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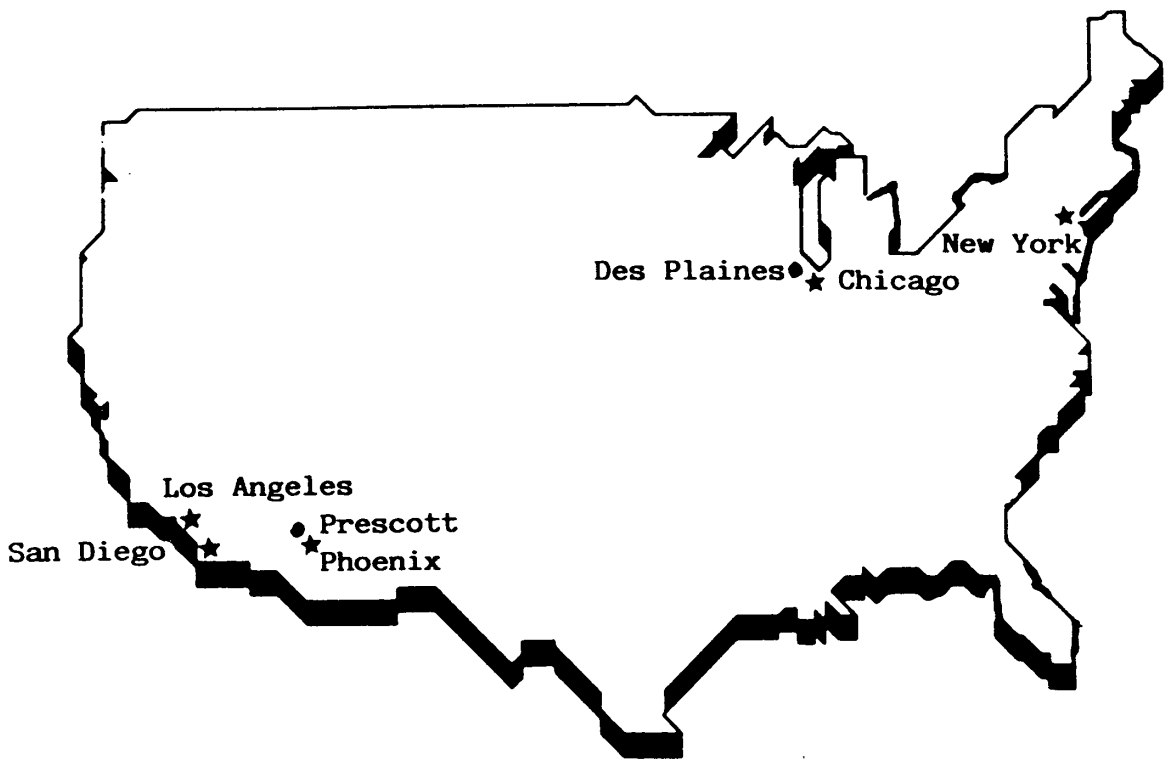
HEALTH AUTHORITY

# Report on a visit to Geriatric Centres of Excellence in the United States of America

by Clive Caswell




August 1988

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The Production Of This Report Would Not Have Been Completed
Without The Patience, Dedication And Hard Work
Of
MRS. GAYE JAMES and MRS. MILINDA RYDQVIST,
To Whom I Wish To Record My Utmost Thanks.

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CHAPTER INDEX

## FIGURES, STATISTICS AND TABLES.

## INDEX OF ILLUSTRATIONS AND DIAGRAMS.




**We acknowledge and would like to record our grateful thanks for the information provided on the above pages.**

This report is a personal view of the way the United States of America views its services for the elderly, illustrating the various initiatives that are being taken, to cater for the elderly of the future.

The report is based on visits to a number of hospitals across the States and their varying strategies to meet the demographic changes which will come about in the next decade.

**Mr. Clive Caswell, pictured here with Georgia Hall, Ph.D., and Dr. Richard Uhrich, is Administrator of St. George's Hospital in Hornchurch, England. Mr. Caswell visited GSMC's Institute of Gerontology and Geriatrics during a hospital tour of five U.S. cities. "My main purpose in these visits," Caswell said, "relates to how the United States intends to tackle the provision for the large number of elderly and very elderly over the next ten years within the framework of increasing emphasis on cost containment."**

## PREFACE AND ACKNOWLEDGEMENTS

This report is based on work carried out with the help of the King Edward's Hospital Fund for London; the Barking, Havering and Brentwood Health Authority; the North East Thames Regional Health Council of the Institute of Health Service Management; Molnlycke Ltd (Hospital Products Ltd); Simpla Plastics Ltd; Ancillar (U.K.) Ltd; Sherwood Medical Industries Ltd; (Incontinence Products); and ACS Medical.

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My travelling Fellowship to the United States of America was organised between January and February 1986. The objective of the Fellowship was to study the projected provision for services for the elderly in the next twenty years related to cost effectiveness.

The report is based on information provided by the American Hospitals Association, Ageing and Long-Term Care Services and hospitals recommended by them as leaders in the development of initiatives for geriatric care.

The success of my study could not have been achieved without the positive response given by the participating hospitals to whom I am extremely grateful.

The American Hospitals Association organised a wide ranging itinerary across the full spectrum of hospitals in the United States which are a mixture of Federal or State funded hospitals, for profit and non-profit hospitals and those that are traditionally established by religious orders.

The range of establishments visited varied from an 1100 bed acute teaching facility to a 100 bed community hospital which, in America, means that they do not provide facilities for training medical or

professional staff, although the ones I visited made it a priority to establish links with local universities for research purposes and secondments.

New York

I visited St. Vincent's Hospital and Medical Center of New York, which is a voluntary hospital founded in 1849 by the Sisters of Charity, originally as a 30 bed infirmary which has, in the intervening 137 years, become a major teaching resource and health care centre providing an 813 bed facility with a full range of specialist services.

I am grateful to Sister Sweeney, President of the Hospital, and Mark Ackerman, the Marketing Manager, for the well-planned programme for my attachment.

Special mention must also be made of the wealth of information provided by Dr. Philip Brickner, Director of Community Medicine at St. Vincent's, who has for many years been at the forefront of developing community programmes for the elderly in Lower Manhattan and Greenwich Village, plus New York State, and is now recognised as a national figure in the development of services for the elderly in the United States.

While in New York, I also spent some time with Dr. Kennedy, a recent immigrant from Glasgow, who has been appointed to develop geriatric services at Montefiore Medical Center which is situated in the Bronx part of New York. Montefiore Hospital is also a very prestigious hospital, providing acute care through five hospitals of 2279 beds for that city.

Chicago

In Chicago, which is the second largest city in America, apart from my time at the American Hospitals Association which is based there, I visited two other locations.

The first was the Johnson R. Bowman Health Center for the Elderly, which is a unique geriatric facility of 176 beds which forms part of the larger hospital of Rush-Presbyterian-St. Luke's Medical Center. Ms Mary Melwak, a member of the management team of this facility, convinced me that the co-ordinated and comprehensive approach available for the geriatric in-patient population from acute and rehabilitation services to their residential apartment complex, is a pattern that would be the envy of many hospitals in this country.

My second visit in Chicago was to Parkside Human Services Corporation, which included the Lutheran Hospital at Des Plaines. They have developed a variety of elder adult services whose mission is to enrich the quality of life of the older person through a full range of services which are geared to appropriately respond as a person experiences varying needs along the ageing continuum.

The United States has enacted national legislation for the elderly, but the pattern of services nationally varies, due to the federal system of States, which allows flexibility in approach. Consequently, there are differing priorities sanctioned by individual States and more particularly it is left to individual hospitals to develop their own approach to services for geriatric care.

It was therefore useful to see the approach to geriatric care in California and Arizona which traditionally have large internal migrations from other parts of the country, similar to the South of England, of persons moving to more pleasant climates.

Los Angeles

Cedars-Sinai Medical Center in Los Angeles is an acute 1115 bedded hospital which is a major teaching hospital for the University College of California at Los Angeles School of Medicine. The range of facilities available for the elderly are extensive, including a variety of services, of hospital-at-home facilites which, in America, are sometimes more cost

effective than the cost of in-patient care, plus access to the latest technology for in-patient care.

San Diego

My next visit was to VillaView Community Hospital in San Diego, which is a community hospital of 100 beds, that has developed a comprehensive five year strategy for the elderly and their President, Mr. T. Pendleton, made my visit to this hospital one of the highlights of my tour. I feel certain that if every hospital could follow their comprehensive approach of planning services for the elderly in their respective catchment areas Senior Citizens would have every confidence in the future for their varying needs.

Arizona

Arizona is one of the last bastions of the old west, believing that wherever possible individuals should look to their own financial resources to meet individual needs. They are therefore the only hospitals in the Union not to have adopted the Medicare legislation for the poor elderly which was enacted in 1965. I was therefore privileged to spend some time with Dr. Georgia Hall, Director of Gerontology/Geriatrics at the Good Samaritan Medical Center, which is the largest acute hospital in Arizona with 777 beds. Dr. Hall was appointed in 1983 to develop geriatric services for the group of hospitals of which the Good Samaritan Hospital forms part. Their interest is in ensuring the best level of care for in-patients, but is also a keen advocate for the development of community programmes, including numerous outreach programmes.

Sun City

Another hospital in Arizona that I visited was the Walter O. Boswell Memorial Hospital Inc. in Sun City, which was built to provide services for the population of 80,000 in the retirement town of Sun City. This has 338 beds, again with a full range of acute and educational services for the

elderly. Community involvement is a vital component, having 1500 volounteers serving the hospital and a donation of over $13,000,000 given to the hospital over the past fifteen years.

## Prescott

My final visit was to Yavapai Regional Medical Centre, a 129 bed acute care unit, not-for-profit hospital, situated in the former capital city of Arizona, at Prescott.

## Approach To Report

In reading my report, the reader may ponder why I have concentrated on hospitals rather than long-term nursing home facilities, which is the established pattern for long-term care in the United States. Visits were made to some of these establishments, but as most were affiliated with the hospitals I have mentioned it was thought that I should concentrate on these in the substantive part of my report. I am grateful to the various sponsors of my Travelling Fellowship and hope that the report provides a better understanding of the American approach to geriatric care.

As previously stated, my itinerary was suggested by Ms Janet Tedesco of the American Hospitals Association, who performs a role of collating new ideas of services for the elderly and disseminating this information to all hospitals or other bodies who subscribe to the Association. Ms Tedesco not only provided me with a list of hospitals and letters of introduction, but during my time in Chicago gave me the opportunity of studying the work they do in terms of publishing a pamphlet entitled "Ageing and Long Term Care" which is issued bi-monthly and also in arranging Study Day seminars and training people working with the elderly. It is also a reliable source of information for politicians who wish to receive background information on this particular client group.

Ms Tedesco provided an abundance of literature and has kept me up to date with further developments which have occurred since my return to

the United Kingdom. She has also provided up to date information to the concerned Select Committee of Politicians, similar to this country, on funding of health care in the United States, including details on recent deliberations from the Special Committee on Ageing, United States Senate, which I have included in my report.

A number of the ideas that were demonstrated during my visit to the United States have been adopted by my employing authority, with more literature being given to patients on various aspects of Health Care which supplement the literature available from the District Health Education Department and the National Guidance issued by Age Concern and the Health Education Council. Arrangements were made for nurses from California and Arizona to receive training in special areas, here in the United Kingdom. There is also the possibility of the establishment of an inter-change scheme for middle management staff with a number of the hospitals I visited.

The wealth of information and assistance provided by my hosts made the Travelling Fellowship extremely worthwhile and has demonstrated possible advantages for health care within my own employing authority.

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## INTRODUCTION

During the production of my Employing Authority's Consultative Document on the 'Future Strategy for the Care of the Elderly', it occurred to me that a comparison of another culture facing a similar population projection of an increased number of elderly, would be useful.

My choice of the United States of America was made on the basis of seeing how another Western country with a totally different approach to funding were planning their services for the elderly, which is geared more closely to individual choice than the British public, who have in the main little choice with 90% of the population looking to the NHS for their care or other statutory provided services.

Whilst many countries in Western Europe and Scandinavia have been to the forefront in developing initiatives for the elderly, I was made aware of the number of reports on those countries that had already been produced.

My terms of reference were:

(1) to obtain literature on the legislation enacted to provide cover for the elderly;

(2) to see the range of services offered to the elderly in an acute hospital setting, especially rehabilitation;

(3) to ascertain what facilities were provided in the community;

(4) to identify differences in approach between British and American societies for geriatric care;

(5) to consider cost containment of services;

(6) to identify initiatives for geriatric care.

Prior to commencing my travelling Fellowship, all participating hospitals had received details of my original brief for funding and a copy of my own District's consultative strategy for geriatrics, together with a questionnaire devised by a nursing colleague to assist in the comparison exercise referred to earlier. I was greatly assisted in having prior knowledge of funding of services in the United States detailed in the King's Fund Publication "Financing Health Services in the United States, Canada and Britain" by J W Hurst, published in 1985. Guidance on the methodology of my study was provided by Dr. J. Watts, District Medical Officer of the Barking, Havering and Brentwood Health Authority.

