance and attitude, and public responsibility.

Within the context of controlling, the determination of the degree to which the goal was achieved serves as a measure of effectiveness (if the goal were appropriate) of the persons responsible for the goal attainment.

Several systematic processes have been developed in the business community utilizing goals as the basis of organizations. The long-term care administrator should know these processes and be able to determine whether or not he/she has the skill and knowledge to

use a particular system or whether the system would be appropriate in a particular setting. Whether or not the administrator elects to use a formal goal base system (e.g. management by objectives; system-goal model; etc.) or not, he/she should be able to write, analyze, and implement organizational goals.

Statement 31. The long-term care administrator should be able to deal with governing bodies of long-term care facilities. Generally speaking, the ultimate evaluation and contractual agreements of the long-term care administrator are between him/her and the board of directors (governing board) of the facility. In part, the relationship between the administrator and the board are determined by the type of ownership of the facility, vis-a-vis partnership, sole proprietorship, corporation, non-profit, etc. Current trends in this industry are toward the growth of corporate chains (Rogers, 1976). This trend has been influenced by economic factors and the need for capital growth in order to compete in the long-term care industry. The administrator must have adequate communication skills and the knowledge to deal with these governing boards.

Statement 32. The long-term care administrator should be able to develop systems of control for patient care and general functions of the institution. Although control (comparison of planned with actual tasks) is involved in all segments of long-term care, the most critical aspect concerns patient care. Lowe and others (1976) identified five requirements for implementing quality assurrance functions in a long-term care setting: planning; appropriate structure; day to day delivery controls (concurrent); and accountability. These

five requirements specify commitments by persons at all levels in the organization.

The controls for patient care include both voluntary and regulatory controls. Regulatory controls are established through federal and state statutes that describe minimum standards to be achieved by the long-term care institution. It should be emphasized that these standards are described in minimum terms and quality patient care should strive to achieve maximum standards, limited only by the resources that are available.

Controlling stresses a systematic process for evaluating levels of achievement. This process should be applied at all levels in the organization and should strive to insure the following: an adequate physical plant, knowledgeable administrators, well-qualified personnel, adequate organizational structure and the necessary structure to perform quality assurance activities, concurrent delivery controls, retrospective medical evaluations, and accountability.

Statement 33. The long-term care administrator should be able to develop policies for maintenance and improvement of the physical plant. Policies provide guidelines, but do not specify the detail or the direction of a particular task. Policies are general in description and are not bound by time or specific target as are goals and objectives. Policies for maintenance and improvement of the physical plant at the administrative level establish the guidelines for the more detailed goals and objectives that are developed at the department level.

The three categories of maintenance are the basic structure,

equipment and furnishings and the exterior and grounds (Rogers, 1977). The size of the facility dictates the degree to which specialists (e.g. electricians, plumbers, etc.) are a part of the regular staff. Policy statements should provide the guidelines for daily preventive and repair maintenance.

Statement 34. The long-term care administrator should be able to develop policies and procedures for operations between departments. The provision of care to patients in a long-term care setting involves providing for the total living needs of the patient. This requires the effort of several disciplines, working in a cooperative fashion to provide the services needed. The long-term care administrator is responsible to develop the organizational means for communication between the members of each discipline. The administrator must be able to facilitate the development of interdepartmental policies that promote a patient-oriented system rather than one that is fragmented by professional isolation (Welch and Tauchen, 1976).

Statement 35. The long-term care administrator should be able to develop procedures for measuring the accomplishments of the institution with the goals of the institution. During the planning phase of administration, short and long range institutional goals should be developed. Goals establish ends to be met, as well as a time framework within which the goal should be accomplished. The long-term care administrator should be able to determine when a goal is attained and the quality of the accomplishment. It should be realized that institutional goals are not achieved without considering the integration of administrator, supervisor, and employee goals.

The quality of the organizational achievements should be measured within the context of a system that considers the impact of all goals at all levels of the institution. The long-term care administrator must know how to write and implement personal and institutional goals and be able to accurately measure the performance of the entire organization.

Statement 36. The long-term care administrator must be able to supervise department heads. Supervision is used synonymously with leadership and is defined as "interpersonal influences, exercised in a situation and directed, through the communication process, toward the attainment of...a goal or goals"(Wofford, 1982, p.262). The purpose, then, of leadership (supervision) is to direct behaviors of personnel towards the achievement of specified ends within a particular time frame.

Wofford (1982) described three levels of leadership effects: attempted leadership; successful leadership; and effective leadership. Attempted leadership reflects any endeavor to influence the behavior of another person but does not describe a level of effectiveness. Successful leadership is accomplished when the behavior of the subordinate is appropriate to the request or desire of the leader, but the behavior may not benefit the organization. Effective leadershp occurs when the behavior reflects positively the influence of the leader and meets the goals of the organization.

The long-term care administrator must be able to provide effective leadership in the process of supervision of department heads. To be an effective leader, the administrator must possess good com-

munication skills, know the theories of leadership in organizations, and be able to measure the effectiveness of his/her own leadership style.

Category V. Legal Problems and Government Regulations

It is not surprising that the category of Legal Problems and Government Regulations experienced the highest degree of consensus in this study. The number of government regulations, at all levels, has increased measurably over the past decade. This escalation in regulations prompted the executive director of the Oregon Health Care Association to describe this process as "regulatory overkill" (Connor and Siebler, 1980).

Connor and Siebler (1980) placed regulations into three categories: "certification regulations, licensing regulations, and reimbursement regulations" (p.20). Regulations are written within the context of each of these categories at the federal, state and local levels. Connor and Siebler undertook a two phase study to investigate regulatory impact on long-term care facilities in Oregon. From their study the paradox of regulation in the long-term care setting becomes evident:

> It is not clear, on balance, whether such a vast array of state and federal regulations help or hinder. To be sure, it is obvious that regulations solve many problems; no one, neither regulators nor those affected, wants the elimination of all regulations. Still, regulations also seem to cause many problems. Their number, their vagueness and their mutual contradictoriness all seem to contribute to a paradoxical environment where uncertainty can be excessive and compliance costly. (Connor and Siebler, 1980, p.4).

The above statement probably represents the general sentiment

of persons working in the long-term care field who must respond to the regulatory process. It also represents the sentiment of many leaders at the federal level who are promoting federal de-regulation. Carolyne K. Davis, head of the Health Care Financing Administration, and United States Vice President Bush, who heads the Task Force on Regulation Relief, are among the proponents for reducing "burdensome nursing home rules" (Pear, 1982). Richard S. Schweiker, Secretary of the Department of Health and Human Services, however, does not share this same sentiment concerning regulation of long-term care industries and stated that:

> Contrary to recent reports in the press, I will not imperil senior citizens in nursing homes, our most vulnerable population, by removing essential federal protections. I will not eliminate any staffing requirements for nursing homes such as medical directors, dieticians, social workers and other necessary health and safety consultants" (in Pear, 1982, p. A10)

Schweiker did, however, support a reduction in the frequency of inspections in facilities that had records of sustained good performance. It appears, then, that the regulatory process will continue at about its current level of intensity, at least for the near future, and that long-term care administrators will be required to have the skills to interpret and implement these regulations.

Statement 37. The long-term care administrator must know government regulations and certification procedures. Government regulations for long-term care facilities exist at all three levels of government; local, state, and federal. Connor and Siebler (1980) identified 52 separate regulatory forms that are required at intervals ranging from daily to yearly and from the beginning of a

process to the point at which it changes. These factors indicate the time commitment that must be dedicated to regulations by the long-term care administrator. To ignore this process or to lack the skills to complete and implement these regulations would jeopardize the legal status of the long-term care facility.

Statement 38. The long-term care administrator should know how to bring the institution into compliance with official regulations. Compliance with the regulations first requires a knowledge of the content of the regulations. Secondly, compliance requires an analysis and evaluation of the facility and its services in respect to the content of the regulations. Federal regulations are written into four categories:

> 1) Patient care regulations, providing standards for patient activities, rehabilitation services, pharmaceutical services laboratory and radiological services, social services, dietetic services, physicians' services, nursing services, and patient care management.
>
> 2) Physical environment and saftey regulations, providing standards for facilities' physical and saftey-related features.
>
> 3) Patient rights regulations, providing standards for establishing and observing rights of patients.
>
> 4) Administrative regulations, providing standards for governing and managing the facility, and for creating and maintaining the facility's medical records.

State and local regulations are usually written in greater detail than the broad federal regulations.

Statement 39. The long-term care administrator should be able to interpret legislative trends that effect long-term care institutions. In an industry that is heavily regulated by federal and state

legislation it is critical that the long-term care administrator be familiar with and maintain close scrutiny of the legislative process. The interpretation of legislative trends provides an indication of what might transpire in the future and, therefore, should be a part of the comprehensive planning process (especially long range). To operate totally from a reactionary perspective would have the potential impact of generating feelings of insecurity among the personnel.

Statement 40. The long-term care administrator should know labor laws and develop policies to comply with these regulations. The hiring and labor practices of a long-term care facility may have a strong influence on personnel, not only from a legal perspective, but also from a morale point of view. Legal aspects of employment have increased in complexity in recent years and have been compounded when federal funds are involved. The long-term care administrator must know those laws that affect employment practices. Failure to abide by Equal Opportunity or Affirmative Action guidelines could result in not only a breakdown in institutional morale, but could have a major financial impact if compensation for services were terminated.

Statement 41. The long-term care administrator should know patient rights. In addition to the moral obligation of considering the rights of patients in long-term care institutions are the legal statutes in federal and state documents. These statutes describe conditions for licensing and accrediting of long-term care institutions. Medicare and Medicaid are two federal amendments which describe conditions for participation in relationship to patient

rights. These amendments describe minimal conditions that must exist, but do not describe the attitude of personnel that must exist to insure the consideration of patient rights.

Summer and Tessaro (1976) stated that "the basic purpose of rights for residents is to promote the recognition of residents as individuals to whom dignity, respect and consideration is to be accorded" (p.313). These writers suggest that patient rights should be put into effect by incorporating them into the objectives of the institution. Additionally, these authors developed the following list of Patient's Rights (pp. 314-315):

Ensure that, at least, each patient admitted to the facility:

1) is fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibility;

2) is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not included under Titles XVIII or XIX or the Social Security Act, or not covered by the facility's based per diem rate;

3) is fully informed by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record) and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

4) is transferred or discharged for medical reasons, or for his welfare or that of other patients, or for non-payment of his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to insure orderly transfer or discharge, and such actions are documented in his medical records;

5) is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coersion, descrimination, or reprisal;

6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect patient from injury to himself or to others;

8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and care of personal needs;

10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened unless medically contraindicated (as documented by his physician in his medical record);

12) May meet with, and participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical records);

13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

14) If married, is assured privacy for visits by his/her spouse; if both are in-patients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

Statement 42. The long-term care administrator should understand the regulations of Title XVIII and XIX of the Social Security Act.

