INTEGRATING RURAL PRIMARY, ACUTE AND LONG-TERM CARE SERVICES: CHALLENGES AND OPPORTUNITIES

Andrew F. Coburn, Ph.D.

INTRODUCTION

Approximately one-fifth of the elderly in the United States—defined as individuals aged 65 and over—live in rural places and in 1995 accounted for 8.2 million people. Historically, rural areas in the United States have had higher concentrations of older people. In 1995, the elderly comprised 14.6 percent of the population in non-metropolitan counties compared with 12.2 percent in metropolitan counties (Figure 1). Non-metropolitan areas generally have a higher proportion of older persons than metro areas. Smaller rural areas of less than 2,500 persons consistently have the highest proportion of older persons across all of the age categories.

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2 The terms “metropolitan” and “non-metropolitan” are official designations developed by the U.S. Office of Management and Budget to define urban (metropolitan) and rural (non-metropolitan) areas of the United States. These terms are used in this paper to refer to rural and urban areas and populations.
Consistent with national and international trends, the elderly population has been growing in rural counties since the 1960s. In the United States, the elderly population rose from 9.2 percent of the total population in 1960 (16.6 million) to 12.6 percent (31.2 million) in 1990 (Fuguitt et al., 1997). Although rural areas in the United States have tended to have higher concentrations of older persons than urban areas, this trend has been changing in recent years (Coburn and Bolda, 1999).

**Figure 1. Age Distribution of Rural and Urban Residents Over Age 65, 1995**

![Age Distribution Chart](chart1.png)

Source: Bureau of Census, Department of Commerce.

**Figure 2. Income of Rural and Urban Elderly Residents (Age 65+), 1995**

![Income Chart](chart2.png)

Compared with urban elders, the rural elderly have lower incomes, they are more likely to be poor (Figure 2), and they are less educated (Coward et al., 1994). Although they are more likely to own their homes, those dwellings are more likely to be substandard; that is, they are more likely to have inadequate heating and plumbing systems and to be in need of costly repairs (Coward et al., 1994). As indicated in Table 1, the rural elderly in the United States are more likely to be in poorer health than their urban counterparts (Coward et al., 1994). A higher proportion of elders in non-metropolitan counties than in metropolitan counties reported a functional status problem—40.5 percent in adjacent non-metropolitan areas and 37.6 percent in non-adjacent non-metropolitan areas versus 34.3 percent in metro areas (Figure 3). Elders living in non-metropolitan areas adjacent to a metro area were somewhat more likely than those living in metropolitan areas to report having a limitation in at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) (Figure 3).

Table 1. Self-Assessed Health Status of the Elderly by Age and Urban Influence Codes, United States, 1990-1994

<table>
<thead>
<tr>
<th>Percentage reporting health status*</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGES 65-69</td>
</tr>
<tr>
<td>Urban Influence Code**</td>
</tr>
<tr>
<td>Metro</td>
</tr>
<tr>
<td>Non-metro Adjacent</td>
</tr>
<tr>
<td>Non-metro Nonadjacent</td>
</tr>
<tr>
<td>Rural &lt;2,500</td>
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</tbody>
</table>


*The percentages are based on weighted frequencies. The percentages may not round to 100 percent.

Despite their greater need, rural elders are less likely to have their health and long-term care needs met due to problems in the availability of health and social services and the obstacles to delivering services in rural areas, including low population densities, limited transportation and longer travel distances (Krout, 1994).

Patterns in the availability and use of health and long-term care services among the rural elderly suggest a number of important challenges for state and federal policy. Efforts to shift the use of services away from costly, institutionally based care in hospitals and nursing homes will be particularly difficult to achieve in rural areas. The rural long-term care service system in the United States is characterized by a larger supply (per elder) of nursing home beds than in urban areas and fewer community-based, in-home services, preventive services and residential care options (Coburn and Bolda, 1999). These and other factors may contribute to the higher than usual rates of institutional service use among rural elders.