The American organisers were:

The American Hospitals Association, Office on Ageing and Long-Term Care Services, based in Chicago.

Participating hospitals were:-

NEW YORK: St. Vincent's Hospital and Medical Center of New York.
Montefiore Medical Center.

CHICAGO: Johnson R Bowman Health Center for the Elderly of Rush-Presbyterian-St Luke's Medical Center.
Parkside Human Services Corporation, and Lutheran Hospital, Des Plaines.

SAN DIEGO: VillaView Community Hospital

LOS ANGELES: Cedars-Sinai Medical Center.

ARIZONA: Good Samaritan Medical Center, Phoenix.
Walter O. Boswell Memorial Hospital Inc., Sun City.
Yavapai Regional Medical Center, Prescott.

**NOTE:** "Financing Health Services in the United States, Canada and Britain", by J.W. Hurst, published in 1985, provides most of the information in the Chapter on 'Funding', beginning page 39.

The arrangements made for my attachment were well planned and in a short space of time provided me with an in-depth knowledge of areas for further investigations, as there would be little value in producing an impressionistic report and not highlighting those areas which I identify as being relevant to the development of health care within the United Kingdom.

I appreciate that many of the major initiatives relating to the cost effectiveness of health care in relation to DRG's (Diagnostic Related Groups) and HMO's (Health Maintenance Organisations) have been well researched in this country and that the former is in the process of being adopted to a greater or lesser extent in the North West Region and some of the Central London teaching hospitals.

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## INTRODUCTION to 'A PROFILE OF OLDER AMERICANS, 1985'.

**A Profile of Older Americans: 1985** was prepared by the Program Resources Department, American Association of Retired Persons (AARP) and the Administration on Ageing (AoA), U.S. Department of Health and Human Services.

Information researched and compiled by Donald G. Fowles, AoA.

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AARP is the nation's largest and oldest organisation of over-50 Americans, retired or not. A non-profit, non-partisan organisation with over 20 million members, AARP serves its members through legislative representation at both federal and state levels, educational and community service programs and direct membership benefits.

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# POPULATION

## A PROFILE OF OLDER AMERICANS, 1985.

### The Older Population

The older population - persons 65 years or older - numbered 28.0 million in 1984. They represented 11.9% of the U.S. population, about one in every eight Americans. The number of older Americans increased by 2.3 million or 10% since 1980, compared to an increase of 4% for the under-65 population. (Note: Total U.S. population 1984 Census, 236.6 million).

In 1984, there were 16.7 million older women and 11.3 million older men, or a sex ratio of 148 women for every 100 men. The sex ratio increased with age, ranging from 123 for the 65-69 group to a high of 246 for persons 85 and older.

Since 1900, the percentage of Americans 65+ has tripled (4.1% in 1900 to 11.9% in 1984), and the number increased nine times (from 3.1 million to 28.0 million).

The older population itself is getting older. In 1984 the 65-74 age group (16.7 million) was over seven times larger than in 1900, but the 75-84 group (8.6 million) was 11 times larger and the 85+ group (2.7 million) was 21 times larger.

In 1984, persons reaching age 65 had an average life expectancy of an additional 16.8 years (18.7 years for females and 14.5 years for males).

A child born in 1984 could expect to live 74.7 years, about 27 years longer than a child born in 1900. The major part of this increase occurred because of reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 2.5 years since 1960.

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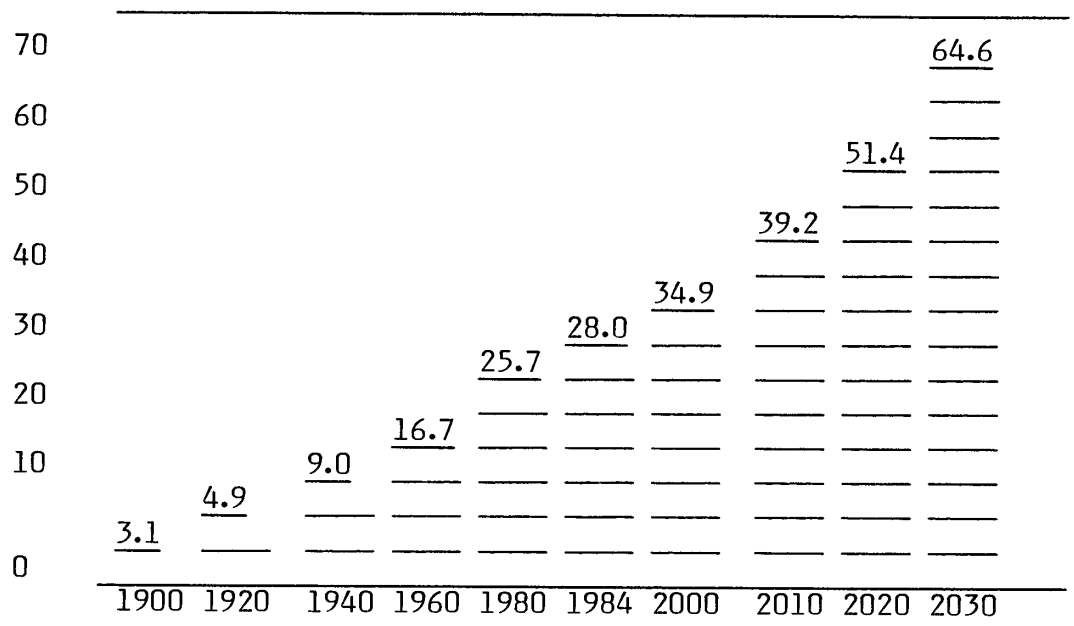
See footnotes at the end of this chapter.

About 2.0 million persons celebrated their 65th birthday in 1984 (5,500 per day). In the same year, about 1.4 million persons 65 or older died, resulting in a net increase of over 560,000 (1,550 per day).

FIGURE 1

NUMBER OF PERSONS 65+ : 1900 to 2030

(in millions)




Note: Increments in years on horizontal scale are uneven.

Based on data from U.S. Bureau of the Census.

## Future Growth

The older population is expected to continue to grow in the future (see fig.1). This growth will slow somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. The most rapid increase is expected between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

By 2030, there will be about 65 million older persons, 2 and one half times their number in 1980. If current fertility and immigration levels remain stable, the only age groups to experience significant growth in the next century will be those past age 55.

By the year 2000, persons 65+ are expected to represent 13.0% of the population, and this percentage may climb to 21.2% by 2030.

Marital Status

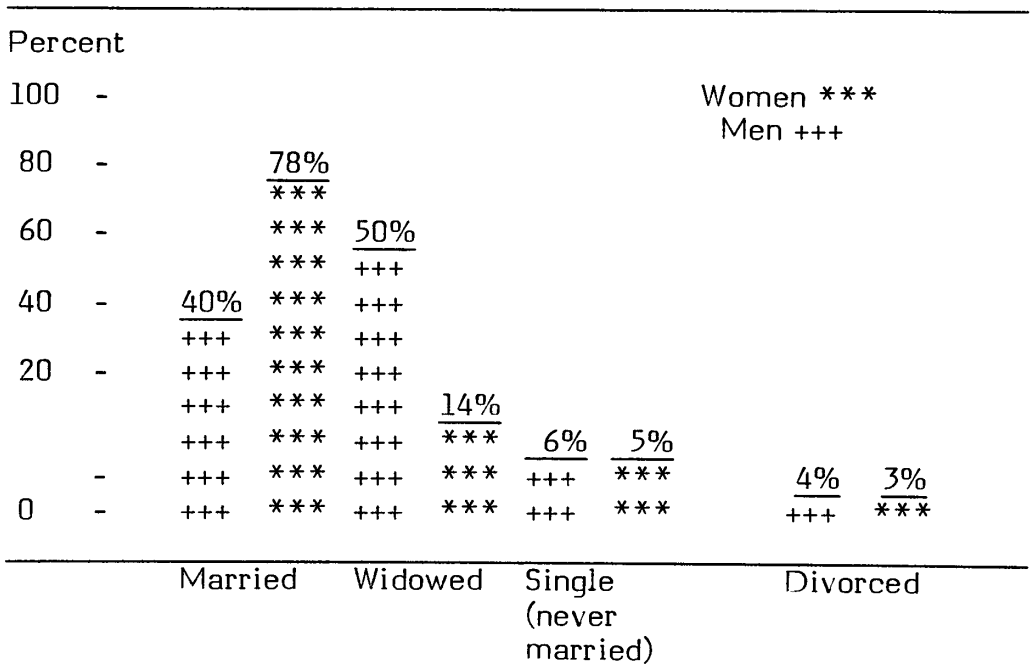
In 1984, older men were twice as likely to be married as older women (78% of men, 40% of women).*

Half of all older women in 1984 were widows (50%). There were over five times as many widows (7.8 million) as widowers (1.5 million).*

Although divorced older persons represented only 4% of all older persons in 1984, their numbers (nearly one million) had increased over three times as fast as the older population as a whole in the preceding 20 years (2.1 times for men, 4.5 times for women).*

FIGURE 2

MARITAL STATUS OF PERSONS 65+ : 1984*




Based on data from U.S. Bureau of the Census.

Living Arrangements

The majority (67%) of older non-institutionalised persons lived in a family setting in 1984. Approximately 8.9 million or 83% of older men, and 8.8

million or 57% of older women, lived in families (see fig.3). The proportion living in a family setting decreased with age. An additional 2% of both men and women, or 625,000 older persons, lived with non-relatives.*

About 30% (8.0 million) of all non-institutionalised older persons in 1984 lived alone (6.4 million women, 1.6 million men). They represented 41% of older women and 15% of older men. Older persons living alone increased in number by 123% between 1964 and 1984, over two and one-half times the growth rate for the older population in general.*

FIGURE 3

LIVING ARRANGEMENTS OF PERSONS 65+ : 1984*

| | Men | Women |
|---|---|---|
| living with spouse | 76% | 38% |
| living with other relatives | 17% | 43% |
| living alone or with non-relatives | 7% | 19% |

Based on data from U.S. Bureau of the Census.

A 1975 study found that 4 of every 5 older persons have children. Of these, 18% lived in the same household with a child and another 55% lived within 30 minutes of a child. Three-fourths (77%) had seen a child within the previous week.*

While a small number (1.3 million) and percentage (5%) of the 65+ population lived in institutions (primarily nursing homes) in 1980, the percentage increased dramatically with age, ranging from 2% for persons 65-74 years to 7% for persons 75-84 years and 23% for persons 85+.