Title XVIII, Medicare was originally designed to assist individuals

sixty-five years of age and older with paying for their health care needs, including specifications for long-term care. Medicaid or Title XIX, was established to aid in meeting health care expenses for the indigent. Both of these amendments include specifications for participation and include regulations that effect long-term care facilities. It is essential that a long-term care administrator have a working knowledge of these amendments.

V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The primary purpose of this study was to identify the competencies necessary to be an effective long-term care administrator. The initial phase of this study involved an extensive search of the literature in the field of long-term care administration. This search revealed that a limited amount of literature exists that is related specifically to long-term care administration and that few scientific studies have been reported in this field. From this literature investigation and interviews with persons involved in long-term care administration, a list of 53 competency statements were generated and placed into questionnaire form.

The questionnaire was submitted to a group of seven experts in the field of long-term care in Oregon as a pretest to determine clarity of statements and instructions. Minor changes were made in the instrument which was identified as Delphi Questionnaire: The Identification of Long-Term Care Administrator Competence.

In order to confirm the content validity of the questionnaire, the questionnaire was submitted to a panel of national experts in the field of long-term care administration to gain their reaction. These experts were identified through one of the following procedures: 1) persons frequently cited in the literature were placed on a list of potential panel members; 2) professional organizations related to the field of long-term care administration were contacted and requested to supply a list of names of persons they viewed as

experts; and 3) public agencies involved with long-term care administration were contacted and requested to submit names of persons they considered experts in the field. Eventually 60 potential panel members were identified, of which 20 accepted the request to participate in this study.

The research procedure used in this study was a modification of the Delphi technique which was originally developed by the Rand Corporation. This procedure involved two iterations of the questionnaire with controlled feedback between rounds one and two. Descriptive statistics were calculated on the responses to both rounds of the questionnaire, using the Statistical Package for Social Science (SPSS) and computed in the Computer Center at Oregon State University. Panelists responded to each statement on a six-point rating scale which ranged from "strongly disagree" to "strongly agree," and thus statistics were computed on all individual statements and by categories of statements. The first round of the questionnaire was administered to the expert panel. Following analysis of the returned questionnaires, controlled feedback was provided to the panelists for their consideration. Subsequently, the panelists were requested to react to the questionnaire a second time, considering the response of all panelists on round one.

The Delphi technique is a process for increasing the strength of decisions by involving a group of experts in a particular area in a consensus task. Delphi consensus is usually determined by calculating the interquartile range (IQR) on the responses. This process identifies the interval that is determined to be the consensus of

the group but does not identify a qualitative standard at which point the decision will determine if the idea is accepted or rejected. In this study, the decision was made to identify a mean level to serve as the point at which statements would be accepted or rejected. Considered in this decision were the precedence of a mean standard in a similar study and the determination that the mean level of acceptance for each statement ought to be at least in the "agree" (4.60 to 5.50) range. The minimum mean level for accepting statements was arbitrarily selected at 4.80.

Using the above mean standard, 43 statements met or surpassed the acceptable qualitative mean standard of 4.80. Ten statements did not reach the mean level of 4.80 during round one. These ten and an additional three statements in round two did not reach the acceptance level in round two of the questionnaire. The "Patient Care" category encompassed the majority of the rejected statements. Nine of the 13 statements in this category were rejected. Two statements each in the categories of "Budgeting and Financing" and "Management and Supervision" were also rejected for the final list of competency statements. Additionally, statement 16 was combined with statement 32 because of content similarity; thus, 42 statements were included in the final list of competencies.

The category of "Legal Problems and Government Relations" received the highest level of agreement with a "strongly agree" mean of 5.889 (6.0 is the highest possible mean). The category of "Patient care" had the lowest collective mean score among the categories with a mean score of 4.571.

To determine if significant changes in responses occurred on each statement between rounds one and two, t-tests were computed on each statement. No statistically significant changes occurred between these two rounds at the .05 or .01 level of probability.

Conclusions

The value of this study concerns the degree to which this information can be used in the decisions that are made in the professional field of long-term care administration. This would include those decisions associated with the following: planning long-term care administration curricula in institutions of higher education; the evaluation of the role of long-term care administrators by official and private agencies; the development of consistent standards between state certification programs; for the development of in-service programs for active long-term care administrators; by long-term care administration in their own self-evaluation; and as a basis for future comparative studies in long-term care administration.

Based upon impressions gained from the literature published in the field of long-term care administration and interviewing persons active in this field, the results of this study both confirm and contradict some of these impressions. In the initial phases of this investigation, the perception was that within the entire field of administration, the competencies required of long-term care administrators were unique. This perception was gained through analyzing

previous studies (e.g. Allison, et al., 1975; Weaver, 1975) that emphasized that the long-term care administrator spent more time interacting with the patients and their families, or spent more time involved in interacting with government and outside agencies. Austin (1979) added to this perspective and pointed out that long-term care is a service industry, that the persons working in this industry are highly credentialed (i.e. M.D.'s, R.N.'s etc.), and the health care industry, in general, operates from a pluralistic base.

During interviews with persons actively engaged in the field of long-term care, the impression was gained that the long-term care industry is highly regulated by federal and state agencies and that this bureaucratic interaction consumes a substantial amount of the administrator's time. This concern with regulations was also an evident theme in a review of the literature.

Comparing the results of this study, vis-a-vis questionnaire responses, with the above perception, several issues were confirmed. The high level of agreement with the competencies included in the category "legal problems and government relations" supports the position presented in the literature and the statements of persons interviewed, that this industry is heavily involved in the regulatory process. The conclusion based on these data supports the contention that long-term care administrators must be competent in their knowledge and understanding of the specific nature of regulations concerning long-term care institutions. These regulations include those that are required for institutional licensing, those regulations concerning

federal reimbursement (i.e. Medicare and Medicaid); and those regulations concerning labor practices at all levels within the facility. Long-term care administrators must be able to interpret legislative trends and how to bring the facility into compliance with existing and newly enacted regulations.

The laws and regulations governing long-term care facilities are specific to these institutions and would, indeed, require a specific orientation to understand why the application of these laws to the long-term care setting. The implications for long-term care administration preparation programs is to ensure the inclusion of these aspects in the curriculum or at least require that upon completion of their academic programs, that the student is competent in the knowledge and understanding of regulations affecting long-term care.

The next level of consideration is that the administrator must be able not only to understand these regulations, but he/she must also apply them in the long-term care setting. This emphasizes the need for students to completely understand all the dimensions of the long-term care facility prior to assuming the responsibility as an administrator. The practical dimensions of the preparation is associated with the "preceptor" or the field experience that should be required of pre-professionals.

This emphasis on legal problems and government relations also extends into the in-service programs that are offered in each state. Most states require long-term care administrators to renew their certification periodically, and included is a requirement that the administrator must accumulate a certain number of in-service hours.

For example, in Oregon, long-term care administrators are required to accumulate 30 contact hours of in-service prior to recertification. Laws and regulations should be consistently included as part of the ongoing in-service program.

Contrary to suggestions in the literature (Weaver, 1975) and personal interviews, the expert panelists did not perceive that long-term care administrator competence included the ability to work directly with patients or their families. The suggestion was that this function was delegated to technical providers (i.e. Director of Nursing Services). This response pattern revealed that administration in long-term care facilities is moving closer to the generic field of administration as described most extensively within the arena of business and industry. It should be realized, however, that even generic administrative theory is dynamic and what has been described as classical administrative theory that evolved during this century, is constantly changing. These changes are reactions to contemporary trends in the organizations where administrative theory is implemented.

Luthans (1978) stated that the trend of management theory is counter to the strict parameters of classical bureaucratically defined organizations and is moving closer to what is described as situational or contigency theory of administration. The basis of this theoretical notion is that each organization is unique, thus it requires a unique form of administrative application and helps explain why administrative patterns are successful in one setting but not in another. Contingency theory requires the analysis of

all the significant variables in order to establish the pattern of administration that will have the highest probability for success.

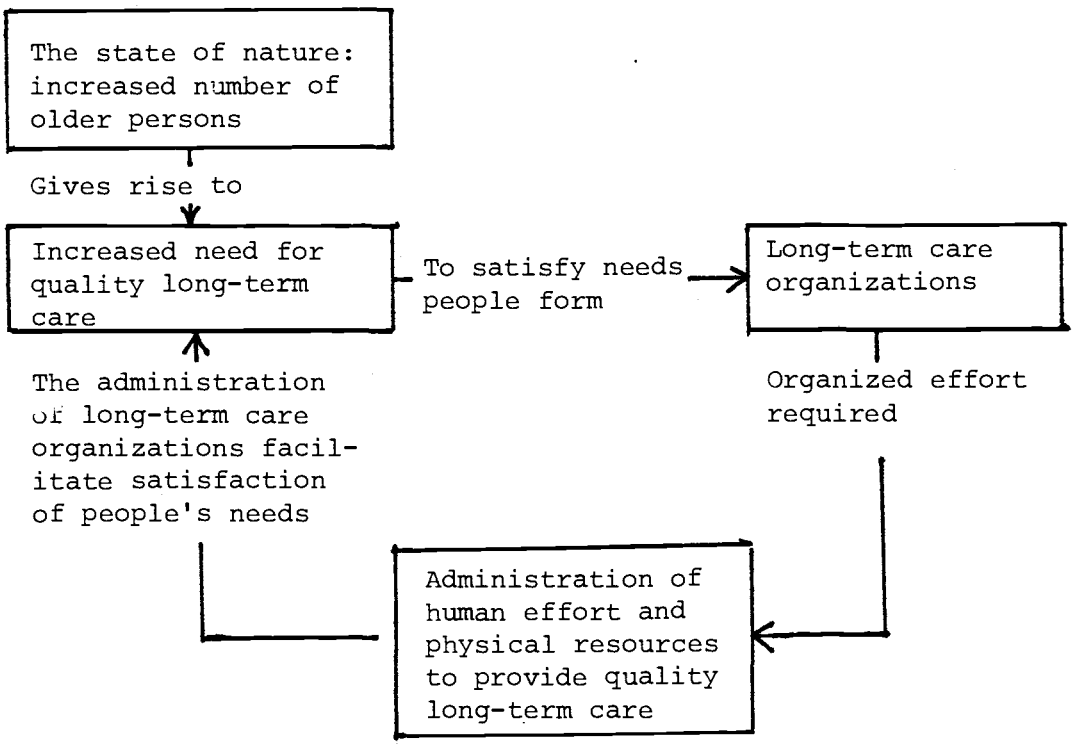
Contingency theory would appear to be highly compatible within the field of long-term care. This statement is based on the fact that the significant variables which impact on a long-term care facility differ from facility to facility. Although only conjecture, it would seem logical that amoung the significant variables would be the following: size of facility; social status of the clients; economic background of the clients; geographic location of the facility; community values; type of sponsoring organization (i.e. religious, fraternal, public, etc.); to identify a few.