Changes in federal and state policies, consumer preferences and other factors are transforming the landscape of America’s long-term care system. These changes are reflected in the increased reliance on private funding for services, the expansion of non-medical residential care alternatives, the growth of in-home care options, and the greater integration and management of services across the primary, acute and long-term care systems. In the face of growing
public expenditures, states, the federal government and health care providers are searching for new financing, organizational and coordinated care strategies that better integrate the financing and delivery of primary care, acute and long-term care services (Health Care Financing Administration, 1995; Booth et al., 1997). Integration and care coordination are viewed as encouraging a substitution of less costly and more appropriate home and community-based services for high cost medical and long-term care services that have been heavily funded under fee-for-service financing systems.

For rural communities, the development of delivery systems that better integrate and manage primary, acute and long-term care services may help address long-standing problems of limited access to long-term care services. This paper discusses the challenges and opportunities that health care providers, state and federal policymakers and others face in developing these new integrated structures, and the future of integrated approaches in rural areas.

**The Rural Health and Long-Term Care Systems**

Data on the use of physician services in the United States do not indicate a consistent pattern of differences across geographic areas (Table 2). Among elders aged 65-69, visit rates (average annual visits per person) were lowest among rural elders living in non-metropolitan areas adjacent to a metro area (9.8). In contrast, among elders aged 70-74, physician visit rates were lowest among elders living in non-metropolitan areas of less than 2,500 population (5.7). Interestingly, rural elders over the age of 75 had similar or higher physician visit rates than urban elders in this same age cohort. Not surprisingly, the rural elderly are more likely than those in urban areas to have to travel more than 30 minutes to obtain services; they also more likely have to wait more than 30 minutes at the site of care for their appointments (Van Nostrand, 1993).
Table 2. Mean Annual Doctor Visits* and Hospital Stays Per Person by Age and Urban Influence Codes, United States 1990-1994

<table>
<thead>
<tr>
<th>Urban Influence Code**</th>
<th>Metro</th>
<th>Non-metro adjacent</th>
<th>Non-metro non-adjacent</th>
<th>Rural &lt;2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 65-69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number of doctor visits per person for 12 months</td>
<td>10.8</td>
<td>9.8</td>
<td>12.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Mean number of short stay hospital episodes per person for 12 months</td>
<td>.19</td>
<td>.20</td>
<td>.25</td>
<td>.22</td>
</tr>
<tr>
<td>Ages 70-74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number of doctor visits per person for 12 months</td>
<td>10.8</td>
<td>13.7</td>
<td>9.12</td>
<td>5.7</td>
</tr>
<tr>
<td>Mean number of short stay hospital episodes per person for 12 months</td>
<td>.22</td>
<td>.25</td>
<td>.24</td>
<td>.17</td>
</tr>
<tr>
<td>Ages 75+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number of doctor visits per person for 12 months</td>
<td>16.5</td>
<td>23.3</td>
<td>15.8</td>
<td>21.9</td>
</tr>
<tr>
<td>Mean number of short stay hospital episodes per person for 12 months</td>
<td>.27</td>
<td>.30</td>
<td>.31</td>
<td>.33</td>
</tr>
</tbody>
</table>


*The mean numbers are estimated using weighted National Health Interview Survey data.


On average, the rural elderly have similar or higher rates of hospitalization compared with those living in urban areas. The average annual number of short stay hospital episodes is the same or higher among the rural elderly in each of the three age cohorts (Table 2), except for rural under 2,500 for ages 70-74. Medicare discharges were approximately 14 percent higher in 1988 among the elderly living in non-metropolitan areas compared with those in metropolitan areas. The number of days of care per 1,000 Medicare
beneficiaries is lower, however, in non-metropolitan than metropolitan counties (Van Nostrand, 1993).

As in most countries, the majority of older persons in the United States rely on their spouses, children, family members and/or informal support networks to help them with their financial, household and other needs. Only a small minority of older individuals use formal, paid health and social support services (e.g., home health services). The family and social support characteristics of the rural and urban elderly are critical, therefore, to understanding differences that may exist in their long-term care needs. In the United States, rural elders are somewhat more likely than their urban counterparts to be married and living with their spouse. In general, however, over half of the population of rural and urban older persons over the age of 75 live alone (the most significant risk factor for use of formal long-term care services) (Figure 4).