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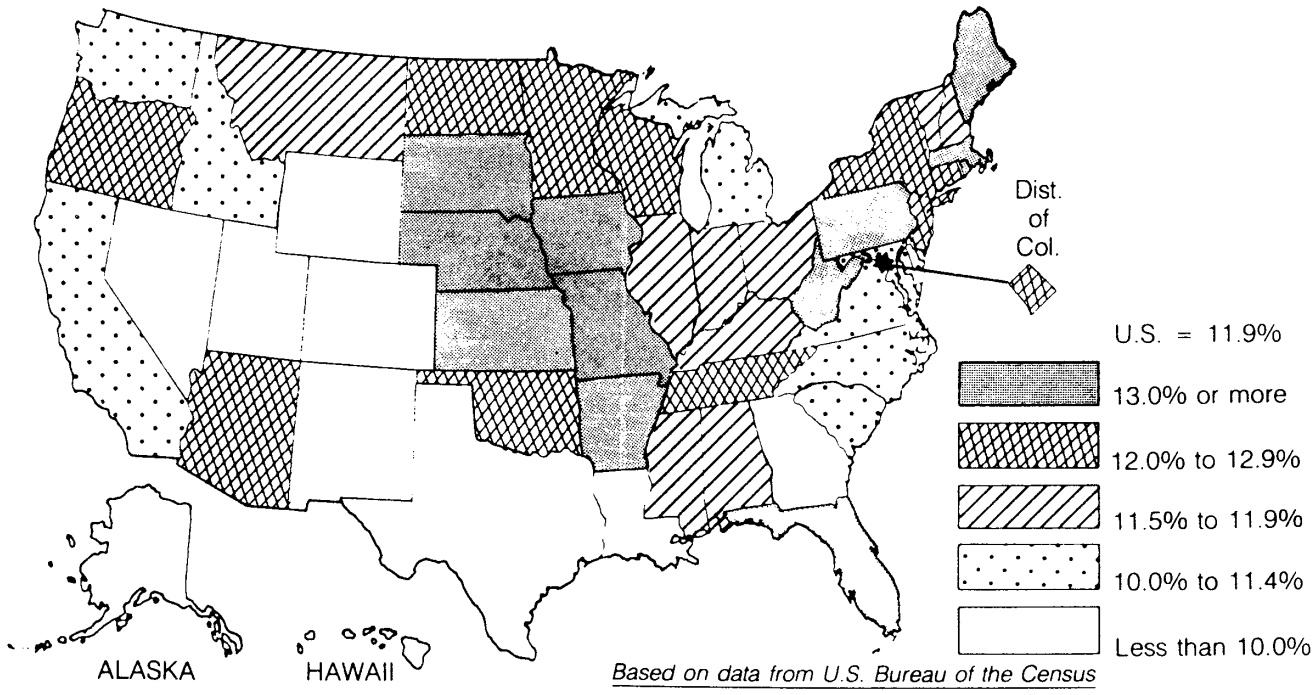
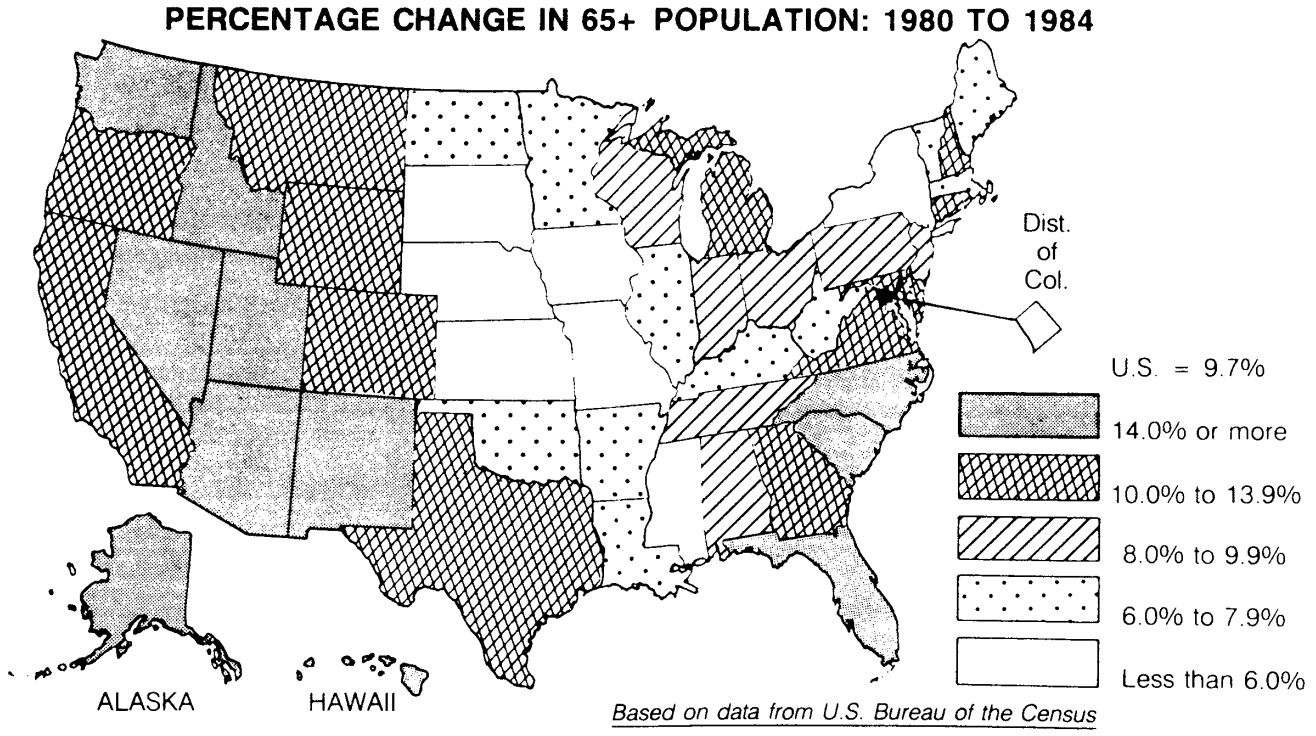
**FIGURE 4**
**PERSONS 65+ AS PERCENTAGE OF TOTAL POPULATION: 1984**




*Based on data from U.S. Bureau of the Census*

**FIGURE 5**
**PERCENTAGE CHANGE IN 65+ POPULATION: 1980 TO 1984**




*Based on data from U.S. Bureau of the Census*

## Racial and Ethnic Composition

In 1984, about 90% of persons 65+ were White, 8% were Black, and about 1% were other races (including American Indian, Eskimo, Aleut, Asian and Pacific Islander). Persons of Hispanic origin (who may be of any race) represented 4% of the older population.

## Geographic Distribution

In 1984, about half (49%) of persons 65+ lived in eight states. California and New York had over 2 million each, and Florida, Illinois, Michigan, Ohio, Pennsylvania and Texas each had over 1 million.

Persons 65+ constituted 13.0% or more of the total population in twelve states in 1984 (see fig.4): Florida (17.6%); Arkansas, Rhode Island, Iowa, and Pennsylvania (14.0% to 14.9%); and Missouri, South Dakota, Massachusetts, Nebraska, Kansas, Maine, and West Virginia (13.0% to 13.9%).

In eleven states, the 65+ population increased by more than 14.0% between 1980 and 1984 (see fig.5): Alaska (33%); Nevada (32%); Hawaii (23%); Arizona (22%); Utah and New Mexico (17% each); South Carolina and Idaho (15%each); and Florida, North Carolina, and Washington (14% each).

Persons 65+ were slightly less likely to live in metropolitan areas in 1980 than younger persons (71% of the elderly, 75% of persons under 65). About 32% of older persons lived in central cities, and 39% lived in suburbs.

The elderly are less likely to change residence than other age groups. In 1980, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). The majority had moved to another home in the same state.

In 1980, over 1.1 million persons 65+ had moved to a different state since 1975. Of these, over two-fifths (42%) had moved from the Northeast or Midwest region to the South or West (compared to 27% for younger persons) and one-fourth (25%) had moved to Florida (8% for younger persons).

FIGURE 6

THE 65+ POPULATION BY STATE: 1984

| State | Number (000s) 1984 | Percent of all Ages 1984 | Percent Increase 1980-84 | Percent Below Poverty Level 1979* |
|---|---|---|---|---|
| U.S. total | 28,040 | 11.9 | 9.7 | 14.8 |
| Alabama | 476 | 11.9 | 8.3 | 28.4 |
| Alaska | 15 | 3.1 | 32.6 | 14.2 |
| ARIZONA | 375 | 12.3 | 21.9 | 12.2 |
| Arkansas | 336 | 14.3 | 7.4 | 28.2 |
| CALIFORNIA | 2,693 | 10.5 | 11.5 | 8.3 |
| Colorado | 280 | 8.8 | 13.4 | 12.8 |
| Connecticut | 407 | 12.9 | 11.6 | 8.8 |
| Delaware | 67 | 11.0 | 13.8 | 13.6 |
| District of Columbia | 75 | 12.1 | 1.5 | 18.9 |
| Florida | 1,931 | 17.6 | 14.4 | 12.7 |
| Georgia | 577 | 9.9 | 11.7 | 25.7 |
| Hawaii | 94 | 9.0 | 22.9 | 10.5 |
| Idaho | 108 | 10.8 | 14.9 | 16.0 |
| ILLINOIS | 1,356 | 11.8 | 7.5 | 11.9 |
| Indiana | 638 | 11.6 | 8.9 | 12.7 |
| Iowa | 410 | 14.1 | 5.9 | 13.3 |
| Kansas | 323 | 13.3 | 5.6 | 14.2 |
| Kentucky | 438 | 11.8 | 6.8 | 23.3 |
| Louisiana | 435 | 9.7 | 7.5 | 27.7 |
| Maine | 152 | 13.1 | 7.6 | 16.4 |
| Maryland | 447 | 10.3 | 13.0 | 12.7 |
| Massachusetts | 777 | 13.4 | 6.9 | 9.7 |
| Michigan | 1,007 | 11.1 | 10.3 | 12.2 |
| Minnesota | 517 | 12.4 | 7.7 | 14.8 |
| Mississippi | 306 | 11.8 | 5.9 | 34.3 |
| Missouri | 682 | 13.6 | 5.3 | 17.4 |
| Montana | 96 | 11.6 | 13.2 | 14.4 |
| Nebraska | 216 | 13.4 | 4.8 | 15.5 |
| Nevada | 87 | 9.5 | 32.2 | 10.7 |
| New Hampshire | 114 | 11.7 | 10.6 | 12.3 |
| New Jersey | 942 | 12.5 | 9.6 | 9.9 |
| New Mexico | 135 | 9.5 | 16.6 | 21.1 |
| NEW YORK | 2,247 | 12.7 | 4.0 | 11.6 |
| North Carolina | 688 | 11.2 | 14.1 | 23.9 |
| North Dakota | 87 | 12.6 | 7.6 | 17.0 |
| Ohio | 1,280 | 11.9 | 9.5 | 12.6 |
| Oklahoma | 401 | 12.1 | 6.5 | 21.0 |
| Oregon | 344 | 12.9 | 13.4 | 11.8 |
| Pennsylvania | 1,676 | 14.1 | 9.5 | 11.9 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Rhode Island | ... | ... | 138 | 14.3 | 8.7 | 12.8 |
| South Carolina | ... | ... | 331 | 10.0 | 15.1 | 25.4 |
| South Dakota | ... | ... | 96 | 13.6 | 5.8 | 20.2 |
| Tennessee | ... | ... | 566 | 12.0 | 9.4 | 25.1 |
| Texas | ... | ... | 1,514 | 9.5 | 10.4 | 21.2 |
| Utah | ... | ... | 128 | 7.7 | 16.9 | 11.8 |
| Vermont | ... | ... | 63 | 11.8 | 7.8 | 13.8 |
| Virginia | ... | ... | 572 | 10.2 | 13.2 | 17.3 |
| Washington | ... | ... | 492 | 11.3 | 14.0 | 11.3 |
| West Virginia | ... | ... | 225 | 13.0 | 7.1 | 18.5 |
| Wisconsin | ... | ... | 611 | 12.8 | 8.4 | 9.6 |
| Wyoming | ... | ... | 42 | 8.2 | 12.3 | 14.0 |

(Below Poverty Level figures reflect most recent information available)
Based on Data From U.S. Bureau of the Census.

## Income

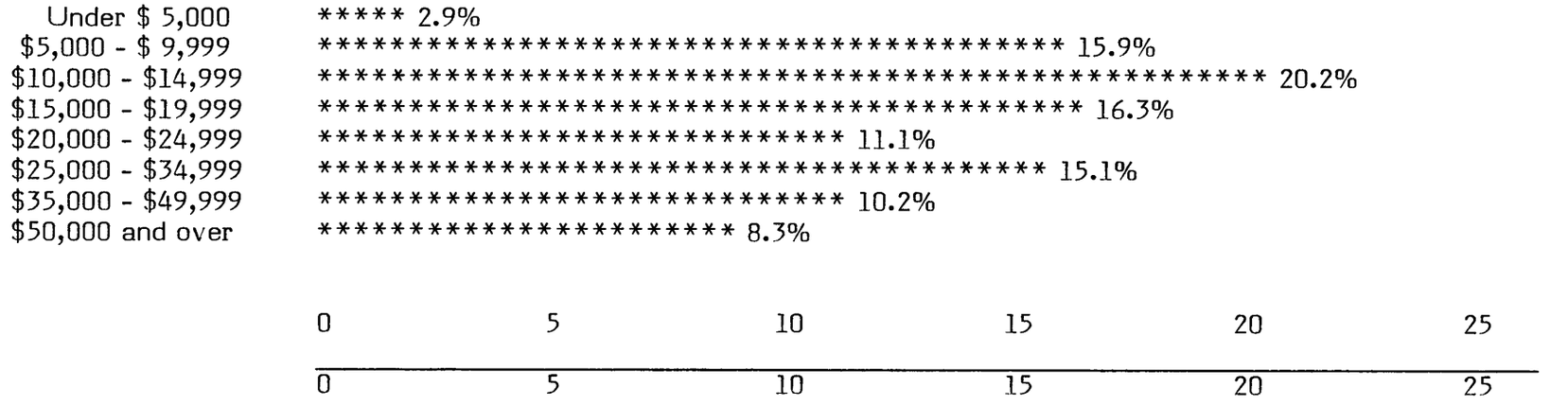
The median income of older persons in 1984 was $10,450 for males and $6,020 for females. These incomes were each 7.7% higher than in 1983, and represented 3.3% increases in "real" income after adjusting for inflation.*

Families headed by persons 65+ reported a median income in 1984 of $18,215 ($18,775 for Whites and $11,983 for Blacks). About one of every five (19%) families with an elderly head had incomes less than $10,000 and 34% had incomes of $25,000 or more (see fig.7).*

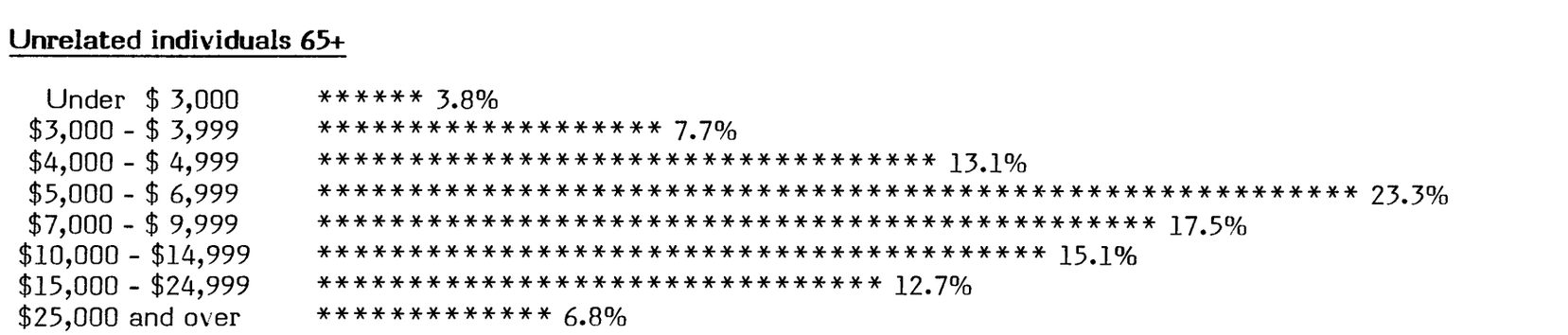
FIGURE 7

PERCENT DISTRIBUTION BY INCOME : 1984*

**Families with head 65+**




**Unrelated individuals 65+**




$18,215 median for families with heads 65+
$ 7,296 median for unrelated individuals 65+

Based on data from U.S. Bureau of the Census.