Contingency theory, however, does not establish a competency foundation or identify those competencies that are pervasive, if indeed there are competencies that can be generalized to all settings. In order to identify those competencies required in various long-term care settings, further studies are necessary. Using the instrument developed in this study (see Appendix P), a variety of settings could be evaluated to determine the competencies perceived to be necessary in each setting. For example, assessing differences by size of facility would be one of the most obvious variables to evaluate.

The following adaptation of Wren's (1979) model provides a conceptual model which underlies the rationale for long-term care administration in contemporary society. As the number of persons in the aged categories increases, and if social values con-

cerning care of the the aged maintains this current pattern, then the need for quality long-term care will increase.

Rationalization for Long-Term Care Administration



Implications of This Study

A major value of this study concerns the usefulness of this information in the development of an educational model, or paradigm, for long-term care administrators. First, three general education models that currently exist will be presented and discussed. This discussion will be followed by some critical comments on each model and a

suggestion for the ideal educational model for the preparation of long-term care administrators.

Generic Administration Model

The generic administrative model assumes that all organizations function basically in the same mode. Oversimplified, this model suggests that persons trained in generic administration can function effectively in all settings and therefore specialization is not necessary. It is assumed that the principles of planning, organizing, staffing, directing, and controlling can be generalized to all organizational settings.

The strength of this model lies in the notion that a strong theoretical base of understanding in each area can be established which will contribute to the administrator's ability to analyze a specific setting and establish organizational procedures that will most efficiently provide the services required. For example, in the area of planning which involves the definition and determination of the appropriate means to achieve defined ends, a thorough understanding of the general principles of planning could be incorporated within the context of most organizational settings (Gibson, Ivancevich, and Donnelly, 1979). The assumption is that definitions of mission, goals, and objectives are accomplished through general processes that can be incorporated within a variety of settings, including those that provide human services.

One observation concerning the limitation of this model is that health care administrators have traditionally been concerned with the

welfare of the client, whereas, business management in general has been concerned about the organization (Richardson, 1975). The question that arises is: can the welfare of the client be considered without considering the welfare of the organization? Put another way, can organizations that provide human services survive if they consider only the welfare of the client?

If the model of education for generic administration is accepted, then the specific matter of the administrative assignment must be acquired through experience. For example, a person trained in generic administration would have to learn while on the job, the complex internal and external organizational dimensions of a long-term care facility. This would include an understanding of the services provided by medically trained and credentialed personnel as well as those non-credentialed persons providing housekeeping and manual services to and for clients. Additionally, this administrator would be required to learn the complex relationship that exists between the long-term care facility and other facilities, such as acute care hospitals, that constitute the total health care delivery system. Included in this learning process would also be the acquisition of the knowledge of the laws and controlling external agencies that impact on long-term care facilities.

The acquisition of these specific competencies would require a substantial amount of time. This model would require two major segments in the training process. The first would take place in an educational setting that would emphasize the acquisition of a strong theoretical base in generic administration. The second phase would

take place in the long-term care setting and would be implemented by practicing administrators.

Health Care Administration Model

The educational model for health care administration in a health care setting is the second model that will be discussed. Richardson (1975) points out that the body of knowledge in health services administration has increased substantially in the past few years and, therefore, a more theoretical base is warranted over the more experiential curriculum. This educational model then would require preparation in two separate areas. The first would be generic management science that would study all phases of organizations in general and involve the acquisition of quantitative skills necessary to analyze organizations in general. The other segment would be related to the understanding of the complexity of the health care delivery system. An understanding of the pluralistic base of health services is necessary to understanding of how all components (i.e., long-term care and acute care) interrelate. This understanding would also allow lateral professional movement of health care administrators in the various segments of the health care delivery system.

The implementation of this educational model in an educational institution would involve the combined efforts of a variety of experts in different schools or departments. For example, generic administration theory is usually taught in schools of business or public administration while the health administration component is usually housed in schools of public health or health services administration.

Long-Term Care Administration Model

This model assumes that long-term care administration is unique and therefore requires that education and training relate specifically to the long-term care setting. The mission, goals, and objectives of planning would be defined in terms of the mission of the long-term care facility wherein goals and objectives would be defined in terms of this setting. This interpretation of functions within the long-term care setting would also apply to the other elements of administration including organizing, staffing, directing and controlling.

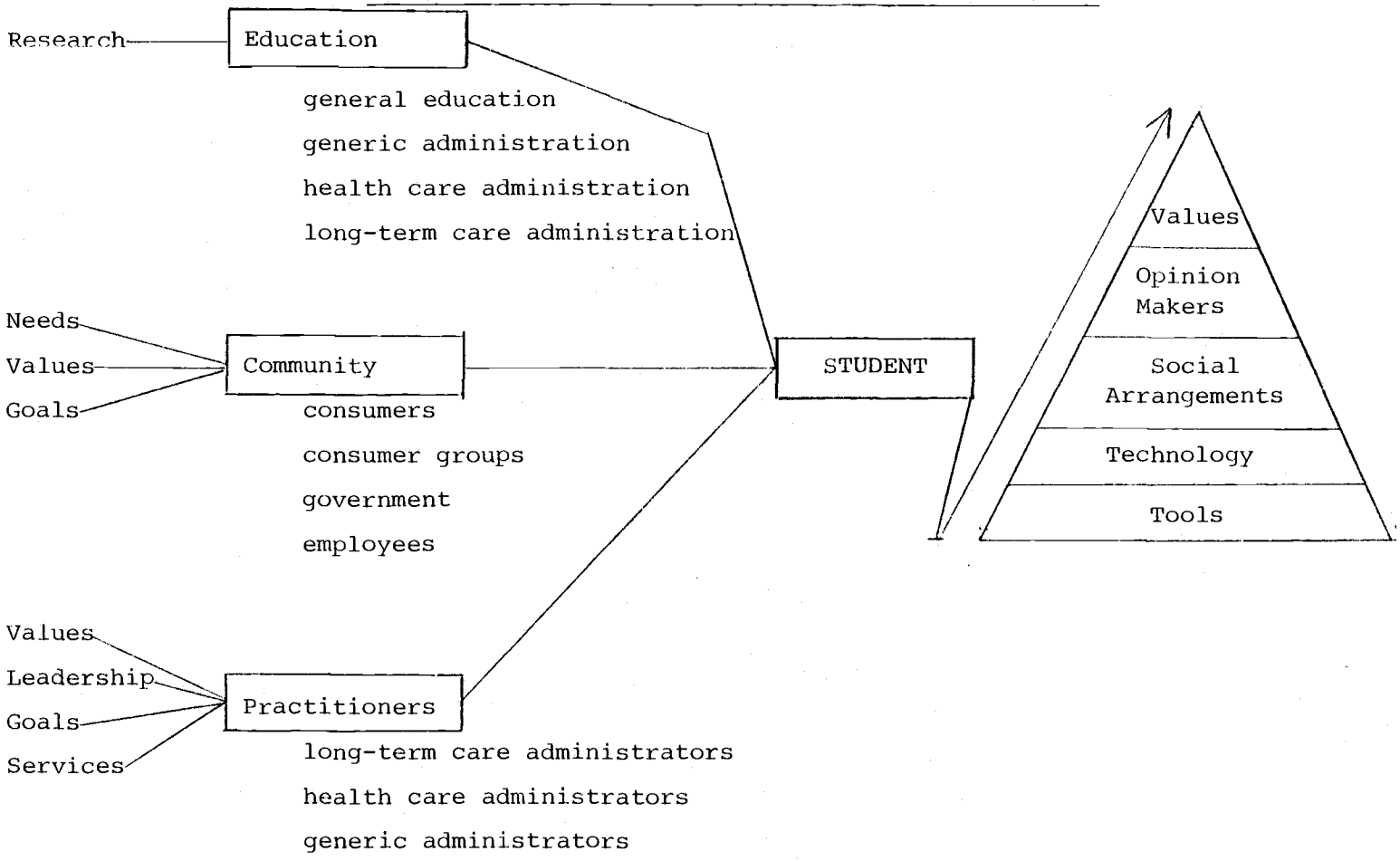
The strength of this model would be that students coming out of a program of this design should be capable of moving directly into an administrative level position in a long-term facility.

The limitation of this model is associated with two factors (Richardson), 1975). One is associated with the concept that faculty are a scarce resource and that a specialized program would not be an efficient or an effective use of these resources. The second limiting factor can be described in terms of the narrowness of focus which limits the breadth of awareness that would be gained by an interdisciplinary mix of faculty and students.

Proposed Education Model for Long-Term Care Administration

The educational model for long-term care administration begins with the rationalization for long-term care administration based on the needs, values, and goals of the community. These aspects are expressed through various individuals and groups in the community

EDUCATION MODEL FOR LONG-TERM CARE ADMINISTRATION



which solicit, demand, work for, and regulate the long-term care organizations. The consumer (patient) and consumer groups demand certain behaviors based on their needs, values, and goals. These behaviors are regulated through governing bodies which write and enforce legislation.

The educational institutions develop programs based on research in the field which attempts to describe the most effective process for accomplishing the goals established by the community. In this model, four levels of education are proposed: general education; generic administration; health care administration; and long-term care administration. General education provides the student with an understanding of man in the greater socio-economic, political and physical world. This foundation is essential to the understanding of the pluralistic base of the health care delivery system.

Generic administration establishes the general theoretical and technical foundation upon which the general principles of working with people and organizations are conceptualized. This foundation in generic administration is then applied to the general field of health care administration. This application focuses the general principles of administration on a pluralistic service industry. What is commonly referred to as the health care delivery system is, in reality, not a system but a collection of independent organizations with interdependent functions. An understanding of this design and relationship is essential to effective performance in any one dimension of the health care system.

Greater educational focus provides the technical skills needed

to perform effectively in the long-term care setting. Concentration on this setting equips the student with the knowledge peculiar to long-term care and promotes a better understanding of the role of long-term care in the total scheme of health care delivery.

The practitioners are the opinion makers. Their opinions are based on their values and are expressed through the services they provide. The practitioner's goals, idealistically, are to provide the highest quality of health care possible through positive leadership of other people.

Through an interaction of the student with all three of these facets of this model (education, community, and practitioners), the student acquires the tools and technology to move up into the social arrangements consisting of the field of long-term care administration. Through this entire process, values are established and are reflected through the behaviors of the administrator. All of the components of this model interact with each other and in all directions. Failure of any one segment of the model to interact with another component would have a profound effect on the total system.

Recommendations for Further Study

Recommendations for additional study are as follows:

1) Additional research should be conducted to determine if variations exist in administrative competencies required in long-term care institutions of various sizes;

2) That specific behavioral objectives within each competency area be defined to establish curricula for training long-term care administrators;
3) That in-service training programs for long-term care administrators reflect the priorities identified in this study; and
4) That the final list of competencies be used as the basis for future comparative studies to establish the relationship between the credentialing process and competent job performance.