**Figure 4. Percentage of Persons 55 and Older Living Alone by Residence, 1996**

<table>
<thead>
<tr>
<th>Urban Influence Code</th>
<th>Metro Residence</th>
<th>Non-metro Residence</th>
<th>Non-metro Residence</th>
<th>Rural Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 65-69</td>
<td>60-74</td>
<td>75+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number of doctor visits per person for 12 months</td>
<td>26.5</td>
<td>10.8</td>
<td>12.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Mean number of short stay hospital episodes per person for 12 months</td>
<td>.22</td>
<td>.25</td>
<td>.24</td>
<td>.17</td>
</tr>
</tbody>
</table>

A body of literature suggests that the rural elderly in the United States are less likely than those living in urban places to use formal, in-home long-term care services (Coward and Cutler, 1989; Kenney, 1993a, 1993b). This is usually attributed to the more limited availability and accessibility of formal home and community-based services in rural areas.
Moreover, among those using services, significant differences exist among the rural and urban elderly in the mix of services used. Studies have shown a higher use of nursing home services (especially custodial level care) among the rural elderly and lower rates of home health and other community-based, in-home services (Shaughnessey, 1994; Coward et al., 1995; Coward et al., 1996). The larger supply of nursing homes in rural areas, combined with the more limited availability of community-based, in-home services, are often suggested as reasons for these higher nursing home use rates (Greene, 1984).

According to the most recent data from the Nursing Home Component of the Medical Expenditure Panel Survey (MEPS) conducted in 1996, the supply of nursing homes and nursing home beds is nearly 43 percent greater in non-metropolitan than metropolitan areas. In 1996, there were nearly 70 beds per 1,000 persons over the age of 65 in non-metropolitan areas compared with 47.6 per 1,000 aged 65-plus in metropolitan areas (Figure 5).

**Figure 5. Nursing Home Bed Supply in Rural and Urban Areas, 1996**

![Bar chart showing nursing home bed supply per 1,000 population 65+](chart)

Source: Agency for Health Care Policy and Research, Medical Expenditure Panel Survey (MEPS)—Nursing Home Component, 1996.

The MEPS data also show that nursing homes located in non-metropolitan areas are less likely than those in metro areas to have certified skilled nursing beds or special care units (Rhoades, Potter and Krause, 1998). These findings are consistent with prior research suggesting that rural nursing homes are more likely to offer a custodial level of care than urban nursing facilities (Shaughnessey, 1994). Nursing homes in non-metropolitan areas are also less likely to have non-nursing beds (i.e. personal care or independent living beds).
Not unexpectedly, rural nursing homes tend to be smaller than those located in urban areas: nearly half (46 percent) of all nursing homes in non-metropolitan areas have fewer than 75 beds compared with 29.1 percent in metro areas. Conversely, only 13.9 percent of homes in non-metropolitan areas have more than 125 beds, compared with 31.5 percent of homes in metro areas (Rhoades, Potter and Krause, 1998). Largely because of the Medicare swing-bed program, a high proportion of nursing homes in rural areas are hospital-based (16.4 percent compared with 8.3 percent in metro areas).

As discussed earlier, there is conflicting evidence regarding differences among the rural and urban elderly in their use of other formal long-term care services. While there is little doubt that many rural areas have a more limited supply of community-based services and that access to these services may be compromised by distance and transportation, affordability and other problems, there is also evidence that among those most in need—the frail and infirm elderly—the use of services may be comparable among the rural and urban elderly (Coward et al., 1993). The reasons for this are not well understood. One explanation may be that the limited supply of community-based services in rural areas is better targeted to those most in need. We also know little about the rates of use of in-home services among the rural and urban elderly, and in particular, whether and to what degree the more limited supply of specialized therapists or other health personnel in rural areas may restrict the availability and use of in-home services. Nor is it known whether the higher cost of providing services in rural areas may affect the ability of agencies to provide care to rural elderly in their homes.