Elderly persons living alone or with non-relatives were likely to have low incomes in 1984, with half (48%) reporting $7,000 or less. One-fourth (25%) had incomes under $5,000, while only 20% had $15,000 or more. The median income in 1984 for these individuals was $7,296 ($7,722 for Whites and $4,876 for Blacks).*

The major source of income for older families and individuals in 1983 was Social Security (37%), followed by earnings and asset income (23% each), public and private pensions (15%) and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).*

Older households were more likely than younger households to have one or more members covered by Medicaid in 1983 (13% vs 9%), but less likely to have received food stamps (7% vs 9%). About one-fourth (23%) of older renter households lived in publicly owned or subsidised housing (9% for younger renters).*

The median net worth (difference between assets and liabilities) of older households, including those 65-74 years old ($50,150) and 75+ years ($35,950), was well above the U.S. average ($24,600) in 1983. Net worth was below $5,000 for 18% of older households but was above $250,000 for 13%.

Poverty

About 3.3 million elderly persons were below the poverty level** in 1984. The poverty rate for persons 65+ was 12.4%, less than the rate for persons under 65 (14.7%). Another 2.4 million or 9% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level).

One of every nine (11%) elderly Whites was poor in 1984, compared to about one-third (32%) of elderly Hispanics.*

Older women had a higher poverty rate (15%) than men in 1984 (9%). Likewise, older persons living alone or with non-relatives were more likely to be poor (24%) than were older persons living in families (7%).*

The nine states with the highest poverty rates for older persons in 1979 were all in the South (see fig. 6): Mississippi (34%); Alabama, Arkansas, and Louisiana (28% each); Georgia (26%); South Carolina and Tennessee (25% each); North Carolina (24%); and Kentucky (23%).*

Housing

Of the 17.9 million households headed by older persons in 1984, 75% were owners and 25% were renters. Older male householders were more likely to be owners (83%) than were females (67%).*

The housing of older Americans is generally older and less adequate than the balance of the nation's housing. About 36% of homes owned by older persons in 1983 were built prior to 1940 (21% for younger owners) and 8% were classified as inadequate (6% for younger owners).*

The percentage of income spent on housing (excluding maintenance and repair) in 1983 was higher for older households than for younger households among homeowners without a mortgage (15% vs 10%), homeowners with a mortgage (24% vs 20%), and renters (32% vs 28%).*

In 1983 the median value of homes owned by older persons was $48,800 ($33,100 for Blacks and $46,200 for Hispanics). About 83% of older homeowners in 1983 owned their homes free and clear.

Employment

About 11% or 2.9 million older Americans were in the labour force (working or actively seeking work) in 1984, including 1.8 million men and 1.2 million women. They constituted 3% of the U.S. labour force. About 3% of these were unemployed.*

Labour force participations of older men has decreased steadily, from about 2 of 3 older men in 1900 to 1 of 6 (16%) in 1984. The participation rate for older females rose slightly from 1 in 12 in 1900 to 1 in 10 during the 1950s, but dropped to 1 in 13 (8%) in 1984.*

Approximately half (52%) of the workers over 65 in 1984 were employed only part-time: 46% of men and 61% of women.*

About 750,000 or 27% of older workers in 1984 were self-employed, compared to 8% for younger workers. Three-fourths of these were men.*

Education

The education level of the older population has been steadily increasing. Between 1970 and 1984, their median level of education increased from 8.7 years to 11.4 years (11.0 years for males, 11.6 years for females), and the percentage who had completed high school rose from 28% to 48%. About 9% in 1984 had 4 or more years of college.*

The median number of years of school completed varied considerably by race and ethnic origin among older persons in 1984: 12.0 years for Whites, 7.9 years for Blacks, and 6.5 years for Hispanics.*

Health and Health Care

In 1982, 35% of older persons assessed their health as fair or poor (compared to 9% for persons under 65). There was little difference between the sexes on this measure, but older Blacks were more likely to rate their health as fair or poor (55%) than were older Whites (33%).*

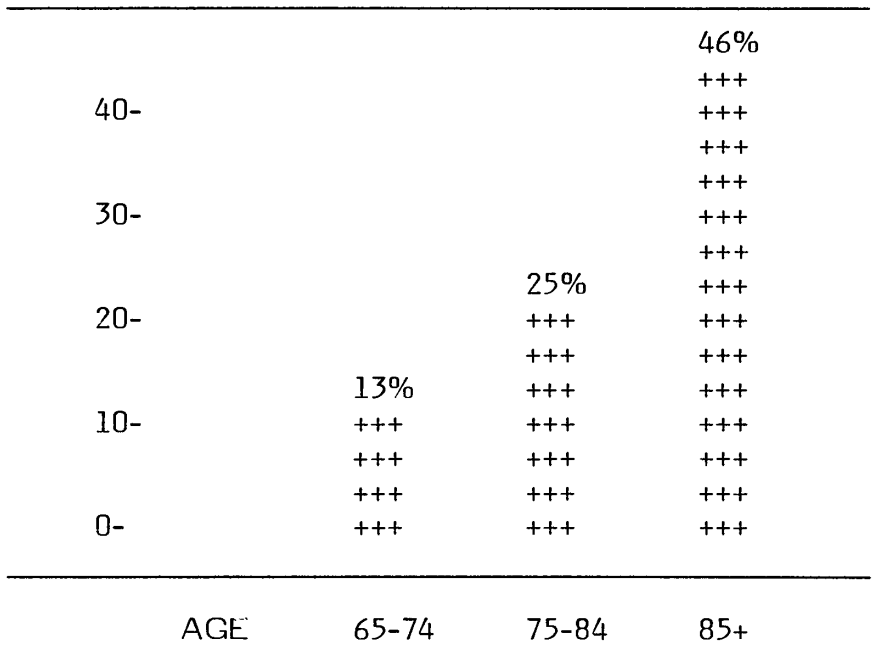
The number of days in which usual activities are restricted because of illness or injury increases with age. Older persons averaged 32 such days in 1982 (27 days for males and 35 days for females, 12 days for younger persons) and spent all or most of 15 of these days in bed (13 days for males, 16 days for females, 5 days for younger persons).*

The need for functional assistance also increases sharply with age (see fig. 8). In 1982, about 4.8 million older persons living in the community needed the assistance of another person to perform one or more selected personal care or home management activities. This figure represented

19% of non-institutionalised older persons (16% of males, 21% of females), but the percentage ranged from 13% for persons 65-74 to 25% for persons 75-84 and 46% for persons 85+ (41% of males, 48% of females). (Selected personal care activities included bathing, dressing, eating, using the toilet, getting in or out of a bed or chair, walking or going outside. Selected home management activities included preparing meals, shopping, routine chores, using a telephone, taking medicine, or managing money. Persons were classified as needing assistance if they needed help from another person to do one or more of these activities, or could not do one or more of them at all.)*

FIGURE 8

PERCENT NEEDING FUNCTIONAL ASSISTANCE, BY AGE: 1982*




Based on data from U.S. Department of Health and Human Services prepared by Duke University.

Most older persons have at least one chronic condition and many have multiple conditions. The most frequently occurring conditions of the elderly in 1982 were: arthritis (50%), hypertension (39%), hearing inpairments (30%), heart conditions (26%), orthopaedic impairments (17%),

cataracts and sinusitis (15% each), visual impairments (10%) and diabetes (9%).*

About 20% of older persons were hospitalised during 1982 compared to 9% of persons under 65. Among those hospitalised, the elderly were more likely than younger persons to have more than one hospital stay per year (27% vs 17%) and to stay in the hospital longer (10 days vs 7 days). Older persons also averaged more visits to doctors in 1982 than did persons under 65 (8 visits vs 5 visits).*

In 1984 the 65+ group represented 12% of the U.S. population but was projected to account for 31% of total personal health care expenditures. These expenditures were expected to total $120 billion and to average $4,202 per year for each older person, more than 3 times the $1,300 spent for younger persons. About $1,000 or one-fourth of the average expenditure was expected to come from direct ("out-of-pocket") payments by or for older persons.

Hospital expenses were projected to account for the largest share (45%) of health expenditures for older persons in 1984, followed by physicians and nursing home care (21% each).

Benefits from government programs, including Medicare ($59 billion), Medicaid ($15 billion), and others ($7 billion), were projected to cover about two-thirds (67%) of the health expenditures of older persons in 1984, compared to only 31% for persons under 65.

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Footnotes:

* Numbers or percentages in paragraphs and figures followed by this symbol refer to the non-institutionalised population only.

** By the official 1984 definition of $6,282 for an older couple household or $4,979 for an older individual living alone.

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TABLE 1. - THE GROWTH OF THE OLDER POPULATION, ACTUAL AND PROJECTED; 1900 - 2050
(Numbers in Thousands)

| | All ages | | 55yrs & over | | 55 - 64yrs | | 65 - 74yrs | | 75 - 84yrs | | 85yrs & over | | 65yrs & over | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| 1900 | 76,303 | 100 | 7,093 | 9.3 | 4,009 | 5.3 | 2,189 | 2.9 | 772 | 1.0 | 123 | 0.2 | 3,084 | 4.0 |
| 1910 | 91,972 | 100 | 9,004 | 9.8 | 5,054 | 5.5 | 2,793 | 3.0 | 989 | 1.1 | 167 | .2 | 3,950 | 4.3 |
| 1920 | 105,711 | 100 | 11,465 | 10.8 | 6,532 | 6.2 | 3,464 | 3.3 | 1,259 | 1.2 | 210 | .2 | 4,933 | 4.7 |
| 1930 | 122,775 | 100 | 15,031 | 12.2 | 8,397 | 6.8 | 4,721 | 3.8 | 1,641 | 1.3 | 272 | .2 | 6,634 | 5.4 |
| 1940 | 131,669 | 100 | 19,591 | 14.9 | 10,572 | 8.0 | 6,375 | 4.8 | 2,278 | 1.7 | 365 | .3 | 9,019 | 6.8 |
| 1950 | 150,697 | 100 | 25,565 | 17.0 | 13,295 | 8.8 | 8,415 | 5.6 | 3,278 | 2.2 | 577 | .4 | 12,270 | 8.1 |
| 1960 | 179,323 | 100 | 32,132 | 17.9 | 15,572 | 8.7 | 10,997 | 6.1 | 4,633 | 2.6 | 929 | .5 | 16,560 | 9.2 |
| 1970 | 203,302 | 100 | 38,588 | 19.0 | 18,608 | 9.2 | 12,447 | 6.1 | 6,124 | 3.0 | 1,409 | .7 | 19,980 | 9.8 |
| 1980 | 226,505 | 100 | 47,244 | 20.9 | 21,700 | 9.6 | 15,578 | 6.9 | 7,727 | 3.4 | 2,240 | 1.0 | 25,544 | 11.3 |
| 1990 | 249,731 | 100 | 52,889 | 21.2 | 21,090 | 8.4 | 18,054 | 7.2 | 10,284 | 4.1 | 3,461 | 1.4 | 31,779 | 12.7 |
| 2000 | 267,990 | 100 | 58,815 | 21.9 | 23,779 | 8.9 | 17,693 | 6.6 | 12,207 | 4.6 | 5,136 | 1.9 | 35,036 | 13.1 |
| 2010 | 283,141 | 100 | 74,097 | 26.2 | 34,828 | 12.3 | 20,279 | 7.2 | 12,172 | 4.3 | 6,818 | 2.4 | 39,269 | 13.9 |
| 2020 | 296,339 | 100 | 96,629 | 30.9 | 40,243 | 13.6 | 29,769 | 10.0 | 14,280 | 4.8 | 7,337 | 2.5 | 51,386 | 17.3 |
| 2030 | 304,330 | 100 | 98,310 | 32.3 | 33,965 | 11.2 | 34,416 | 11.3 | 21,128 | 6.9 | 8,801 | 2.9 | 64,345 | 21.1 |
| 2040 | 307,952 | 100 | 101,307 | 32.9 | 34,664 | 11.3 | 29,168 | 9.5 | 24,529 | 8.0 | 12,946 | 4.2 | 66,643 | 21.6 |
| 2050 | 308,856 | 100 | 104,337 | 33.8 | 37,276 | 12.1 | 30,022 | 9.7 | 20,976 | 6.8 | 16,063 | 5.2 | 67,061 | 21.7 |

The above table has been reproduced from the U.S. Department of Commerce Bureau of the Census Decennial Census of Population, 1900 - 1980 and Projection of the Population of the United States: 1982 to 2050 (advanced report). Current Population Reports, Series P-25, No. 922, October 1982 Projection are middle series.