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APPENDICES

APPENDIX A

LETTER TO PRE-TEST PANEL REQUESTING PARTICIPATION

Research is being conducted under the auspices of Oregon State University Health Care Administration Program to identify the competencies necessary to perform effectively as a long-term care administrator. The initial phase of this research involves compiling a list of competency statements based on an extensive review of the literature and input from persons representing practitioners and officials and professional organizations concerned with long-term care administration.

Dr. John Ellis, my major professor and Director of the Health Care Administration Program at Oregon State, has identified you and your professional position as one that would be an integral part of the initial phase of this study. Specifically, I am requesting your assistance in the identification and refining of the competency statements which are being presented to you for evaluation. You would be one of eight persons in Oregon involved in this phase of the study.

My second phase of this research will involve submitting the refined list of competency statements to a national panel of experts for input and verification. The final product of this research will be a listing of valid competency statements that would be useful in several ways including: development of curricula for the preparation of long-term care administration at the undergraduate level; the identification of inservice needs of long-term care practitioners; and establishing a base for determining educational requirements for long-term care administrator licensure.

The attached list of competency statements has been taken from an extensive search of the literature with the categories of statements specifically identified by research conducted by the American College of Nursing Home Administrators under the direction of Dr. Robert Burmeister. The literature includes several ways to categorize long-term care administrator functions; however, Burmeister's arrangement appeared to be most practical for this study. An attempt to limit the number of statements has also been intentional in order to make the instrument as functional as possible.

My request to you is to evaluate both the procedures to be followed by the national panel and the competency statements themselves. I would appreciate your comments and suggestions for additions, deletions, or changes for any of the procedures or statements.

I know that you are extremely busy, but hope that this research will be of value to you and the long-term care field upon its completion. In order to expedite this research, I am asking you to return the attached materials in the stamped self-addressed envelope by December 12, 1980. I assure you that your responses will be completely confidential.

I thank you very much for your time and effort with this research.

Sincerely,

Dell Smith
Candidate for Doctor of Philosophy Degree
Department of Health
Oregon State University

DS:lb

APPENDIX B

PRETEST PARTICIPANTS

Pretest Participants

Ralph Ballande
Regional Manager
Roderick Enterprises
1820 S.W. Vermont
Portland, OR 97219

John Ellis, PH.D.
Director of Health Care Administration
Waldo Hall
Oregon State University
Corvallis, OR 97331

Carol Hall, R.N.
Director of Nursing
Heart of the Valley Nursing Center
2750 N.W. Harrison
Corvallis, Oregon 97330

Charles Miller
Manager
Health Care Facilities and Certification
Oregon State Health Division
P.O. Box 231
Portland, Oregon 97207

John Park
President
Board of Examiners of Nursing Home Administrators
P.O. Box 231
Portland, Oregon 97207

Minnie Stryffeler, R.N.
Dallas Nursing Home
1348 W. Ellendale
Dallas, Oregon 97338

Fern Ward
Associate Director
Oregon Health Care Association
801 N.E. 28th
Portland, Oregon 97232

Harvey Young
Administrator
Douglas County Nursing Home
778 West Harvard
Roseburg, Oregon 97470

APPENDIX C

LETTER TO DELPHI PANEL REQUESTING PARTICIPATION

OREGON STATE UNIVERSITY
Department of Health
Corvallis, Oregon

I am a doctoral candidate at Oregon State University conducting research to identify the competencies required for a person to perform effectively as a long-term care administrator.

Because of your recognized expertise in the field of long-term care administration, I am asking if you would be willing to serve on a national panel of experts to assist in this process. If selected, you would be one of approximately twenty individuals in the nation actively involved in the field of long-term care administration invited to participate in this study. Criterion used for the selection of candidates for this study was the person's reputation as a leader in the field of long-term care administration as determined by other leaders in the field; officials in public agencies; professionals; and professional organizations.

The research process to be used in this study will be the Delphi technique; a procedure designed to gain collective expert opinions without bringing the experts together in a face-to-face confrontation. An initial list of fifty-three brief competency statements has been generated from the literature and interviews with long-term care administrator practitioners in the state of Oregon. Your task as a member of this panel would involve reviewing this list of competency statements on two occasions. Specifically, you would be asked to: react on a six point scale to the pertinence of each statement; to clarify the statements; to suggest additions and/or deletions to the list of statements; and to return the materials to me. I will analyze the data and formulate a second set of competency statements incorporating the recommendations of all the panel members. I will then send the revised statements and comments to you for your final reaction. Each reviewal should not require an excessive amount of your time (30-60 minutes).

Page 2.

We would be honored and pleased if you would be able to participate in this study. Enclosed is a self-addressed, stamped envelope in which I am asking you to return the attached response sheet at your earliest convenience. Thank you for your time and consideration of this request.

Sincerely,

David A. Smith
Doctoral Candidate
Department of Health
Oregon State University

DS:lb
Encl.

Below is an example of the form and type of competency statement on which you would be requested to react:

Category I. Patient Care.

The Long-Term Care Administration should be able to:

	Strongly Disagree	Disagree	Disagree with Reservation	Agree with Reservation	Agree	Strongly Agree	Reasons for Disagreeing
I-1. Work with the director of nursing services in the supervision and determination of patient needs.	SD	D	DR	AR	A	SA	
I-2. Meet with and motivate patients towards rehabilitation.	SD	D	DR	AR	A	SA	

Modification of statements Section (Include item number):

Additional statements Section:

APPENDIX D

DELPHI PANEL PARTICIPATION RESPONSE SHEET

RESPONSE SHEET

Re: Participation as a Delphi panel member:
"Identification of Competencies for Long-Term Care Administrators."

Please check one of the following and return to me in the attached stamped, self-addressed envelope.

_____I will be able to participate as a panel member.

_____I will not be able to participate as a panel member.

Signature_____

Thank you,

David A. Smith
Candidate for Doctor of Philosophy
Department of Health
Oregon State University
Corvallis, Oregon 97330

APPENDIX E

EXPERT PANEL MEMBERS

EXPERT PANEL MEMBERS

Carl Adams, M.D., (NHA), Chairman of the Board, National Health Corporation, Murfreesboro, Tennessee.

Harry L. Anderson, Director for Administrative Personnel and Education, Ev. Lutheran Good Samaritan Society, Sioux Falls, South Dakota.

Patrick F. Donnelan Jr., C.P.A., Munns and Dobbins, CPA's, Scarsdale, New York.

H. J. Friedsan, Dean, School of Community Service, North Texas State University, Denton, Texas.

Sister Lucia Gamroth, Administrator, Benedictine Nursing Center, Mt. Angel, Oregon.

David Glaser, Executive Vice President, Jewish Institute for Geriatric Care, New Hyde Park, New York.

J. Scott Houston, Jr., President, Wesley Homes, Inc. Atlanta, Georgia.

Chisato, Kawabori, Ph.D., Regional Program Director, Region X, United States Administration on Aging, Seattle, Washington.

Curtis A. Milton, Controller, The Masonic Charity Foundation of Connecticut, Wallingford, Connecticut.

Bertram B. Moss, M.D., Director, Clinical Gerontology Program, Illinois Masonic Medical Center, Chicago, Illinois.

Gailan L. Nichols, FACNHA, Licensed Nurse, Chairman, Western Gerontological Society Task Force on Long-Term Care, Vice President, American Health Care Association, Washington, D.C.; Executive Board Member California Association of Health Facilities, Ojai, California.

Donald A. Peterson, NHA, Administrator, St. John's Lutheran Home; Billings, Montana.

J. Rex Pippin, President, Bensenville Home Society, Bensenville, Illinois.

Wesley Wiley Rogers, Program Director for Nursing Home Administration; Mclennan Community College, Waco, Texas.

Sister Mary John Sapp, Executive Director, St. Benedict Hospital and Nursing Home, San Antonio, Texas.

Herbert Shore, Ed.D., Executive Vice President, Dallas Home for Jewish Aged, Adjunc Professor, Center for Studies on Aging, North Texas State University, Dallas, Texas.

Sister Michael Sibille, Special Consultant for Long-Term Care, Louisiana Health and Human Resources, Baton Rouge, Louisiana.

Ruth Stryker-Gordon, Associate Professor, Center for Long-Term Care Administration Education, University of Minnesota, Minneapolis, Minnesota.

Helen Tweedy, R.N., Administrator, Hearthstone Manor, Medford, Oregon.

*Jason N. Druitt, Lakeview Dev. Disabled Center, Whittier, California.

*Completed only the first round of the questionnaire.

APPENDIX F

LIST OF ORGANIZATIONS THAT CONTRIBUTED NAMES TO THE POOL OF EXPERT PANELESTS

LIST OF ORGANIZATIONS THAT CONTRIBUTED NAMES TO THE POOL OF EXPERT PANELISTS

American Association of Homes for the Aging

American College of Nursing Home Administration

American Health Care Association

Federal Council on Aging

Gerontological Society - (National)

International Federation on Aging

Oregon Association of Homes for the Aging

Oregon Board of Examiners of Nursing Home Administrators

Oregon Health Care Association

Oregon State Health Division, Health Facilities Services

APPENDIX G

DELPHI PROCEDURE LETTER TO PANEL OF EXPERTS

OREGON STATE UNIVERSITY
Department of Health
Corvallis, Oregon 97331

May 1, 1981

Thank you for agreeing to participate in this research to identify the competencies required to perform effectively as a long-term care administrator. Your suggestions should contribute greatly to the development of a valid list of competency statements. The procedure that will be used for this research is called the Delphi technique and involves the following steps:

1) Each panel member is sent a questionnaire upon which they will provide feedback for retaining, revising, adding or deleting each competency statement.

2) The original list of statements will be statistically analyzed and revised based upon the suggestions of the Delphi panel of experts.

3) The second questionnaire will be sent to each panel member and will include panel member comments from the first questionnaire. Panel members will be asked to respond to the second questionnaire in the same manner as the first.

4) The second questionnaire will be analyzed and suggestions incorporated in the final list of competency statements. The final list will consist of those competency statements upon which the members of the panel have reached consensus.

I appreciate your professional interest and willingness to participate in this research. I want to assure you that your individual responses will be confidential; however, you will be given credit in the text of this study for participating.

Page 2.

If you have any questions concerning this research, please call.

Thank you.

Sincerely,

Dell Smith
Candidate for Doctor of Philosophy
Department of Health
Oregon State University
Corvallis, Oregon 97331

DS:lb
Encl.

APPENDIX H

COVER LETTER - DELPHI QUESTIONNAIRE #1

Instructions for Completing Delphi Questionnaire

Attached is the first set of materials for your review. You are asked to:

1. Indicate on the scale provided the extent to which you agree or disagree that a long-term care administrator should be able to perform a given competency. (An attempt has been made to make each statement as brief and concise as possible; however, please make suggestions that would add clarity.)