There are numerous barriers and challenges to reducing the differences in health and long-term care access and use for older persons living in rural places. Two are especially important. First, the current financing of long-term care generally, and in rural areas in particular, limits the availability of services (and therefore their use) in rural areas. With a more limited capacity to pay for long-term care services out of their own pockets, rural elders are more dependent on public programs for funding to meet their long-term care needs. Moreover, the smaller economies of scale, higher costs of developing and providing services, and lower supply of therapists and other critical health personnel represent significant barriers to the development of adequate long-term care services in rural areas.
A second challenge will be to develop better models for delivering health and long-term care services in rural communities. This problem is especially important in light of the limited financing for long-term care and the competition for health personnel. Incentives are needed in new and existing programs to encourage rural providers and communities to expand available services and develop better integrated service models. The development of partnerships and service networks among rural and urban health and long-term care providers may be needed to achieve these objectives, as it is unlikely that smaller rural communities can support the full service network that may be needed.

**SERVICE INTEGRATION**

The American health-care system is increasingly moving toward the development of organized delivery systems in which the financing and/or delivery of hospital, physician, therapy, lab and other services are better integrated. In its simplest definition, the term “integration” means the bringing together into a more unified structure previously independent administrative and service functions, services, and/or organizations (Morris and Lescohier, 1978; Bird et al., 1998; Leutz, 1999). Integration can occur at different levels of both the organization and service system: policy, financing, organization/structure, administrative, and clinical.

There are a number of vehicles that promote integration including organizational and service system planning, the development of integrated information systems that support administrative and clinical integration, integrated care planning and management, and staff training (Leutz, 1999).

Organizations may engage in a combination of strategies to integrate medical and long-term care services. There is no clear continuum or hierarchy that can easily classify approaches to integration. To understand the concept of integration as applied to primary, acute and long-term care, it is important to distinguish between:

- **what is being integrated** (the target population/s and scope of services);
- **how functional and clinical integration occurs** (types of integration); and
- **the level of financial incentive and strategic management that is being achieved** (degree of integration).
APPLICATION TO THE LONG-TERM CARE SECTOR

Until very recently, trends toward greater system integration and care coordination have proceeded along very separate tracks in the medical care and long-term care sectors. Networks and systems for care of persons with chronic care needs are in their infancy (Stone and Katz, 1996; Fox and Fama, 1996). Few integrated organizational networks and systems include in-home and non-medical residential long-term care services.

Acute and long-term care services vary on multiple dimensions and operate within very different frames of references, (Table 3) not the least of which is the reality that acute care costs are driven by intensity of services while long-term care costs are more sensitive to duration of services (Vladeck, 1994). Fundamental differences between the medical care and long-term care systems contribute to the challenges of developing integrated programs spanning these two sectors. In addition, unlike changes in the medical sector, neither public policies and programs nor private purchasers have exercised much direct influence on system integration and the development of service integration models within the long-term care sector. In the last five years, however, various states across the United States have begun to search for new financing and care integration models for controlling Medicaid-financed long-term care costs through the application of managed care principles and systems (Booth et al., 1997). These efforts have been premised on the assumption that integrating the financing and management of care across primary, acute and long-term care services (and across the Medicare and Medicaid programs) is critical for controlling costs and assuring appropriate care for persons with chronic illness and disability who are the highest cost users of services. The basic features of these systems include:

- the development of financing arrangements that encompass medical and long-term care services and provide incentives for cost control across both services;
- incentives for the creation of service networks capable of providing or accessing the full range of covered services; and
- the development of care management mechanisms necessary for assuring consumer-centered care, care quality and the appropriate mix and use of resources/services.
Table 3. Differences in Acute Versus Long-Term Care