## LEGISLATION

### VETERANS ADMINISTRATION PROGRAMMES

The Veterans Administration Act was passed in 1930 with various programmes of Government assistance but confined to veterans only.

Although not in its present form, this was the earliest provision of health care in the United States. This has now expanded where today, it operates the largest medical service in the United States with some 400 facilities and 200,000 doctors, nurses and other employees, treating about 1.3 million patients a year at a current cost of nearly $8 billion. One hundred and seventy-two acute care hospitals represent the traditional core of the V.A. Medical/Centre system. Recognising the rapid ageing of the veteran population however, the V.A. has embarked on an ambitious new geriatric programme involving both the expansion of existing facilities and services and the deliberate re-orientation of exisiting resources towards long-term care. Among the new developments are:-

1. The number of beds in long-term care or extended care facilities are being increased.

2. Eight Geriatric Research, Educational and Clinical Centres have been established in V.A. Medical Centres around the country for research into ageing and geriatric care and for the education of health professionals in such care.

3. Five Adult Health Care Centres are operating as demonstration projects to explore out-patient treatment of the elderly.

4. A variety of programmes have been established in community, state and V.A. homes to care for patients with chronic conditions.

5. A palliative treatment centre has been established in Los Angeles to study the latest developments in the care of the terminally ill.

6. A Geriatric Fellowship programme has been established for physicians; now in its fifth year. Its largest class graduated in 1983. In terms of dollars and other resources, the new long-term care programmes are still overshadowed by acute care.

The V.A. leadership appears to understand the "geriatric imperative" and is committed to trying to meet it as effectively and humanely as possible, even if this involves some transfer of resources. A significant portion of V.A. research is also targeted to this end.

As part of Reagan's strategy of reducing direct expenditure from central government for long-term care, it has proposed that veterans who need long-term care services will be treated in less costly state and community-based nursing homes, rather than in Veterans Administration facilities.

Under the budget proposals sent to Congress earlier this year, the Veterans Administration health care system will lose about 7,500 employees under the plan, which would appropriate $9.1 billion to the system in the fiscal year of 1987, a decrease of about 43.8 million from the financial year 1986.

The Veterans Administration will be encouraged to find low cost ways to meet the needs of the growing number of elderly veterans under the budget/nursing plan provided to veterans. V.A. nursing facilities cost about $114 per day according to budget documents. By contrast, the care given to veterans in community nursing homes cost the Veterans Administration about $64 per day.

Proposed personnel cuts in the plan to use community services have created a great deal of controversy in the 'House'.

In the financial year 1984, the Veterans Administration spent more than $8 billion providing services to veterans. Health policy experts estimate that the amount of money spent on health care for veterans will rise sharply in the next decade as more veterans become eligible for free care from the Veterans Administration. In addition, the President's budget plan would require higher income veterans with non-serious related health problems to purchase medical care in the private sector before becoming eligible for free care in the system. Veterans would have to exhaust all private resources before they could obtain free care under this proposal.

Veterans with service-connected medical problems and certain special category veterans, such as those exposed to 'agent orange' which was extensively used in the Vietnam War as a defoliation agent, would still be

eligible to obtain free care at Veterans Administration facilities under the plan. Also private insurance companies and other third-party payers would have to pay for care provided to veterans with non-service connected health problems in Veteran Administration facilities.

## SOCIAL SECURITY ACT

Attempts on the part of Government to develop a basis for long-term care services can be traced to the Social Security Act of 1935. This legislation, as Dr Brickner of St. Vincent's Hospital in New York has pointed out, established the cash welfare payments for the elderly, to inmates of public institutions, which provided an impetus for placing people in private orientated board and care homes rather than County Services systems. These homes formed part of the provider base when nursing home benefits subsequently were explicitly adopted. In 1950, States for the first time were permitted to pay health service costs for individuals receiving welfare benefits. Prior to this date, care for this group was a local responsibility and dealt with haphazardly.

The Hill-Burton Act as amended in 1954 authorised funding through grants for nursing home construction in the not-for-profit sector. This critical development set a precedent for public support for nursing homes.

The U.S. Department of Housing and Urban Development and the legislation passed in 1959 can also allow direct loans for elderly and handicapped housing. Section 8 of the Housing and Community Act 1977 also offers low income rental assistance for the elderly.

In 1960, the Kerr Mills amendments to the Social Security Act provided federal funds with State money for health service to the aged poor. Thus the concept of medical indigency was recognised in federal legislation. In large part, the funds made available through this Bill were used to house the old people in nursing homes. The major pieces of legislation impinging on the elderly in the United States were enacted in the mid-60's.

## MEDICARE

Medicare is a contributory social programme run by the Federal Government mainly for the elderly - 65+, but also for the disabled and those with chronic renal failure. Part A of Medicare covers hospital, nursing and home care and is financed by the same compulsory payroll tax that finances social security benefits.

Part B covers doctors' services and other medical expenses and is financed by general taxation and voluntary contributions for the elderly. Both parts of Medicare are subject to cost sharing and limitations; for example, a maximum of 90 days in hospital with a lifetime reserve of 60 days. The amount one has to pay changes from year to year depending on increases in the average cost on the day of hospitalisation.

After 90 days of hospital care, a patient must draw on their lifetime reserves of 60 days as explained earlier. For each day used, they must pay $246 (versus $200 in 1985). It is up to the individual whether they want to use these reserve days or save them. Once used, the reserve days are not replenished.

The following example is taken from the "Handy Guide to Medicare 1986":

**"Examples of Medicare Benefits for Hospitalisation"**

Matilda, age 67, broke her hip in February 1986 and was taken to the hospital. The surgeon had to use open surgery to install a prosthetic hip joint. A private nurse was hired to stay with her at the hospital the first day after the surgery. She moved from this hospital after 7 days directly to a skilled nursing home for 4 days where she received therapy. After returning home, she still needed a physical (physio) therapist and a nurse for some treatments.

Her expenses totalled $6,064, of which Medicare paid $4,541. She had to pay the remaining $1,523. (She had previously paid the $74 Medical Insurance deductible for earlier expenses).

Because doctor and ambulance charges were higher than the recognised charges for the same services in her area, only the lower of such charges was allowed for Medicare reimbursement.

Her expenses are itemised below, along with the amounts paid by various parties:

| Expenses | Amount | Allowed | Medicare Paid | Patient Paid |
|---|---|---|---|---|
| Ambulance/hospital | 70 | 60(a) | 48(b) | 22 |
| Hospital | 3,500(c) | 3,275(d) | 2,783(e) | 717 |
| Anaesthesiologist | 340 | 300(a) | 240(b) | 100 |
| Surgeon | 1,200 | 1,000(a) | 800(b) | 400 |
| Private Nurse | 110 | 0(f) | 0. | 110 |
| Ambulance/nursing home | 70 | 60(a) | 48(b) | 22 |
| Skilled nursing home | 320 | 320. | 320. | 0 |
| Ambulance/residence | 70 | 60(a) | 48(b) | 22 |
| Rental, wheelchair | 25 | 25. | 20(b) | 5 |
| Rental, hospital bed | 75 | 75. | 60(b) | 15 |
| Home visits, therapist | 87 | 87. | 87. | 0 |
| Home visits, nurse | 87 | 87. | 87. | 0 |
| Medicines taken home | 110 | 0. | 0. | 0 |
| TOTALS $ | 6,064 | 5,349 | 4,541 | 1,523. |

(a) Actual charge was higher than the customary charge.

(b) Covered by Medical Insurance - 80% paid.

(c) Amount payable to hospital or skilled nursing facility by Medicare (based on complex rules which are not necessarily equal to hospital costs or charges) and by patient, including additional charges for services not covered by Medicare.

(d) $225 for private room and TV rental, not paid by Medicare but by patient.

(e) First $492 (deductable for 1986) paid by patient, not by Medicare.

(f) Charges by private nurse not covered by Medicare.

THIS EXAMPLE SHOWS HOW HELPFUL MEDICARE IS WHEN THE ELDERLY ARE FACED WITH MAJOR EXPENSES. IT ALSO SHOWS THAT THEY STILL HAVE TO PAY SOME OF THE EXPENSES THEMSELVES.

The following description is based on 1986 amounts which increased in 1987.

## 1. Hospital Benefits

When admitted to hospital a patient has to pay an initial amount of $492 - an increase from $400 from 1985, After that, for the next 60 days a patient would have to pay nothing more except for luxury items. If admitted again within 60 days after being discharged from the hospital or skilled nursing facility, this represents a single benefit period and the patient does not have to pay another initial sum. However, the hospital days in both periods count towards the 60 days maximum.

After 60 days of hospital care, in a benefit period, a patient can get an additional 30 days of care but they must pay an additional premium of $123 a day, an increase from $100 in 1985.

## 2. Skilled Nursing Facility Benefits

If they have had a hospital stay of at least 3 days and are then transferred within 30 days after discharge from the hospital to a skilled nursing facility, which meets Medicare's strict standards, for further less intensive care and recuperation, they pay nothing for the first 20 days then, for each of the next 80 days they pay $61.50 (versus $50 in 1985). No benefits are provided after 100 days unless they begin a new benefit period. Custodial or domicilliary care in a nursing home is not covered.

## 3. Home Health Service Benefits

Home health services, such as part-time nursing care, physiotherapy, medical social services, use of medical supplies and appliances, not drugs, and some rehabilitation equipment, are fully paid for when the patient is confined at home. There is no requirement for private hospitalisation nor any maximum on the number of visits.

4. **Hospice Benefits**

A hospice, in an American setting, is defined as an organisation which furnishes a co-ordinated programme of in-patient, out-patient and home care for terminally ill patients. Hospice benefits are available for those who elect them. Emphasis on counselling, symptomatic control of pain reduction but not curative treatment. A patient will only pay 5% of the cost of prescription drugs for symptoms management and pain relief and for respite care, not to exceed 5 consecutive days; then they have the opportunity to choose hospice benefits. All other Medicare benefits stop, with the exception of physician services and treatments of conditions not related to the terminal illness.

5. **Care in a Christian Science Sanitorium**

Hospital insurance can help pay for in-patient hospital and skilled nursing services received in a Christian Science Sanitorium, if it is operated or listed and certified by the First Church of Christ's Scientists in Boston.

6. **Limitations on Benefits for Care in Psychiatric Hospitals**

Hospital insurance will pay for 190 days of psychiatric care in a lifetime. Restrictions apply to persons who are hospitalised for psychiatric care when they are first covered by Medicare.

7. **Limitations on Benefits for Care in Non-Participating Hospitals**

In general, hospital insurance helps pay a hospital bill only if the patient is in a participating hospital. There are a few qualified hospitals that are not participating in the programme. If in an emergency the closest hospital is one of these, expenses will be paid. The patient must however pay the bill and be reimbursed by Medicare.

At present no means test is required for elegibility for Medicare. There is therefore a situation that even the wealthiest person in America is

entitled to this benefit as are those at the lowest level of the social ladder.

## MEDICAID

Medicaid was legislation, enacted in 1965 as an amendment to the Social Security Act, with a summary of prior legislation to a large extent, rather than a new concept. The aim of the programme is to provide medical assistance for certain low income persons and this excludes most older Americans. Medicaid has nonetheless become the primary source of public funds for nursing home care. About 88% of all public funds for nursing home care is paid by Medicaid. Each state administers its own programme and subject to federal guidelines determines the medical income eligibility standard. State Medicaid programmes are required by federal law to cover the category "needy". That is, all persons receiving assistance under the "aid to families with dependant children" programme and most persons receiving assistance under the "supplementary security income" programme. States may also cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities or intermediate care facilities. In addition, States may have the discretion to cover the medically needy, that is perhaps those whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but not large enough to pay for medical care. These State variations mean that persons with identical circumstances may be able to receive Medicaid benefits in one state but not in another.

To control costs and provide a range of community-based services to the Medicaid eligible population, many States have applied to the Department of Health and Human Services for 2,176 Medicaid waivers. In 1981 Congress enacted legislation giving the Department of Health and Human Services (DHHS) the authority to waive certain Medicaid requirements, to allow the States to broaden coverage, to include a range of community-based services for persons who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility.