2. If you disagree, briefly comment on your reason in the space provided under "Reasons for Disagreeing."

The competencies have been grouped into the following categories:

1. Patient Care
2. Personnel Relations
3. Budgeting and Financing
4. Management and Supervision
5. Legal Problems and Government Relations

In order to develop an instrument with practical value, the number of statements have been limited to under sixty. The statements were developed after an extensive literature review, however, space is provided at the end of each category to add additional competency statements that you consider essential.

After receiving the first questionnaire from all panel members, I will tabulate the data, add, delete or make changes in the statements and formulate a second questionnaire. The second questionnaire will also include statements of reasons for disagreeing made by panel members. The competency statements gaining consensus of the National Panel will be the end product of this research.

Your responses will become part of a pool of information and will not be identified individually. You will receive a report of the findings upon completion of this study.

Please complete the questionnaire and return it by May 15, 1981, in the stamped, self-addressed envelope provided.

Page 2.

The following abbreviations will be used for the agree-disagree categories:

SD - Strongly Disagree
D - Disagree
DR - Disagree with reservation
AR - Agree with reservation
A - Agree
SA - Strongly agree

Dell Smith
Department of Health
Oregon State University

APPENDIX I

DELPHI QUESTIONNAIRE #1

THE IDENTIFICATION OF LONG-TERM CARE
ADMINISTRATOR COMPETENCE

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

This is the first of two rounds of the questionnaire in this study. You are asked to:

1. Read each competency statement and rate each as to its importance/ appropriateness for consideration as a necessary competence to be an effective long-term care administrator. This rating is accomplished by checking one of the following categories of agreement or disagreement:

   1 - Strongly Disagree
   2 - Disagree
   3 - Disagree With Reservation
   4 - Agree With Reservation
   5 - Agree
   6 - Strongly Agree

2. If you are in disagreement with a specific competency statement, briefly state your reason in the space provided: Reason for Disagreeing

3. Please note that space has been provided at the end of each section for you to add competency statements that may have been overlooked.

4. If you wish to modify a competency statement, simply make the modifications next to the statement.

DELPHI QUESTIONNAIRE #1: THE IDENTIFICATION OF LONG-TERM CARE ADMINISTRATOR COMPETENCE

Category I. Patient Care

The Long-Term Care Administrator should be able to:	Strongly Disagree		Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
I.1 work with the director of nursing services in the supervision and determination of patient needs.	1	2	3	4	5	6		
I.2 meet with and motivate patients towards rehabilitation.	1	2	3	4	5	6		
I.3 work with the director of nursing services to develop policies for determining and improving nursing care practices.	1	2	3	4	5	6		
I.4 develop policies for coordinating medical services to the patient	1	2	3	4	5	6		
I.5 work directly with the patient's family	1	2	3	4	5	6		

Category I. Patient Care (Continued)	Strongly Disagree		Disagree	Disagree With Reservation	Agree With Reservation		Agree Strongly Agree	Reasons for Disagreeing
I.6 work with the director of nursing services to develop and periodically evaluate patient care plans and policies.	1	2	3	4	5		6	
I.7 provide an environment that is attractive and conducive for good patient morale and care.	1	2	3	4	5		6	
I.8 develop policies that insure standards of environmental health and safety and comply with official regulations.	1	2	3	4	5		6	
I.9 understand anatomical and physiological principles of patient care.	1	2	3	4	5		6	
I.10 understand psychological principles of patient care.	1	2	3	4	5		6	

Category I. Patient Care (Continued)	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
1.11 understand principles of therapeutic and supportive care.	1	2	3	4	5	6	
1.12 understand sociological principles of patient care.	1	2	3	4	5	6	
1.13 develop procedures for patient admission and discharge to and from the institution	1	2	3	4	5	6	

Additional Statements Section: Patient Care

Category II. Personnel Relations

The Long-Term Care Administator should be able to:	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
II.14 recruit competent and discharge incompetent professional employees.	1	2	3	4	5	6	
II.15 motivate all staff to accomplish tasks that fulfill the goals of the institution.	1	2	3	4	5	6	
II.16 deal with personal problems.	1	2	3	4	5	6	
II.17 make available inservice training opportunities for employees.	1	2	3	4	5	6	
II.18 develop procedures for employee evaluation.	1	2	3	4	5	6	
II.19 improve own professional knowledge and skill.	1	2	3	4	5	6	

Category II. Personnel Relations		Strongly Disagree		Disagree	Disagree With Reservation	Agree With Reservation		Agree Strongly Agree	Reasons for Disagreeing
11.20	establish the philosophy and goals of the organization	1	2	3	4	5	6		
11.21	establish administative lines of authority	1	2	3	4	5	6		
11.22	develop and communicate policies and procedures to department heads.	1	2	3	4	5	6		
11.23	conduct meetings effectively	1	2	3	4	5	6		
11.24	deal with governing bodies of long care facilities	1	2	3	4	5	6		
11.25	plan and implement long and short range objectives of the facility	1	2	3	4	5	6		
11.26	delegate responsibility appropriately	1	2	3	4	5	6		
11.27	interpret governing board's philosophy and goals	1	2	3	4	5	6		

Category II. Personnel Relations (continued)	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
II.28 establish management policies and procedures.	1	2	3	4	5	6	

Additional Statements Section: Personnel Relations

Category III. Budgeting & Financing

The Long-Term Care Administrator should be able to:		Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
III. 29	develop a sound annual budget.	1	2	3	4	5	6	
III.30	develop financial policies and establish financial controls.	1	2	3	4	5	6	
III.31	develop policies that determine employee salary and fringe benefits.	1	2	3	4	5	6	
III.32	understand procedures of third party payment organizations.	1	2	3	4	5	6	
III.33	secure adequate resources to accomplish goals of the institution.	1	2	3	4	5	6	
III.34	understand the principles of investment	1	2	3	4	5	6	
III.35	develop procedures for billing and collecting payments.	1	2	3	4	5	6	

Category III. Budgeting & Financing

Additional Statements Section: Budgeting & Financing

Category IV. Management & Supervision

The Long-Term Care Administrator should be able to:		Strongly Disagree		Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
IV.36	understand the principles of the management process (planning, organizing, directing, controlling and coordinating.	1	2	3	4	5	6		
IV.37	develop procedures to inform community about the institution.	1	2	3	4	5	6		
IV.38	establish policies of operation.	1	2	3	4	5	6		
VI.39	formulate goals and objectives of the institution	1	2	3	4	5	6		
VI.40	deal with the governing board of the institution	1	2	3	4	5	6		
VI.41	develop systems of control for patient care, financial management and general functions of the institution.	1	2	3	4	5	6		

Category IV. Management & Supervision (Continued)	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
IV.42 develop policies for maintenance and improvement of the physical plant.	1	2	3	4	5	6	
IV.43 develop policies and procedures for operations between departments.	1	2	3	4	5	6	
IV.44 develop procedures for measuring the accomplishments of the institution with the goals of the institution	1	2	3	4	5	6	
IV.45 supervise the purchasing of supplies and manage the inventory.	1	2	3	4	5	6	
IV.46 determine procedural policies concerning medical records.	1	2	3	4	5	6	

Category IV. Management & Supervision (Continued)	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
IV.47 supervision of department heads	1	2	3	4	5	6	

Additional Statements Section: Management and Supervision

Category V. Legal Problems and Government Relations

The Long-Term Care Administrator should be able to:	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree	Reasons for Disagreeing
V.48 know government licensing and certification procedures	1	2	3	4	5	6	
V.49 know how to bring institution into compliance with official regulations.	1	2	3	4	5	6	
V.50 interpret legislative trends that effect long-term care institution.	1	2	3	4	5	6	
V.51 know labor laws and develop policies to comply with these regulations.	1	2	3	4	5	6	
V.52 know patient rights	1	2	3	4	5	6	
V.53 understand the regulations of Titles XVIII and XIX of the Social Security Act	1	2	3	4	5	6	

Additional Statements Section: Legal Problems and Government Relations

APPENDIX J

SUMMARY REPORT - DELPHI QUESTIONNAIRE #1

SUMMARY REPORT

Delphi Questionnaire #1

The Identification of Long-Term Care Administrator Competence

The following summaries and computations are included in this report:

1. The number of responses for each value on all statements. For example:

I.1 work with the director of nursing services in the supervision and determination of patient needs

$\frac{1}{1}\ \frac{1}{2}\ \frac{3}{3}\ \frac{6}{4}\ \frac{3}{5}\ \frac{6}{6}$ = responses of expert panel
= value of disagreement to agreement

SD D DR AR A SA

2. The mean (arithmetic average) for each statement.

1 to 1.5	=	Strongly Disagree	(SD)
1.6 to 2.5	=	Disagree	(D)
2.6 to 3.5	=	Disagree with Reservation	(DR)
3.6 to 4.5	=	Agree with Reservation	(AR)
4.6 to 5.5	=	Agree	(A)
5.6 to 6	=	Strongly Agree	(SA)

3. The Interquartile Range (IQR)

The IQR is the interval containing the middle 50 percent of the responses and is used to determine consensus. For example, in the case below, the IQR would be found in the interval 4-5 (AR-A)

$\frac{\ }{1}\ \frac{\ }{2}\ \frac{5}{3}\ \frac{5}{4}\ \frac{5}{5}\ \frac{5}{6}$

SD D DR AR A SA

4. Reasons stated by expert panelists for disagreeing with a particular statement.

The mean and IQR will also be computed on Questionnaire #2 and be used to determine levels of consensus and whether or not the statements will be accepted in or rejected from the final list.

SUMMARY REPORT

Delphi Questionnaire #1: The Identification of Long-Term Care Administrator Competence

CATEGORY I. Patient Care The Long-Term Care Administrator should be able to:	Strongly Disagree	Disagree	Disagree with Reservation	Agree with Reservation	Agree	Strongly Agree	Mean	IQR
I.1 work with the director of nursing services in the supervision and determination of patient needs	1/1	1/2	3/3	6/4	3/5	6/6	4.35 (AR)	4-6 (AR-SA)

Reasons for Disagreeing:

I.1.1 Should work with the director of nursing services in formulating policy regarding patient needs.

2 Administrator not qualified to determine patient needs.

3 This is primarily delegated to patient care unit. Only as administrator has direct contact would he make a contribution.

4 The words "supervision and determination" imply the administrator has nursing knowledge. The administrator supervises the D.O.N. and evaluates the effectiveness of the department.

5 Administrator should be supportive but not actually involved in direct supervision.

								Mean	IQR
I.2	meet with and motivate patients towards rehabilitation	2/1	2/2	2/3	7/4	4/5	3/6	3.90 (AR)	3-5 (DR-A)

Reasons for Disagreeing:

I.2.1 It is not the administrator's job to deliver care, but rather to select, motivate and assess care-givers. In a larger institution it is also an impossible task.