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Acute Care</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand Source</td>
<td>Acute Illness</td>
<td>Chronic Illness</td>
</tr>
<tr>
<td>Critical Source</td>
<td>Diagnosis</td>
<td>Function</td>
</tr>
<tr>
<td>Site</td>
<td>Hospital-&gt;Outpatient Department</td>
<td>Nursing Home-&gt;Home</td>
</tr>
<tr>
<td>Boundaries</td>
<td>Sharply Delineated</td>
<td>Fuzzy</td>
</tr>
<tr>
<td>Desired Outcomes</td>
<td>Cure</td>
<td>Maintenance</td>
</tr>
<tr>
<td>Caregivers</td>
<td>Professional</td>
<td>Family Members</td>
</tr>
<tr>
<td>Professional Roles</td>
<td>Physician Directed</td>
<td>Physician is absent—Other Turf is Disputed</td>
</tr>
<tr>
<td>Styles of Care</td>
<td>Interventionist</td>
<td>Maintenance</td>
</tr>
<tr>
<td>Technology</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Intellectual Basis</td>
<td>Dynamic Science</td>
<td>Pre-paradigmatic</td>
</tr>
<tr>
<td>Cost Drivers</td>
<td>Intensity (Duration Minimized)</td>
<td>Duration (Intensity Minimized)</td>
</tr>
<tr>
<td>Primary Public Payer</td>
<td>Medicare</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>


Are the rural medical and long-term care systems ready to integrate?

The limited rural examples of integrated primary, acute and long-term care programs suggest that there are a number of critical issues for states, rural communities and health-care providers to consider as they contemplate ways of redesigning the financing and delivery of services to achieve better integration, access and quality. Although many of these issues can be characterized as “barriers” to integrated financing and service delivery approaches in rural areas, some may also represent opportunities.
Limited Services and Service Delivery Mechanisms in Rural Areas

To adequately address the complex health-care and social support needs of frail, older persons, programs that seek to integrate acute and long-term care services in rural areas must deal with the common service limitations that exist in many rural areas. Access to specialty services, such as physical therapists, psychiatrists and transportation is among the most significant hurdles that must be overcome. In addition, integration programs must recognize that transportation and other costs are often higher in rural areas.

Rural integrated programs are most likely to be developed through partnerships between rural medical and long-term care service providers and larger organizations such as county health systems, hospitals and/or managed care organizations. The model of urban-based providers reaching out into surrounding rural areas to establish local satellite programs is one that may fit in a number of rural areas. In this way, the rural sites may gain access to a broader range of specialty and other services than could be developed locally. The other side to this coin is that some fear that linkages with urban-based plans or providers may undermine the ability of rural providers and health systems to control their own fates (Amundson, 1993).

Aligning the Incentives and Professional Culture

There are few incentives for communities, medical and long-term care providers, or health plans to develop programs that integrate long-term care into the continuum of primary and acute care services. Until recently, hospitals have had incentives under current payment policies to add home health care and, in some cases, skilled nursing facility care to their continuum of health services. Few have ventured into the arena of non-medical home care, residential care and other long-term care services, however. The primary reason is that there are few financial or other incentives for doing so.

It is hard to overestimate the importance of state policy in shaping the strategies that health plans and providers will develop in forming service networks that better integrate the delivery of primary, acute and long-term care services. There is a far greater likelihood of rural participation and experimentation with different program models in states where the Medicaid and state long-term care program(s) have been active in developing new financing and managed care arrangements for chronic care populations.
As noted earlier, differences in professional cultures and distrust between those who provide medical services and long-term care services can represent a fundamental barrier to integrating the financing and delivery of services across these two sectors. Traditionally, long-term care providers are more comfortable with models of care that emphasize the use of social support services to maximize independence and quality of life. Conversely, for many medical providers, inexperience in working with the long-term care sector can often be a barrier to effective communication and collaboration.

These differences are often reflected in professional licensure laws in the United States that restrict the ability of some long-term care personnel to perform certain tasks. For example, nursing practice regulations limit the ability of non-professional nursing aides to administer medications except under direct supervision of professional nurses. This is impractical in rural areas where professional nurses are less available and where cost factors make it impractical to rely on professional nurses for this function. Restrictions and barriers imposed by professional licensing laws and regulation also stand in the way of hospitals and other service providers developing shared staffing approaches that may be needed to make integrated service delivery models cost-effective in rural areas.

**Impact of Distance and Location**

In addition to inter-professional conflicts, the location of services and service providers and, in particular, the distance between them pose significant barriers to the integration of clinical and administrative services. Physical proximity and, preferably, co-location of providers is highly desirable in encouraging effective communication. Where this is not possible, information systems and communication technologies become important. Long distances among providers make the care management process more challenging. Establishing both formal and informal information and communication systems is critical to effective care management in these circumstances.