Services covered under the waiver include:- Case Management, Homemaker, Home Health Aid, Personal Adult Day Care, Rehabilitation, Respite and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration support for the programme due to financial impact.

## THE OLDER AMERICANS ACT

The Older Americans Act (OAA) of 1965 carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural and recreational opportunities and social services. While the Older Americans Act does fund a wide range of supportive services, in-home services such as home health aide, visiting and telephoning reassurance and home helps, have been given explicit priority by Congress.

Each OAA area agency is required to spend a quarter of its supportive services allotment on home care services. It should be noted that the number of home care visits to older persons, supported under this legislation represents only a small fraction of the amount under Medicare and Medicaid. In addition an amendment to this Act in 1972 created a Nutrition Programme for the elderly which has three main purposes:-

(1) to provide nutritious meals in a group setting

(2) to encourage social interaction and reduce isolation

(3) to make needed supportive services available and easily accessible to participants.

The programme is designed to serve older persons over the age of 60 and their spouses regardless of age, who do not eat well because:-

(a) they cannot afford to do so

(b) they lack the skills to select and prepare nourishing and well-balanced meals

(c) they have limited mobility and are therefore unable to shop and cook for themselves

(d) they have feelings of rejection and loneliness which may result in little or no incentive to prepare and cook meals.

This programme also particularly serves low income elderly, minority groups and limited English speaking individuals who must be served at least in proportion to their numbers of eligible persons within the State. The programme is designed to help the older isolated person become involved with other people and enjoy better health through improved nutrition and remain self-sufficient and independent as long as possible.

The Nutrition Programme is more than just a meal, its purpose is to nourish the whole person. The programme gives highest priority to those who are in greatest need of nutrition, social contact and supportive services. Often these people with the greatest needs are the most difficult to reach and to serve.

In order to ensure that the goals of the programme are met, certain policies and standards have been set by the Administration on Ageing in the Department of Health, Education and Welfare. Some more basic policies are outlined here: additional policies are determined by individual states.

(a) Meals are to be served in a group setting with at least one hot meal per day, served five or more days a week

(b) rural sites may serve less if the state agency on ageing permits

(c) each meal must provide one-third of the current dietary allowances

(d) the amount of nutrients recommended for daily consumption by nutritional scientists.

**Menus**

(1) Food selection and meal preparation must include consideration of special needs of the elderly and of minority groups if they represent a major portion of site participants.

(2) These must be planned for at least four weeks at a time, certified in writing by a dietician nutritionist and submitted to the State Agency on Ageing at least two weeks before the meal.

(3) These are to be posted where they can be read easily by participants.

(4) Hot foods are to be available at least one half hour after serving begins so that any participants who come late may be served.

(5) Participants must have an opportunity to pay whatever they wish for the meal.

There is a limit on federal funds for the nutrition project which must not exceed 90% of the total budget with a minimum of 10% local matching funds or in kind resources from non-federal services. A nutrition project must provide outreach to isolated elderly and supportive services as needed by the participants, if not readily available elsewhere.

## SOCIAL SECURITY SERVICES BLOCK GRANT

The Social Security Act of 1974 authorises reimbursement by States for social services. Among other objectives the Social Service Block Grant is designed to prevent or reduce inappropriate institutional care by providing for community-based care and to secure referral for admission institutional care when other forms of care are not appropriate. Although the Federal Government makes this the major platform for its social services for the community, its ability to support the long-term care population is limited because it provides a variety of social services to a diverse population.

Prior to 1981, States were required to make public a report on how the social services block grant funds were to be used, including information on the type of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated. Data concerning the extent to which this legislation now supports long-term care is therefore unavailable.

**NOTE:** Certain Sections of the preceding Chapter entitled, 'Legislation' have been provided from Papers produced by the American Hospital Association.

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## FUNDING

Unlike the British system of funding, the United States has pluralistic arrangements for financing health care which are still evolving, some of which I shall mention briefly in this chapter.

Historically, American society has always looked to the individual to make their own financial arrangements for treatment, the earliest was direct payment combined with private charities.

There are 3 Government health insurances, the 2 main ones being Medicare and Medicaid which account for 60% of health care spending.

Medicare is a contributory insurance which caters mainly for the elderly, financed by general taxation and voluntary contributions from the elderly, while Medicaid is a non-contributory programme with a wider ranging scope. This mostly covers the aged-poor, blind, disabled and families with dependant children. It also holds a particularly important function in financing nursing home care.

The third Government programme is the Veterans Administration (V.A.), this provides hospitals, nursing homes and personal services for servicemen and elderly veterans, although nursing home care for non-military service related conditions is limited to 6 months.

## TAX EXEMPTIONS

Apart from the visible funding from the American Government on health care, tax exemptions provide financial support even greater than the amount provided by Medicaid.

Contributions paid either by individuals or employers are subject to tax exemptions but the greater advantages are in employer-run schemes and provide strong incentives to acquire health insurance.

As the cost of health care has increased, especially with the development of new technology, more members of society have found it necessary to take out private health insurance, similar to that in Britain for BUPA and the other organisations that fund treatment in private hospitals. This accounts for 25% of all personal health care expenditure and is mostly subscribed to by employer-related group schemes.

There are three types of private insurance organisations in the United States.

1. Commercial profit-making Mutual Companies.
2. Health Maintenance Organisations or Pre-paid group practices.
3. Non-profit making Blue Cross and Blue Shield Associations.

1. The Commercial Insurance Companies emerged strongly in the 50's and 60's as a major provider of health insurance.

   The main difference in the early years was that they paid the subscriber rather than the provider but this has changed, whereby now they tend to pay the actual charges of the providers. They also have ceilings and exclusions, particularly for individual subscribers. Apart from the usual comprehensive insurance they provide economy insurance packages with greater consumer cost sharing.

2. Health Maintenance Organisations are usually non-profit making. The main difference is they combine health insurance with provision for health care itself. In some ways they resemble the National Health Service except they are private, membership is voluntary and once the subscription is paid, care is either free or there is a nominal charge to subscribers. Health Maintenance Organisations acquire their income by offering fairly comprehensive health care to subscribers for a regular capitation payment, usually set by community rating.

There is not the universal access to comprehensive health care such as we have here because the United States relies on voluntary insurance and government aid. A percentage of Americans are either not insured at all or under-insured although there is a certain amount of charitable care.

3. Blue Cross and Blue Shield, usually referred to as the 'Blues' have evolved over the years into providing a fairly comprehensive insurance that often requires the patient to pay a deductable (all costs up to a maximum) or co-insurance (a fixed percentage of each medical bill).

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**Blue Cross/Blue Shield at a glance**

* As of Nov. 1, there were 85 Blue Cross plans, operating in all 50 states. As of June 30, they served 77.5 million subscribers. Blue Cross plans re-imburse patients for hospital expenses; Blue Shield plans re-imburse for physicians' fees.
* Each plan offers traditional health insurance. In addition, as of Sept. 1, 52 plans sponsored 73 health maintenance organisations (HMOs) in 35 states; and as of Oct. 1, 37 plans sponsored 37 preferred provider organisations (PPOs) in 31 states.
* Eight of the plans are mutual insurance companies, owned by the policyholders. The rest are organised under state "enabling acts", which authorise the creation of not-for-profit, prepaid healthcare plans.
* Blue Cross/Blue Shield plans cover employees at 70% of the nation's top 100 companies.

| | **(000,000 omitted)** | **Six months ending 6/30/85** | **1984** |
|---|---|---|---|
| 1. | Premium revenues | $20,736 | $39,954 |
| 2. | Claims paid | 18,860 | 35,744 |
| 3. | Administrative expenses | 1,718 | 3,159 |
| 4. | Net premium income (1-(2+3)) | 157 | 1,051 |
| 5. | Other income | 613 | 1,019 |
| 6. | Gain transferred to reserves (4+5) | 770 | 2,070 |

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Source: Blue Cross & Blue Shield Asan., Washington. Modern Health Care Dec. 6. 1985.

## SOURCES OF PRIVATE GRANTS.

The United States tradition of grants from large scale organisations is still relevant within American society although the proportion of money they are able to contribute to projects for the elderly has diminished over the years.

In 1985, - 919 grants totalling more than $53.5 million were awarded by 212 independant, incorporate and community foundations for programmes to benefit the aged. The grants covered a wide range of programmes including advocacy, health and medical care, nursing homes, housing and home services, gerontology and medical and social research. Medical care, medical and health education, and medical research programmes benefitting the aged received 234 grants totalling more than $26 million. Direct service agencies received nearly $24 million, hospitals and medical care facilities received more than $12 million in grants.

The following is a list of organisations who presently can be approached for funding:-

Robert Wood Johnson Foundation, Princeton, New Jersey.
W.K. Kellogg Foundation, Battle Creek, Michigan.
Kresk Foundation, Troy, Michigan.
The Pugh Memorial Trust, Glenmead Trust Co. Philadelphia.
Retirement Research Foundation, Park Ridge, Illinois.
Villa Foundation, Washington.

Other potential funding sources, corporations and foundations:-

R.C. Baker Foundation, Orange, California.
Florence A. Burden Foundation, New York.
Charles E. Culpepper Foundation, New York.
Digital Equipment Corporation Foundation, Maynard, Mass.
Excon Corporation, New York.
Joan A. Hartford Foundation, New York.
Henry K. Kaiser Foundation, Menlow Park, California.
Kimberley-Clarke Foundation, Nina, Wisconsin.
Merg, Sharpe and Doyne, West Point, Pennsylvania.

A number of the afore-mentioned organisations have sponsored many of the projects detailed later in this report, for the development of initiatives for geriatric care, particularly where it is possible to develop community programmes.

## MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) - DIAGNOSTIC RELATED GROUPS (DRGs)

Total health care expenditure within the United States is consuming a growing proportion of the nation's resources, 5.9% of the gross national product in 1982 compared with 5% in 1965. Since 1965 consumer prices have risen 250%, while hospital costs increased 550%. In 1982 health care costs increased to three times the national inflation rate. Through Medicare and Medicaid the American taxpayer will pay 40% of all hospital bills; for the five years from 1978 to 1983 medical costs have risen at an average annual rate of 90%. Given these facts according to the U.S. Department of Health and Human Services report to Congress in December 1982, the Federal Government felt it must take some action to control the cost of health care. Historically, hospitals have been reimbursed for patient cases based on room, board and other services actually provided to individual patients. This cost-based reimbursement system whilst fostering high quality care had been criticised for providing incentives to keep patients in hospital longer than necessary and to provide more services than may be warranted medically. In March 1983, Congress passed a new system of reimbursing hospitals for medical patients, Prospective Payment System, based on Diagnostic Related Groups (DRGs). This system applies only to in-patient hospital services, not to physician services or patients who pay their own bills or commercial insurance companies.

The DRG classification system was designed by researchers at Yale University and brought into effect in 1983 after a 3 year trial period in New Jersey Hospitals.

DRGs reflect medical homogeneity and predict resource consumption as measured by costs and length of stay. They were a new approach to containing increasing costs of health care. From October 1983 a total of 3,800 hospitals began using DRGs followed by another 2,200 hospitals at the beginning of their fiscal year. Medicare placements to hospitals are based on DRGs rather than actual resources used in caring for those patients.

The Government determines a reasonable payment needed to care for patients within each DRG. If the hospital's cost is below the reimbursement level, the hospital keeps the difference - if the hospital spends more money providing care, it will take less of that expense. According to American Hospital Association reports, the major advantages of DRGs are expected to be:-

(1) Hospitals have clear incentive to provide more efficient patient care so they can keep funds collected above their costs;

(2) Medicare expenditure and hospital revenues will be more predictable making long range planning easier and more accurate;

(3) More equity will exist between hospitals than under the old system. The hospital is not motivated to run more efficiently than its neighbours;

(4) With Prospective Payment, hospitals that are managing cost effectively will be rewarded by being able to keep the dollar difference between the operating costs and the DRG reimbursement payments;

Disadvantages noted in the report include:-

(1) Physicians are key decision makers in all aspects of hospital administration and their individual incentives are not affected under the new system. They determine length of patient stay, diagnostic tests, x-rays, drugs, surgical procedures and other major cost items;

(2) Unnecessary surgical procedures might be performed because of the higher reimbursement rates involved;

(3) Some hospitals may skim the cream of patients and not be willing to treat patients who require sources above the reimbursement level.

The excessive inflation rate illustrated in the preceeding paragaphs and the legislation which enacted DRGs, has meant the health care industry in America is undergoing its most revolutionary change since the enactment of Medicaid. Now health care delivery is entering the competitive area, assuming a business focus never before experienced. This competition is within hospitals themselves and amongst hospitals and other kinds of health providers such as out-patient clinics, surgery centres, diagnostic centres, and minor emergency centres.