2 Not an administrator's role.

3 This is primarily delegated to patient care unit.

4 This is the duty of the physical therapist and nursing staff.

5 The administrator should not be a clinician.

6 This responsibility relates to direct patient care which is not the responsibility of the administrator.

								Mean	IQR
I.3	work with the director of nursing services to develop policies for determining and improving nursing care practices	—/1	—/2	1/3	—/4	10/5	9/6	5.35 (A)	5 (A)

Reasons for Disagreeing:

I.3.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

								Mean	IQR
I.4	develop policies for coordinating medical services to the patient	—/1	—/2	1/3	5/4	5/5	9/6	5.10 (A)	4-6 (AR-SA)

Reasons for Disagreeing:

I.4.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

I.5 work directly with the patient's family	_ 1	1 2	3 3	2 4	8 5	6 6	Mean 4.75 (A)	IQR 4-6 (AR-SA)

Reasons for Disagreeing:

I.5.1 It is not the administrator's job to deliver care, but rather to select, motivate and assess care-givers. In a large institution it is also an impossible task. In addition, it is best for the medical and social team to work with families. The administrator becomes involved with unresolved problems in directing new approaches in working with families.

2 Available to meet with them about overall problems. Someone else's job.

3 Only as necessary to resolve difficulties that cannot be settled at other levels.

I.6 work with the director of nursing services to develop and periodically evaluate patient care plans and policies	_ 1	2 2	2 3	7 4	5 5	4 6	Mean 4.35 (AR)	IQR 4-5 (AR-A)

Reasons for Disagreeing:

I.6.1 Policies to set up a multi-disciplinary team are within the realm of the administrator, but not to review patient care plans.

2 Not role of administrator.

3 Unless the administrator is a professional expert, the best he can do is require that there be such policies and procedures.

I.6 (continued)

I.6.4 The patient care plan is a delegated function. Policies are responsibilities of administrator and governing board.

I.7	provide an environment that is attractive and conducive for good patient morale and care	_ 1	_ 2	_ 3	_ 4	5 5	15 6	Mean 5.75 (SA)	IQR 6 (SA)
I.8	develop policies that insure standards of environmental health and safety and comply with official regulations	_ 1	_ 2	_ 3	1 4	4 5	15 6	Mean 5.65 (SA)	IQR 5 (SA)

Reasons for Disagreeing:

I.8.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

I.9	understand anatomical and physiological principles of patient care	_ 1	1 2	4 3	8 4	6 5	1 6	Mean 4.10 (AR)	IQR 4-5 (AR-A)

Reasons for Disagreeing:

I.9.1 Requires much more technical education.

2 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

3 Knowledge to affect environment health--not direct care.

4 Can be indirectly helpful.

I.9 (continued)

I.9.5 Helpful but not mandatory.

I.10 understand psychological principles of patient care — _1 _2 3/3 4/4 7/5 6/6 — Mean: 4.80 (A) — IQR: 4-6 (AR-SA)

Reasons for Disagreeing:

I.10.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

2 Know effects of institutionsl impact on patient.

3 Can be indirectly helpful.

I.11 understand principles of therapeutic and supportive care — _1 _2 2/3 4/4 7/5 7/6 — Mean: 4.95 (A) — IQR: 4-6 (AR-SA)

Reasons for Disagreeing:

I.11.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

2 Can be indirectly helpful.

I.12 understand sociological principles of patient care — _1 _2 2/3 4/4 8/5 6/6 — Mean: 4.90 (A) — IQR: 4-6 (AR-SA)

Reasons for Disagreeing:

I.12.1 Unless the administrator is a professional expert, the best he can do is to require that there be such policies and procedures.

I.12 (continued)

I.12.2 Can be indirectly helpful.

							Mean	IQR
I.13 develop procedures for patient admission and discharge to and from the institution	1	2	1/3	5/4	7/5	7/6	5.00 (A)	4-6 (AR-SA)

Reasons for Disagreeing:

I.13.1 Delegated job of someone else.

CATEGORY II. Personnel Relations

The Long-Term Care Administrator should be able to:

							Mean	IQR
II.14 recruit competent and discharge incompetent professional employees	1	2	4/3	3/4	1/5	12/6	4.05 (A)	4-6 (AR-SA)

Reasons for Disagreeing:

II.14.1 Would agree if meant in a broad sense through department heads.

2 If no specific department head is available.

3 Recruitment can be part of administrator's function. Hiring and firing should be done by supervisor.

4 Criteria? (incompetence)

II.15	motivate all staff to accomplish tasks that fulfill the goals of the institution	1	2	3	4	5	6	Mean 5.60 (SA)	IQR 5-6 (A-SA)
II.16	deal with personnel problems	1	2	3	4	5	6	Mean 5.45 (A)	IQR 5-6 (A-SA)
II.17	make available in-service training opportunities for employees	1	2	3	4	5	6	Mean 5.80 (SA)	IQR 6 (SA)
II.18	develop procedures for employee evaluation	1	2	3	4	5	6	Mean 5.40 (A)	IQR 5-6 (A-SA)
II.19	improve own professional knowledge and skill	1	2	3	4	5	6	Mean 5.95 (SA)	IQR 6 (SA)
II.20	establish philosophy and goals of the organization	1	2	3	4	5	6	Mean 5.45 (A)	IQR 5-6 (A-SA)

Reasons for Disagreeing:

II.20.1 Should be the responsibility of the board and/or sponsoring group.

II.21	establish administrative lines of authority	1	2	3	4	5	6	Mean 5.95 (SA)	IQR 6 (SA)
II.22	develop and communicate policies and procedures to department heads	1	2	3	4	5	6	Mean 5.65 (SA)	IQR 6 (SA)

II.23	conduct meetings effectively	— 1	— 2	— 3	— 4	2 5	18 6	Mean 5.90 (SA)	IQR 6 (SA)
II.24	deal with governing bodies of long-care facilities	— 1	— 2	— 3	— 4	3 5	17 6	Mean 5.85 (SA)	IQR 6 (SA)
II.25	plan and implement long- and short-range objectives of the facility	— 1	— 2	— 3	3 4	3 5	14 6	Mean 5.55 (SA)	IQR 5-6 (A-SA)
II.26	delegate responsibility appropriately	— 1	— 2	— 3	— 4	— 5	20 6	Mean 6.0 (SA)	IQR 6 (SA)
II.27	interpret governing board's philosophy and goals	— 1	— 2	— 3	— 4	2 5	18 6	Mean 5.90 (SA)	IQR 6 (SA)
II.28	establish management policies and procedures	— 1	— 2	— 3	— 4	5 5	15 6	Mean 5.75 (SA)	IQR 6 (SA)

CATEGORY III. *Budgeting & Financing*

The Long-Term Care Administrator should be able to:

III.29	develop a sound annual budget	— 1	— 2	1 3	3 4	3 5	13 6	Mean 5.40 (A)	IQR 5-6 (A-SA)

III.29 (continued)

Reasons for Disagreeing:

III.29.1 Assist in developing budget.

III.30	develop financial policies and establish financial controls	_1	1/2	_3	3/4	5/5	11/6	Mean 5.25 (A)	IQR 5-6 (A-SA)

Reasons for Disagreeing:

III.30.1 Requires too much technical knowledge.

III.31	develop policies that determine employee salary and fringe benefits	_1	_2	_3	3/4	8/5	9/6	Mean 5.30 (A)	IQR 5-6 (A-SA)
III.32	understand procedures of third party payment organizations	_1	_2	_3	3/4	5/5	12/6	Mean 5.45 (A)	IQR 5-6 (A-SA)
III.33	secure adequate resources to accomplish goals of the institution	_1	1/2	_3	4/4	7/5	8/6	Mean 5.05 (A)	IQR 5-6 (A-SA)

Reasons for Disagreeing:

III.33.1 Administrator need not be fund/resource raiser.

III.34	understand the principles of investment	_1	1/2	1/3	7/4	6/5	5/6	Mean 4.65 (A)	IQR 4-6 (AR-SA)

III.34 (continued)

Reasons for Disagreeing:

III.34.1 His job is to administer program, not worry about investments.

2 Most administrators will not have this responsibility.

III.35	develop procedures for billing and collecting payments	1	2/2	2/3	3/4	3/5	10/6	Mean 4.85 (A)	IQR 4-6 (AR-SA)

Reasons for Disagreeing:

III.35.1 Job of business office.

2 Needs understanding, but subordinate should handle this.

3 Strictly a financial function.

4 Should really be the business manager's responsibility. However, a small facility may not have such a position.

CATEGORY IV. Management and Supervision

The Long-Term Care Administrator should be able to:

IV.36	understand the principles of the management process (planning, organizing, directing, controlling and coordinating)	1	2	3	4	2/5	18/6	Mean 5.90 (SA)	IQR 6 (SA)

IV.37	develop procedures to inform community about the instituion	_ 1	_ 2	_ 3	1 4	4 5	15 6	Mean 5.70 (SA)	IQR 6 (SA)
IV.38	establish policies of operation	_ 1	_ 2	_ 3	_ 4	3 5	17 6	Mean 5.85 (SA)	IQR 6 (SA)
IV.39	formulate goals and objectives of the institution	_ 1	_ 2	_ 3	4 4	4 5	12 6	Mean 5.40 (A)	IQR 5-6 (A-SA)
IV.40	deal with the governing board of the instituion	_ 1	_ 2	_ 3	_ 4	3 5	17 6	Mean 5.85 (SA)	IQR 6 (SA)
IV.41	develop systems of control for patient care, financial management and general functions of the institution	_ 1	_ 2	_ 3	2 4	3 5	15 6	Mean 5.65 (SA)	IQR 6 (SA)
IV.42	develop policies for maintenance and improvement of the physical plant	_ 1	_ 2	_ 3	7 4	5 5	8 6	Mean 5.05 (A)	IQR 5-6 (A-SA)
IV.43	develop policies and procedures for operations between departments	_ 1	_ 2	_ 3	2 4	6 5	12 6	Mean 5.50 (A)	IQR 5-6 (A-SA)
IV.44	develop procedures for measuring the accomplishments of the institution with the goals of the institution	_ 1	_ 2	_ 3	2 4	4 5	14 6	Mean 5.60 (SA)	IQR 5-6 (A-SA)

IV.45 supervise the purchasing of supplies and manage the inventory

2/1	3/2	2/3	8/4	3/5	2/6	Mean	IQR
						3.65 (AR)	3-4 (DR-AR)

Reasons for Disagreeing:

IV.45.1 Function of purchasing department.

2 Not his job.

3 Best left to others.

4 Should utilize department head.

5 Should formulate policies and develop systems but may not be the one to manage inventory.

6 This should be done by the purchasing department or business office. Depends on size of institution.

IV.46 determine procedural policies concerning medical records

1/	2/2	3/3	4/4	10/5	1/6	Mean	IQR
						4.25 (AR)	4-5 (AR-A)

Reasons for Disagreeing:

IV.46.1 Function of medical and nursing departments.