**Integration Costs Money**

The development of integrated acute and long-term care programs is expensive, requiring an intensive investment of capital and organizational leadership that is often lacking in rural areas (Kane, Illston, and Miller, 1992). The development of the organizational, administrative and clinical systems
needed to integrate and manage care is well beyond the capacity of the average rural provider or health system.

Notwithstanding the fact that there are many rural hospitals that have faced serious financial problems, rural hospitals are still the financial engine for health system development in most rural communities in the United States. There is a dilemma, however, regarding hospital involvement in the development of integrated primary, acute and long-term care systems. On the one hand, the hospital’s financial and administrative clout is needed to support the development of these new systems. Yet, given their predominantly medical orientation, hospitals may not be the most appropriate provider base for the development of an integrated primary, acute and long-term care delivery system. The problem of differing professional cultures between the medical and long-term care sectors, discussed above, applies at both the clinical and organizational level and undermines efforts to achieve better integration across these service sectors.

In some rural communities, financial pressures on small rural hospitals and other health-care providers may restrict access to the financial resources needed to develop the critical administrative and clinical systems that are central to an integration strategy. Many rural hospitals have fared very well in recent years and have invested heavily in the development of expanded rural health networks as a strategy for survival in the increasingly competitive world of managed care. For example, over 65 percent of all rural hospitals have developed or acquired home health agencies; over a third of rural hospitals own both a home health agency and a skilled nursing facility. Recent changes by the Medicare program and other payers in hospital, home health or other payment policies, however, have created uncertainties that may reduce the willingness and/or ability of rural hospitals to invest in strategies and programs for achieving greater integration across the primary, acute and long-term care sectors (Rural Policy Research Institute, 1999).

**Rural Means Small**

Size could provide a distinct advantage for rural communities and providers attempting to achieve greater integration across the spectrum of primary, acute and long-term care services. In smaller communities where medical and long-term care service providers are likely to know their clients and provider colleagues better, care management across systems may be easier to achieve.
than in urban settings. Moreover, in smaller communities, health and long-term care providers must work together on a regular basis, which may make it possible to achieve cooperation more easily than in more complex organizational environments.

**Future of Medical and Long-Term Care Integration in Rural Areas**

Many of the more formal efforts to integrate services in the United States involve the creation of new programs or organizational units where financial, staff and other resources from multiple systems are pooled. Most of these models do not conform to the realities of rural delivery systems. Yet, this does not necessarily mean that rural communities and health and long-term care providers cannot pursue efforts to improve the provision of primary, acute and long-term care services.

Integration is not necessarily the gold standard for improving the care of older persons. Other strategies that involve “linkage” or “coordination” approaches may be just as effective and certainly more feasible in most rural areas (Bird et al., 1998; Leutz, 1999). Rural providers already engage in a great deal of “linking” behavior that connects rural consumers to medical and long-term care services to which they are entitled. To encourage this behavior, rural health-care providers must understand the eligibility requirements for long-term care services and they must actively screen consumers to assess their needs and eligibility for such services. One strategy for system improvement in rural areas is for rural medical and long-term care providers to more systematically develop the knowledge and support systems needed to expand and improve these linkage strategies.

“Coordination” represents a more formal approach to service linkage. A coordination strategy involves the development of explicit structures, systems and protocols for linking consumers to services and managing their care (Leutz, 1999). There can be different components to a coordination strategy, ranging from the coordination of benefits to the development of mechanisms to share clinical information among providers. Although there is usually a designated organization and staff responsible for managing the coordination process, coordination differs from integration in maintaining the autonomous roles of separate organizations and structures.
In the final analysis, integration is not an end to itself. Rather, it is a means toward the goal of improving the care of older persons by enhancing timely access to appropriate and high quality health and long-term care services. In rural areas, linkage and coordination approaches may be the most appropriate and effective incremental strategies toward the noble, but more difficult goal of service integration.

REFERENCES