*****The following passages are excerpts from **'Overview of the Medicare Prospective Payment System (PPS)' produced by Rush-Presbyterian-St. Luke's Medical Center**

Prior to this, Medicare programme paid each participating hospital its reasonable costs of providing care to Medicare beneficiaries. This system was known as retrospective cost reimbursement because the exact amount a hospital would be paid was not determined until after the services had been provided. Hospitals submitted cost reports, that detailed the expenses incurred in providing care to Medicare beneficiaries during the previous year and subject to some limitations, Medicare paid for the costs of these services. Retrospective cost reimbursement provided limited incentives for hospitals to control spending. Furthermore, the Government had difficulty predicting and controlling Medicare expenditures.

The Social Security Amendments Act of 1983 is intended to correct the deficiences of cost reimbursement by paying hospitals for in-patient services at a pre-determined price per discharge. This new system is known as Prospective Payment because rates are set in advance of when the services are delivered and are not adjusted at the end of the year in light of actual hospital expenses. The Medicare Prospective Payment System (PPS) became effective on 1st October 1983. However, hospitals are being phased into the system according to their fiscal years.

To ease the impact of the change from retrospective cost reimbursement to prospective DRG prices, the law provided for a three year transition period. During this transition period a declining portion of the total prospective payment will be based on a hospital's historical costs in its base year, while an increasing portion will be based on a blend of national and regional rates per discharge. After the three year transition period, Medicare payment will be based entirely on national DRG payment rates adjusted by local wage indices.

A hospital's calculation of the Base PPS Rate during the three year transition period is comprised of two components - the hospital - specific portion and the federal portion.

**Hospital Specific Portion**

The hospital-specific portion is based on the individual hospital's own allowable costs per discharge in its base year. The base year cost per discharge is updated to account for inflation between the base year and the first prospective payment year. This updated cost per discharge is the hospital-specific rate. For each of the remaining years of the system's transition period, an updating factor is applied to the prior year's hospital-specific rate.

**Federal Portion.**

The second component of the base prospective payment rate is the federal portion. The federal portion is a blend of two components - a regional and national rate. Hospitals are divided into urban and rural groups and each group has its own national and regional rates. The regional rate is set at the average cost per Medicare discharge for all hospitals in the region and the national rate is set at the average cost per Medicare discharge. Both the regional and national rates are divided into labour-related and non-labour related components. The regional/national non-labour related components are the same for all hospitals in the region/nation, with the exception of hospitals in Hawaii and

Alaska for which an adjustment is made to account for those States' higher costs of living. The labour-related component is adjusted by a wage index that accounts for area wage differences. For the Chicago metropolitan area, the wage index is 1.2196, indicating that hospital wages in this area are approximately 22% higher than the national average for urban hospitals.

For teaching hospitals another adjustment is made to account for the indirect medical education costs attributable to an approved graduate medical education programme. The additional payment is based on the hospital's ratio of full-time equivalent interns and residents to beds.

## DRG CLASSIFICATION SYSTEM

The key to the new Medicare Prospective Payment System (PPS) is a patient classification system known as Diagnosis Related Groups, (DRGs). Under the new Medicare Payment System, each discharge is classified into one of 468 DRGs based on the patient's principal diagnosis, operating room procedures, secondary diagnoses and the patient's age.

Associated with each of the 468 DRGs is a weight that reflects the costliness of treating patients in the particular DRG relative to the average for all patients. Thus, patients in DRGs with weights greater than one are generally more costly to treat than average, while those in DRGs with weights less than one are less costly. These DRG weights, when multiplied by the base prospective payment rate described above, determine the amount that Medicare will pay for Medicare patients, regardless of the individual services furnished or the number of days spent in the hospital. These amounts are the DRG prices. Three examples are:-

| DRG | DRG Name | Base Prospective Payment Rate $ | DRG Weight | DRG Price |
|---|---|---|---|---|
| 39 | Lens Procedure | 6,079 | 0.5010 | $3,046 |
| 82 | Respiratory Neoplasms | 6,079 | 1.1400 | 6,930 |
| 315 | Other Kidney /Urinary Tract O.R. Procedures | 6,079 | 2.4884 | 15,127 |

**Costs not included in the DRG price.**

The DRG prices described above include only in-patient operating costs. Capital related costs, such as depreciation and interest and the direct expenses of medical education programmes, will continue to be paid on a reasonable cost basis. These costs are referred to as pass-throughs. However, the Health Care Financing Administration (HCFA) is developing proposals for eventual inclusion of capital-related costs in the prospective price setting system.

**In-Patient Services Exempt from Prospective Payment.**

Services provided in specialty hospitals and in distinct part-rehabilitation and psychiatric units of hospitals are exempted from prospective payment. These exemptions are provided because the current DRGs do not adequately recognise the very long-stays and specialised services that rehabilitation and psychiatric patients require.

**Special Payments**

Transfers

Under the Prospective Payment System, the distinction between a discharge and a transfer is important because the payment differs for each.

A discharge is defined as the formal release of the patient without admission to another hospital paid under the Prospective Payment System. Thus, if a patient is transferred from an acute care unit to either an exempt unit or hospital excluded from prospective payment, the case is considered a discharge. If a patient dies in the hospital, the case is also considered a discharge. A discharge results in payment of the full DRG rate.

A transfer occurs when a patient is transferred from one non-exempt in-patient area to another within the same hospital or is transferred to another hospital which is subject to

prospective payment. In the former case, one DRG payment is made for the entire stay. In the latter situation, the final discharging hospital is paid the full DRG rate and the transferring hospital, is paid a per diem rate for each day the patient stayed prior to being transferred. The payment to the transferring hospital, however, cannot exceed the full DRG rate.

As with pass-through cost issues, the treatment of transfer is viewed by HCFA as an interim policy. HCFA's long-term preference is to pay only the discharging hospital and leave payment to the transferring hospital as a matter of negotiation between the two hospitals.

Outliers

Cases that have abnormally long lengths of stay or extraordinarily high costs are considered outliers and are eligible for payment in addition to the DRG price.

A case is considered a day outlier if the length of stay exceeds a specific number of days for the particular DRG. This specified number of days is called the outlier threshold. An additional payment for each day beyond the outlier threshold will be made to compensate for the marginal cost of the additional days of care.

If a case is not a day outlier but has charges in excess of approximately $27,200 (the charge is higher for 30 high cost DRGs), the case is eligible for additional payment as a cost outlier. The cost outlier payment is also set at levels to approximate the marginal cost of the additional care provided to the patient.

Payment for both day and cost outlier cases is subject to medical review by the Peer Review Organisation (PRO). If

the PRO approves the admission as medically necessary and the extra days and services as appropriate the outlier payment will be made.

**Medical Review Under PPS.**

To guard against utilisation abuses under the DRG Prospective Payment System, the Government has developed new requirements for medical review. The requirements are necessary because the DRG Prospective Payment System creates incentives that work in the opposite direction of the former payment system's incentives.

Under retrospective cost-based reimbursement the incentives were to lengthen stay and increase ancillary service utilisation, thereby increasing costs and revenue. Thus, medical review was focused on preventing over-utilisation of services. Under PPS the incentive is to provide care in as few days and with as few ancillary services as necessary, in order to minimise cost and maximise profit. In addition, the new payment system provides a financial incentive to admit very low cost cases which could be cared for on an out-patient basis.

The new medical review requirements directly reflect the different incentives the new payment system creates. The medical review functions under PPS will be performed by a Peer Review Organisation (PRO). All hospitals must contract with a PRO by 15th November 1984. Until then, the medical review function is being performed by the existing Professional Standards Review Organisation (PSRO). Hospital delegated medical review is eliminated under PPS.

The PROs will be performing several types of reviews as follows:-

Admission Review

A 5% sample of all Medicare discharges at each hospital to determine the medical necessity and the appropriateness of admission.

All transfers to other hospitals and all transfers to psychiatric and rehabilitation exempt units, to detect inappropriate transfers.

All cases re-admitted within seven days of discharge from an acute hospital, to detect premature discharges or admitting practices designed solely for the purpose of increasing payment.

Sanction: Possible loss of favourable waiver of liability presumption status if the number of cases denied exceeds 2.5% of the cases reviewed. If favourable presumption status is lost, admission reviews will increase to 100% of discharges and payment will be denied for admissions found to be unnecessary.

Admission Pattern Monitoring

Analysis of the hospital's number of discharges during each quarter compared with those over the previous eight quarters to detect significant changes.

Sanction: Intensified review activities where increases in discharges cannot be justified.

Outlier Review

All day outliers to determine if all days of stay were necessary and appropriate.

Sanction: Denial of outlier payment for outlier days found to be unnecessary.

All cost outliers to determine if the services billed for were:-

(1) ordered by the physician, (2) delivered, (3) not duplicatively billed and (4) medically necessary.

Sanction: Denial of outlier payment for the cost of services which do not meet all of these four criteria.

Procedure Review

All permanent cardiac pacemaker implants.

Approximately 15 surgical procedures which the Health Care Financing Administration (HCFA) has identified as appropriate for ambulatory settings (pre-admission review).

Sanction: DRGs will be re-assigned excluding any procedures found to be medically unnecessary and payments will be adjusted accordingly. In some cases payment for the entire admission may be denied. Patterns of abuse will be reported to HCFA.

DRG Validation

Review of all cases grouped into DRG 468 (operating room procedure unrelated to the principal diagnosis) and a random sample of discharges each quarter to verify that:-

Diagnoses and procedure codes submitted on the bill and used to assign the DRG are substantiated by the documentation in the medical record.

Sanction: Payment adjustments on cases where DRG assignment changes. Intensified review if pattern of significant coding errors continues.

Attending physician attested on the face sheet to the correctness of diagnoses and procedures used for coding and billing purposes.

Sanction: Denial of payment for cases in which the physician attestation is missing or was not made prior to bill submission.

Quality Review

Review of a random sample of discharge with the objectives of:

* Reducing unnecessary re-admissions due to sub-standard care during prior admissions.
* Reducing avoidable deaths.
* Reducing unnecessary surgery or other invasive procedures.
* Assuring the provision of services that when not performed have significant potential for causing serious patient complications.
* Reducing avoidable post-operative or other complications.

Sanction: Quality problems where found will be reported to the HCFA.

The introduction of this new system of funding Medicare patients has required hospitals to set specific objectives which must be met. The two major areas are:-

**(1) Medicare cost per case.**

Cost per case must be held at least constant over the next four years in order to avert the loss under PPS that is projected for the fiscal year 1986 and beyond.

**(2) Length of stay for Medicare patients.**

Length of stay is obviously an influencing factor in the cost per case. While implicit in the Cost Per Case goal is the need to reduce length of stay, setting a separate goal for it is warranted because length of stay is easily measured and provides a visable target that can be clearly communicated.

Individual hospitals have set their own target of an 11.9 average length of stay for Medicare patients for the fiscal year 1988, a 2 day reduction from a previous fiscal year of 1984 when the average length of stay was 13.9 days.

- end of excerpt *****

The Rush-Presbyterian Hospital have also published a booklet for the year 1st July 1984 to 30th June 1985 entitled, "Questions and Answers about DRG Prospective Payment" with details of the DRG categories, in relation to the national average length of stay, outlier threshold and payment per case for each DRG. The 468 DRG's are divided into 23 categories with a varying number of diagnoses in each. Further divisions for some specific illnesses are by age, e.g.

| | 1* | 2* | 3* |
|---|---|---|---|
| Concussion Age > = And/Or C.C. | 4.6 | 25 | 4,363 |
| Concussion Age 18-69 W/O C.C. | 3.3 | 19 | 3,259 |
| Concussion Age 0-17 | 1.6 | 5 | 1,790 |

A DRG with C.C. in the title means the patient has a secondary diagnosis that represents a comorbidity or complication.

Potential changes in the rates and the audit of the Rush-Presbyterian Hospital's "base year" costs may have resulted in final payment rates that were as much as $300 above or below the listed rates.

It should be noted that these rates included payment for "indirect education" and "capital-related" costs which accounted for approximately 20% of the listed DRG payments per case. These payments will actually be paid separately from the DRG payments on a lump sum basis.

NOTE:-

1* Nationwide Average length of stay for Medicare Patients.

2* Additional payment will be received for patients whose lengths of stay exceed the outlier threshold.

3* Payment (dollars) per case for Rush for Medicare patient discharged between July 1, 1984 and June 30, 1985.