2 Not his job.

3 Should be done by others.

4 Should utilize department heads.

IV.47	supervision of department heads					3	17	Mean	IQR
		1	2	3	4	5	6	5.85 (SA)	6 (SA)

CATEGORY V. Legal Problems and Government Relations

The Long-Term Care Administrator should be able to:

V.48	know government licensing and certification procedures					3	17	Mean	IQR
		1	2	3	4	5	6	5.85 (SA)	6 (SA)
V.49	know how to bring institution into compliance with official regulations					3	17	Mean	IQR
		1	2	3	4	5	6	5.85 (SA)	6 (SA)
V.50	interpret legislative trends that effect long-term care institutions					7	13	Mean	IQR
		1	2	3	4	5	6	5.65 (SA)	6 (SA)
V.51	know labor laws and develop policies to comply with these regulations				1	5	14	Mean	IQR
		1	2	3	4	5	6	5.65 (SA)	5-6 (A-SA)
V.52	know patient rights					1	19	Mean	IQR
		1	2	3	4	5	6	5.95 (SA)	6 (SA)
V.53	understand the regulations of Titles XVIII and XIX of the Social Security Act				1	5	14	Mean	IQR
		1	2	3	4	5	6	5.65 (SA)	5-6 (A-SA)

APPENDIX K

DUNNING LETTER TO EXPERT PANELISTS

OREGON STATE UNIVERSITY

Department of Health
Corvallis, Oregon 97331
(503) 754-2686

June 1, 1981

Dr. Chisato Kawabori, Dir.
Office of Aging, Reg. X
1321 Second Avenue
Seattle, WA 98101

Dear Dr. Kawabori:

RE: The Identification of Long-Term Care Administrator Competencies, Questionnaire Number One

I have not received from you the questionnaire concerning the identification of long-term care administrator competencies which I sent to you near the first of May. In the event that the first questionnaire did not reach you, or was misplaced, I am enclosing a copy of the questionnaire with a stamped, self-addressed envelope for your convenience.

The procedures for this study require that all questionnaires be returned before the next step of the study can be accomplished. I recognize that you have a heavy schedule and appreciate the time you are donating to this study.

Thank you for noting this reminder and your promptness in replying.

Sincerely,

David A. Smith

Enclosures: 2

P.S. If you have already mailed the questionnaire to me, please disregard this letter. Thank you.

APPENDIX L

COVER LETTER - DELPHI QUESTIONNAIRE #2

OREGON STATE UNIVERSITY

Department of Health
Corvallis, Oregon 97331
(503) 754-2686

June 23, 1981

Dear:

RE: Identification of Long-Term Care Administrator Competence

Thank you for the excellent job you did in responding to the first questionnaire. I hope you will find the summary results and comments interesting and helpful when filling out Questionnaire #2. Included in this summary are the mean (arithmetic average); the interquartile range (the middle fifty percent which is used to determine consensus); and reasons for disagreeing.

Questionnaire #2 includes all of the original statements plus three additional statements recommended by the expert panel. Please complete the questionnaire within five days and return it to me in the stamped self-addressed envelope. I know how busy you are and am grateful for your cooperation in this study.

Your answers and comments will be kept confidential and only summarized results of this study will be used in subsequent reports. This dissertation will acknowledge the expert panel participants.

It is a privilege for me to be working with such recognized experts in the field of long-term care administration, and I appreciate your willingness to serve as an expert panelist for this study.

Sincerely,

David A. Smith
Department of Health
Oregon State University
Corvallis, Oregon 97331

DS:ck

APPENDIX M

DELPHI QUESTIONNAIRE #2

The Identification of Long-Term Care Administrator Competence

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE #2

Please do not be concerned about your responses to Questionnaire #1. In this second questionnaire you are asked to:

1. Read the Summary of Responses for Questionnaire #1.

2. Reach each statement in Questionnaire #2 and decide upon and check a category of agreement or disagreement. The categories of agreement or disagreement are:

1	Strongly Disagree	(SD)
2	Disagree	(D)
3	Disagree with Reservation	(DR)
4	Agree with Reservation	(AR)
5	Agree	(A)
6	Strongly Agree	(SA)

3. With the exception of the three additional statements, no written comments are necessary in this questionnaire.

4. Return Questionnaire #2 and Expert Panelist-Data Sheet in the stamped, self-addressed envelope.

DELPHI QUESTIONNAIRE #2: THE IDENTIFICATION OF LONG-TERM CARE ADMINISTRATOR COMPETENCE

Category I. Patient Care The Long-Term Care Administrator should be able to:	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree
I.1 work with the director of nursing services in the supervision and determination of patient needs.	1	2	3	4	5	6
I.2 meet with and motivate patients towards rehabilitation.	1	2	3	4	5	6
I.3 work with the director of nursing services to develop policies for determining and improving nursing.	1	2	3	4	5	6
I.4 develop policies for coordinating medical services to the patient.	1	2	3	4	5	6
I.5 work directly with the patient's family.	1	2	3	4	5	6
I.6 work with the director of nursing services to develop and periodically evaluate patient care plans and policies.	1	2	3	4	5	6

Category I. Patient Care (Continued)

I.7	provide an environment that is attractive and conducive for good patient morale and care.	1	2	3	4	5	6
I.8	develop policies that insure standards of environmental health and safety and comply with official regulations.	1	2	3	4	5	6
I.9	understand anatomical and physiological principles of patient care.	1	2	3	4	5	6
I.10	understand psychological principles of patient care.	1	2	3	4	5	6
I.11	understand principles of therapeutic and supportive care.	1	2	3	4	5	6
I.12	understand sociological principles of patient care.	1	2	3	4	5	6
I.13	develop procedures for patient admission and discharge to and from the institution.	1	2	3	4	5	6

New Statement

I.13a	establish and be involved in an on going community public relations program.	1	2	3	4	5	6

Category II. Personnel Relations

The Long-Term Care Administrator should be able to:

II.14	recruit competent and discharge incompetent professional employees.	1	2	3	4	5	6
II.15	motivate all staff to accomplish tasks that fulfill the goals of the institution.	1	2	3	4	5	6
II.16	deal with personnel problems	1	2	3	4	5	6
II.17	make available inservice training opportunities for employees.	1	2	3	4	5	6
II.18	develop procedures for employee evaluation.	1	2	3	4	5	6
II.19	improve own professional knowledge and skill.	1	2	3	4	5	6
II.20	establish philosophy and goals of the organization.	1	2	3	4	5	6
II.21	establish administrative lines of authority.	1	2	3	4	5	6
II.22	develop and communicate policies and procedures to department heads.	1	2	3	4	5	6
II.23	conduct meetings effectively.	1	2	3	4	5	6

Category II. Personnel Relations (Continued)

II.24	deal with governing bodies of long-term care facilities.	1	2	3	4	5	6
II.25	plan and implement long and short range objectives of the facility.	1	2	3	4	5	6
II.26	delegate responsibility appropriately.	1	2	3	4	5	6
II.27	interpret governing board's philosophy and goals.	1	2	3	4	5	6
II.28	establish management policies and procedures.	1	2	3	4	5	6
New Statement							
II.28a	employ a nursing staff that is capable of providing good quality care.	1	2	3	4	5	6
New Statement							
II.28b	identify the standards in the field of long-term care administration.	1	2	3	4	5	6

Category III. Budgeting & Financing

The Long-Term Care Administrator should be able to:

III.29	develop a sound annual budget.	1	2	3	4	5	6
III.30	develop financial policies and establish financial controls.	1	2	3	4	5	6
III.31	develop policies that determine employee salary and fringe benefits.	1	2	3	4	5	6
III.32	understand procedures of third party payment organizations.	1	2	3	4	5	6
III.33	secure adequate resources to accomplish goals of the institution.	1	2	3	4	5	6
III.34	understand the principles of investment.	1	2	3	4	5	6
III.35	develop procedures for billing and collecting payments.	1	2	3	4	5	6

Category IV. Management & Supervision

The Long-Term Care Administrator should be able to:

IV.36	understand the principles of the management process (planning, organizing, directing, controlling and coordinating).	1	2	3	4	5	6
IV.37	develop procedures to inform community about the institution.	1	2	3	4	5	6
IV.38	establish policies of operation.	1	2	3	4	5	6
IV.39	formulate goals and objectives of the institution.	1	2	3	4	5	6
IV.40	deal with the governing board of the institution.	1	2	3	4	5	6
IV.41	develop systems of control for patient care, financial management and general functions of the institution.	1	2	3	4	5	6
IV.42	develop policies for maintenance and improvement of the physical plant.	1	2	3	4	5	6
IV.43	develop policies and procedures for operations between departments.	1	2	3	4	5	6

Category IV. Management & Supervision (Continued)

IV.44	develop procedures for measuring the accomplishments of the institution with the goals of the institution.	1	2	3	4	5	6
IV.45	supervise the purchasing of supplies and manage the inventory.	1	2	3	4	5	6
IV.46	determine procedural policies concerning medical records.	1	2	3	4	5	6
IV.47	supervision of department heads.	1	2	3	4	5	6

Category V. Legal Problems and Government Relations

The Long-Term Care Administrator should be able to:

V.48	know government licensing and certification procedures.	1	2	3	4	5	6
V.49	know how to bring institution into compliance with official regulations	1	2	3	4	5	6
V.50	interpret legislative trends that effect long-term care institutions.	1	2	3	4	5	6
V.51	know labor laws and develop policies to comply with these regulations.	1	2	3	4	5	6
V.52	know patient rights.	1	2	3	4	5	6
V.53	understand the regulations of Titles XVIII and XIX of the Social Security Act.	1	2	3	4	5	6

APPENDIX N

EXPERT PANELIST DATA SHEET

EXPERT PANELIST - DATA SHEET

In order to insure that the data I have on each expert panelist are current and accurate, I would like to ask you to provide the following information. This information will be cited in the appendix section of the dissertation.

Your name and title as you would like it to appear in the dissertation:

_____

_____

_____

_____

_____

_____

Please include this data sheet when you return Questionnaire #2. Thank you.

APPENDIX O

SUMMARY REPORT OF DELPHI QUESTIONNAIRE #2

SUMMARY REPORT

Delphi Questionnaire #2

The Identification of Long-Term Care Administrator Competence

The following summaries and computations are included in this report:

1. The number of responses for each value on all statements.

   For example:

   I. 1 work with the director of nursing services in the supervision and determination of patient needs — $\underset{1}{\_}\ \underset{2}{2}\ \underset{3}{1}\ \underset{4}{9}\ \underset{5}{3}\ \underset{6}{4}$ = panelist responses

2. The mean (arithmetic average) for each statement.

   For example:

   $\underset{1}{\_}\ \underset{2}{2}\ \underset{3}{1}\ \underset{4}{9}\ \underset{5}{3}\ \underset{6}{4}$ mean = 4.316

   (For this study, a mean level of 4.80 must have been achieved before the statement would be acceptable for the final list.)

3. The Interquartile Range (IQR).

   The IQR is the interval containing the middle 50 percent of the responses and is used to determine consensus.

   For example: $\underset{1}{\_}\ \underset{2}{2}\ \underset{3}{1}\ \underset{4}{9}\ \underset{5}{3}\ \underset{6}{4}$ IQR = 4 - 5

DELPHI QUESTIONNAIRE #2: THE IDENTIFICATION OF LONG-TERM CARE ADMINISTRATOR COMPETENCE

Category I. Patient Care The Long-Term Care Administrator should be able to:	Strongly Disagree	Disagree	Disagree With Reservation	Agree With Reservation	Agree	Strongly Agree		Mean	IQR
I.1 work with the director of nursing services in the supervision and determination of patient needs.	1	2/2	1/3	9/4	3/5	4/6	*	4.316	4-5
I.2 meet with and motivate patients towards rehabilitation.	1/1	5/2	3/3	5/4	2/5	3/6	*	3.579	2-5
I.3 work with the director of nursing services to develop policies for determining and improving nursing.	1	2	3	6/4	5/5	8/6		5.105	4-6
I.4 develop policies for coordinating medical services to the patient.	1	1/2	3/3	6/4	5/5	4/6	*	4.421	3-5
I.5 work directly with the patient's family.	1/1	1/2	3/3	2/4	10/5	2/6	*	4.316	3-5
I.6 work with the director of nursing services to develop and periodically evaluate patient care plans and policies.	1	4/2	2/3	7/4	4/5	2/6	*	3.895	3-5

Category I. Patient Care (Continued)								Mean	IQR
I.7	provide an environment that is attractive and conducive for good patient morale and care.	1	2	3	4	4/5	15/6		5.789	6
I.8	develop policies that insure standards of environmental health and safety and comply with official regulations.	1	2	3	1/4	3/5	15/6		5.737	6
I.9	understand anatomical and physiological principles of patient care.	1/1	2/2	5/3	6/4	4/5	1/6	*	3.684	3-5
I.10	understand psychological principles of patient care.	1	1/2	2/3	4/4	7/5	5/6	*	4.684	4-6
I.11	understand principles of therapeutic and supportive care.	1	1/2	2/3	4/4	8/5	4/6	*	4.632	4-5
I.12	understand sociological principles of patient care.	1	1/2	1/3	4/4	8/5	5/6	*	4.789	4-6
I.13	develop procedures for patient admission and discharge to and from the institution.	1	1/2	2/3	2/4	5/5	9/6		5.000	4-6
New Statement										
I.13a	establish and be involved in an on going community public relations program.	1	2	3	1/4	7/5	11/6		5.526	5-6

Category II. Personnel Relations

The Long-Term Care Administrator should be able to:								Mean	IQR
II.14	recruit competent and discharge incompetent professional employees.	1	2	2/3	3/4	3/5	11/6	5.211	4-6
II.15	motivate all staff to accomplish tasks that fulfill the goals of the institution.	1	2	3	4	6/5	13/6	5.684	4-6
II.16	deal with personnel problems	1	2	3	3/4	5/5	11/6	5.421	5-6
II.17	make available inservice training opportunities for employees.	1	2	3	1/4	5/5	13/6	5.632	5-6
II.18	develop procedures for employee evaluation.	1	2	3	2/4	5/5	12/6	5.526	5-6
II.19	improve own professional knowledge and skill.	1	2	3	4	5	19/6	6.000	6
II.20	establish philosophy and goals of the organization.	1/1	2	1/3	1/4	4/5	12/6	5.263	5-6
II.21	establish administrative lines of authority.	1	2	3	4	5	19/6	6.000	6
II.22	develop and communicate policies and procedures to department heads.	1	2	3	4	1/5	18/6	5.947	6
II.23	conduct meetings effectively.	1	2	3	1/4	2/5	16/6	5.789	6

Category II. Personnel Relations (Continued)							Mean	IQR
II.24 deal with governing bodies of long-term care facilities.	1	2	3	4	15	186	5.947	6
II.25 plan and implement long and short range objectives of the facility.	1	2	3	14	45	146	5.684	5-6
II.26 delegate responsibility appropriately.	1	2	3	4	15	186	5.947	6
II.27 interpret governing board's philosophy and goals.	1	2	3	4	15	186	5.947	6
II.28 establish management policies and procedures.	1	2	3	4	25	176	5.895	6
New Statement								
II.28a employ a nursing staff that is capable of providing good quality care.	1	2	3	44	55	106	5.316	5-6
New Statement								
II.28b identify the standards in the field of long-term care administration.	1	2	3	14	55	136	5.632	5-6

Category III. Budgeting & Financing								Mean	IQR
The Long-Term Care Administrator should be able to:									
III.29 develop a sound annual budget.	1	2	1/3	3/4	4/5	11/6		5.316	5-6
III.30 develop financial policies and establish financial controls.	1/1	2	3	2/4	5/5	11/6		5.263	5-6
III.31 develop policies that determine employee salary and fringe benefits.	1	2	3	2/4	8/5	9/6		5.368	5-6
III.32 understand procedures of third party payment organizations.	1	2	3	3/4	7/5	9/6		5.316	5-6
III.33 secure adequate resources to accomplish goals of the institution.	1	1/2	1/3	2/4	3/5	12/6		5.263	5-6
III.34 understand the principles of investment.	1	1/2	2/3	5/4	6/5	5/6	*	4.632	4-6
III.35 develop procedures for billing and collecting payments.	1/1	1/2	1/3	4/4	7/5	5/6	*	4.579	4-6

Category IV. Management & Supervision								Mean	IQR
The Long-Term Care Administrator should be able to:									
IV.36	understand the principles of the management process (planning, organizing, directing, controlling and coordinating).	1	2	3	4	1/5	18/6	5.947	6
IV.37	develop procedures to inform community about the institution.	1	2	3	1/4	5/5	13/6	5.632	5-6
IV.38	establish policies of operation.	1	2	3	2/4	5/5	12/6	5.526	5-6
IV.39	formulate goals and objectives of the institution.	1	2	3	1/4	6/5	12/6	5.579	5-6
IV.40	deal with the governing board of the institution.	1	2	3	4	1/5	18/6	5.947	6
IV.41	develop systems of control for patient care, financial management and general functions of the institution.	1	2	3	2/4	3/5	14/6	5.632	5-6
IV.42	develop policies for maintenance and improvement of the physical plant.	1	2	1/3	3/4	6/5	9/6	5.211	5-6
IV.43	develop policies and procedures for operations between departments.	1	2	3	1/4	6/5	12/6	5.579	5-6

Category IV. Management & Supervision (Continued)								Mean	IQR
IV.44	develop procedures for measuring the accomplishments of the institution with the goals of the institution.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{3}{5}$	$\frac{16}{6}$		5.842	6
IV.45	supervise the purchasing of supplies and manage the inventory.	$\frac{1}{1}$	$\frac{3}{2}$	$\frac{3}{3}$	$\frac{2}{4}$	$\frac{4}{5}$	$\frac{1}{6}$	*	3.684	3-5
IV.46	determine procedural policies concerning medical records.	$\frac{}{1}$	$\frac{1}{2}$	$\frac{5}{3}$	$\frac{8}{4}$	$\frac{4}{5}$	$\frac{1}{6}$	*	3.947	3-5
IV.47	supervise department heads	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{2}{5}$	$\frac{17}{6}$		5.895	6

Category V. Legal Problems and Government Relations								Mean	IQR
The Long-Term Care Administrator should be able to:									
V.48	know government licensing and certification procedures.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{3}{5}$	$\frac{16}{6}$	5.842	6
V.49	know how to bring institution into compliance with official regulations	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{4}{5}$	$\frac{15}{6}$	5.789	6
V.50	interpret legislative trends that effect long-term care institutions.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{7}{5}$	$\frac{12}{6}$	5.632	5-6
V.51	know labor laws and develop policies to comply with these regulations.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{2}{4}$	$\frac{4}{5}$	$\frac{13}{6}$	5.579	5-6
V.52	know patient rights.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{}{4}$	$\frac{3}{5}$	$\frac{16}{6}$	5.842	6
V.53	understand the regulations of Titles XVIII and XIX of the Social Security Act.	$\frac{}{1}$	$\frac{}{2}$	$\frac{}{3}$	$\frac{1}{4}$	$\frac{6}{5}$	$\frac{12}{6}$	5.579	5-6

* mean below 4.80 standard of acceptance

APPENDIX P

FINAL LIST OF COMPETENCY STATEMENTS

Final List of Long-Term Care Administrator Competencies

Category I. Patient Care

The long-term care administrator should be able to:

1. work with the director of nursing services to develop policies for determining and improving nursing.
2. provide an environment that is attractive and conducive for good patient morale and care.
3. develop policies that insure standards of environmental health and safety and comply with official regulations.
4 develop procedures for patient admission and discharge to and from the institution.
5. establish and be involved in an on-going community public relations program.

Category II. Personnel Relations.

The long-term care administrator should be able to:

6. recruit competent and discharge incompetent professional employees.
7. motivate all staff to accomplish tasks that fulfill the goals of the institution.
8. deal with personnel problems.
9. make available in-service training opportunities for employees.
10. develop prodedures for employee evaluation.
11. improve own professional knowledge and skill.
12. establish philosophy and goals of the organization.
13. establish administrative lines of authority.
14. develop and communicate policies and procedures to department heads.
15. conduct meetings effectively.
16. plan and implement long and short range objectives of the facility.
17. delegate responsiblity appropriately.
18. interpret governing board's philosophy and goals.
19. establish management policies and procedures.
20. employ a nursing staff that is capable of providing good quality of care.
21. identify the standards in the field of long-term care administration.

Category III. Budgeting and Financing.

The long-term care administrator should be able to:

22. develop a sound annual budget.
23. develop financial policies and establish financial controls.
24. develop policies that determine employee salary and fringe benefits.
25. understand procedures of third party payment organizations.
26. secure adequate resources to accomplish goals of the institution.

Category IV. Management and Supervision.

The long-term care administrator should be able to:

27. understand the principles of the management process (planning, organizing, directing, controlling, and coordinating).
28. develop procedures to inform community about the institution.
29. establish policies of operation.
30. formulate goals and objectives of the institution.
31. deal with the governing board of the institution.
32. develop systems of control for patient care and general functions of the institution.
33. develop policies for maintenance and improvement of the physical plant.
34. develop policies and procedures for operations between departments.
35. develop procedures for measuring the accomplishments of the institution with the goals of the institution.
36. supervise department heads.

Category V. Legal Problems and Government Regulations.

The long-term care administrator should be able to:

37. know government licensing and certification procedures.
38. know how to bring institution into compliance with official regulations.
39. interpret legislative trends that effect long-term care institutions.
40. know labor laws and develop policies to comply with these regulations.
41. know patient rights.
42. understand the regulations of Titles XVIII and XIX of the Social Security Act.