The following are a few examples from the booklet relating only to patients of 70 and over:-

Category 1 - Diseases and Disorders of the Nervous System.

| | 1* | 2* | 3* $ |
|---|---|---|---|
| Nervous System Neoplasms Age >= 70 And/Or C.C. | 9.6 | 30 | 9,437 |
| Nervous System Neoplasms Age <70 W/O C.C. | 8.5 | 29 | 9,046 |
| Concussion Age >=70 And/Or C.C. | 4.6 | 25 | 4,363 |
| Other Disorders of Nervous System >=70 And/Or C.C. | 7.1 | 27 | 7,158 |

Category 4 - Diseases and Disorders of the Respiratory System.

| | | | |
|---|---|---|---|
| Pleural Effusion Age >= 70 And/Or C.C. | 8.4 | 28 | 8,264 |
| Pleural Effusion Age <70 W/O C.C. | 7.6 | 28 | 8,089 |
| Interstitial Lung Disease Age >=70 And/Or C.C. | 7.8 | 28 | 7,478 |
| Interstitial Lung Disease Age <70 W/O C.C. | 6.9 | 27 | 7,012 |
| Bronchitis & Asthma Age >=70 And/Or C.C. | 6.9 | 24 | 5,766 |

Category 5 - Diseases and Disorders of the Circulatory System.

| | | | |
|---|---|---|---|
| Major Chest Trauma Age >=70 And/Or C.C. | 8.1 | 28 | 7,073 |
| Major Chest Trauma Age <70 W/O C.C. | 5.3 | 22 | 5,580 |
| Cardiac Arrhythmia & Conduction Disorders Age >=70 And/Or C.C. | 5.7 | 26 | 6,704 |
| Syncope & Collapse Age >=70 And/Or C.C. | 5.0 | 21 | 4,669 |
| Syncope & Collapse Age <70 W/O C.C. | 4.3 | 18 | 4,096 |

Note:-
1* Nationwide average length of stay for Medicare Patients.
2* Additional payment will be received for patients whose lengths of stay exceed the outlier threshold.
3* Payment (dollars) per case for Rush for Medicare patient discharged between July 1, 1984 and June 30, 1985.

| Category 6 - Diseases and Disorders of the Digestive System | 1* | 2* | 3* $ |
|---|---|---|---|
| Rectal Resection Age >=70 And/Or C.C. | 19.1 | 39 | 19,529 |
| Rectal Resection Age <70 W/O C.C. | 17.9 | 38 | 18,090 |
| Major Small and Large Bowel Procedures Age >=70 And/Or C.C. | 17.0 | 37 | 18,382 |
| Major Small and Large Bowel Procedures Age <70 W/O C.C. | 15.2 | 35 | 15,974 |
| Appendectomy With Complicated Princ. Diag. Age >=70 And /Or C.C. | 11.9 | 32 | 13,210 |
| Appendectomy With Complicated Princ. Diag. Age <70 W/O C.C. | | | |
| **Category 8 - Diseases and Disorders of the Musculoskeletal System & Connective Tissues.** | | | |
| Hip & Femur Procedures Except Major Joint Age >=70 And/Or C.C. | 17.8 | 38 | 16,522 |
| Bone Diseases and Septic Arthropathy Age >=70 And/Or C.C. | 7.5 | 28 | 5,445 |
| Back & Neck Procedures Age >=70 And/Or C.C. | 15.6 | 36 | 13,287 |
| Back & Neck Procedures Age <70 W/O C.C. | 13.0 | 33 | 10,758 |
| **Category 11 - Diseases and Disorders of the Kidney and Urinary Tract.** | | | |
| Prostatectomy Age >=70 And/Or C.C. | 8.6 | 29 | 8,220 |
| Prostatectomy Age <70 W/O C.C. | 7.2 | 26 | 6,860 |
| Kidney and Urinary Tract Infections Age >=70 And/Or C.C. | 7.0 | 27 | 5,857 |
| Urinary Stones Age >=70 And/Or C.C. | 4.9 | 25 | 5,142 |
| Urinary Stones Age >70 W/O C.C. | 3.9 | 19 | 3,946 |

Note:-
1* Nationwide average length of stay for Medicare Patients.
2* Additional payment will be received for patients whose lengths of stay exceed the outlier threshold.
3* Payment (dollars) per case for Rush for Medicare patient discharged between July 1, 1984 and June 30, 1985.

| Category 12 - Diseases of the Male Reproductive System. | 1* | 2* | 3* |
|---|---|---|---|
| Malignancy, Male Reproductive System, Age >=70 And/Or C.C. | 6.9 | 27 | 6,775 |
| Malignancy, Male Reproductive System, Age <70 W/O C.C. | 5.7 | 26 | 5,988 |
| Benign Prostatic Hypertrophy Age >=70 And/Or C.C. | 6.2 | 26 | 6,391 |
| Benign Prostatic Hypertrophy Age <70 W/O C.C. | 4.9 | 22 | 5,046 |
| Category 13 - Diseases and Disorders of the Female Reproductive System. | | | |
| Non-Radical Hysterectomy Age >=70 And/Or C.C. | 9.6 | 20 | 8,010 |
| Non-Radical Hysterectomy Age <70 W/O C.C. | 8.8 | 17 | 7,323 |
| Malignancy, Female Reproductive System Age >=70 And/Or C.C. | 5.2 | 25 | 6,088 |
| Malignancy, Female Reproductive System Age <70 W/O C.C. | 3.5 | 24 | 4,173 |
| Category 17 - Myeloproliferative Diseases and Disorders & Poorly Differentiated Neoplasm. | | | |
| Lymphoma or Leukemia Age >=70 And/Or C.C. | 7.1 | 27 | 8,447 |
| Category 21 - Injury, Poisoning and Toxic Effects of Drugs. | | | |
| Multiple Trauma Age >=70 And/Or C.C. | 6.7 | 27 | 6,367 |
| Toxic effects of Drugs Age >=70 And/Or C.C. | 5.6 | 26 | 5,287 |
| Other Injuries, Poisoning & Toxic Eff Diag. Age >=70 And/Or C.C | 5.3 | 25 | 5,930 |
| Other Injuries, Poisonings & Toxic Eff Diag. Age <70 W/O C.C. | 3.5 | 22 | 4,460 |

Note:-
1* Nationwide average length of stay for Medicare Patients.
2* Additional payment will be received for patients whose lengths of stay exceed the outlier threshold.
3* Payment (dollars) per case for Rush for Medicare patient discharged between July 1, 1984 and June 30, 1985.

## PROVISION OF CARE FOR THE ELDERLY.

American society, similar to that of the United Kingdom, faces significant challenges during the next decade/two decades to meet the needs of frail older people. This requires analysis of the degree of help older people need to remain independant. Also required is the establishment of a spectrum of different programmes that meet the varying needs of the elderly, by moving away from the current dependence on institutions and a clear definition of the clinical disorders.

### Acute Hospital Care

The following points indicate the urgency of this matter. About 5,000 people in the United States turn 65 every day and about 3,000 of that age or older die. It is obvious that the proportion and the gross numbers of the elderly in the American population are steadily increasing. This growth is expected to continue unabated well into the next fifty years.

In a free market economy, like the United States, there is no shortage of hospital provision which is mainly geared to short stay. As much of the funding for the elderly comes from Medicare, access to the latest technology is only limited by an individual's ability to meet the costs either from their own resources or one of the three insurance systems described in the Chapter entitled 'Funding', (page 39).

The present pattern is for money to flow into institutions for long-term care of the frail aged.

Patients requiring admission for a particular illness or surgery usually arrange this through their community physician who will arrange for them to be referred to a specialist and hospital of their choice. The marketing strategy of individual hospitals is geared to providing the highest number of referrals to their particular establishment, emphasising the standard of care and back-up services that are available to them in terms of new technology. The full range of media for individual hospitals are displayed in journals, newspapers, T.V., radio stations and even in the recent past, included in cable T.V. networks.

Government departments and some federal agencies also issue a guide to consumers on selecting long-term care health services for the elderly. Some states provide information direct to the public, such as Arizona, who produce a guide to the cost of attending a particular hospital.

The guide entitled 'Comparative Hospital Costs - State of Arizona', is divided firstly into DRG categories and then into Health Service Areas.

The introductory page shows why the cost to a patient can vary to such a degree for the same illness, at different hospitals. This is followed by a few examples which demonstrate the DRG factor relating to patients of 70 or older and comprises the top and bottom of the range for specific complaints and includes the three hospitals I visited.

* The average charge per patient listed for a particular hospital may be unusually high or low if there is a very small number of patients indicated in that DRG category.

* The type of hospital may contribute to variations in the average charge per patient. Specialty and teaching hospitals may have higher costs, which may increase the charge to the patient.

* Some of the DRG categories list fewer hospitals than others because some hospitals do not treat all illnesses or medical conditions or at least they did not for this reporting period.

* This report does not indicate anything about the quality of care that a patient may receive at a particular hospital nor does it indicate the actual hospital costs that you may be billed as a hospital patient. Some hospitals (County Hospitals and others) include certain physician services and costs in their hospital charges while others do not. Some hospitals offer relatively inexpensive "package" deals which include certain physician services as part of the hospital bill. These "package" deals are not reflected in this report. The report does not indicate certain comparative hospital costs which you should seriously consider and discuss with your doctor and any hospital that he has admitting privileges at, or that you may use prior to being hospitalised.

## DRG 089
## SIMPLE PNEUMONIA AND PLEURISY AGE 70 OR OLDER.

| HOSPITALS | Avg. Charge Per Patient | Total Number Of Patients |
|---|---|---|
| **HEALTH SERVICE AREA 1** | | |
| Good Samaritan | 8,579 | 138 |
| Walter O. Boswell | 4,594 | 152 |
| Pinal General | 3,189 | 20 |
| **HEALTH SERVICE AREA 3** | | |
| Flagstaff Medical Ctr. | 4,592 | 22 |
| Yavapai Reg. Med. Ctr. | 3,269 | 61 |

## DRG 132
## ATHEROSCLEROSIS AGE 70 OR OLDER.
(Hardening of the Arteries)

| | | |
|---|---|---|
| **HEALTH SERVICE AREA 1** | | |
| Valley View Community | 8,504 | 6 |
| Walter O. Boswell | 3,310 | 10 |
| Good Samaritan | 3,254 | 14 |
| Scotsdale Memorial | 1,697 | 1 |

## DRG 138
## CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS AGE 70 OR OLDER
(Heartbeat Irregularity with Disorder of the Heart Muscle)

| | | |
|---|---|---|
| **HEALTH SERVICE AREA 1** | | |
| Good Samaritan | 5,338 | 87 |
| Walter O. Boswell | 2,940 | 102 |
| Pinal General | 1,007 | 2 |
| **HEALTH SERVICE AREA 3** | | |
| Flagstaff Medical Ctr. | 2,527 | 12 |
| Yavapai Reg. Med. Ctr. | 1,788 | 37 |

## DRG 182
## OESOPHAGITIS, GASTROENTERITIS AND OTHER DIGESTIVE DISORDERS AGE 70 OR OLDER.
(Ex. Dysentery, Food Poisoning)

| | | |
|---|---|---|
| **HEALTH SERVICE AREA 1** | | |
| Humana Phoenix | 5,227 | 58 |
| Good Samaritan | 3,127 | 159 |
| Walter O. Boswell | 2,947 | 115 |
| Gila County General | 1,235 | 15 |
| **HEALTH SERVICE AREA 3** | | |
| Marcus J. Lawrence | 1,854 | 46 |
| Yavapai Reg. Med. Ctr. | 1,824 | 66 |
| Flagstaff Medical Ctr. | 1,547 | 29 |

In such a competitive environment, the geriatric centres of excellence I visited in the United States have to provide a variety of services for the elderly in addition to the basic acute services. The amount of planning associated with a booked admission in many cases is far more detailed than one would find in a British setting.

For example, the Good Samaritan Medical Centre in Phoenix, Arizona prior to admission, organise a multi-dimensional screening of prospective patients. This requires prospective patients to complete a detailed questionnaire, providing information on the sections listed below.

**Sociodemographic Information.**

1. Name
2. Home address
3. Telephone Number
4. Birthdate
5. Birthplace
6. Sex
7. Marital status
8. Religious preference
9. Racial/ethnic
10. Summary of providers
11. Family income
12. Usual living arrangements
13. Employment status
14. Health care coverage
15. Number of children living
16. Usual occupation
17. Non-institutional living space
18. Social support willing and able to provide.
19. Directory of health care professionals.
20. Utilisation information

**Service**

1. Therapies
2. Other services/social contacts
3. Nutrition
4. Special nursing procedure
5. Professional visits
6. Medication
7. Medication administration.

**Translation to Service Needs.**

This section outlines a method to project an individual's need for several types of services. Hospitals and local health department screening teams can use it for discharge planning.

**Functioning Status.**

1. Bathing
2. Dressing
3. Toileting
4. Transferring
5. Bowel function
6. Bladder
7. Eating and Feeding
8. Behaviour
9. Orientation
10. Mobility level
11. Walking
12. Wheeling
13. Stair climbing
14. Communication of needs

**Medical Status**

1. Sight
2. Hearing
3. Speech
4. Dentition
5. Fractures/dislocations
6. Missing limbs
7. Paralysis/paresis
8. Allergies
9. Diagnosis
10. Risk factor measurement
11. Joint motion
12. Medical history
13. Family history

**Physicians Order for Care.**

Space is provided here for a physician's review of the patients status and subsequent orders for medical care.

Other options, such as the development of community services have traditionally been starved of resources.

Based on 1980 census figures, about 5% of people 65 and older live in chronic care institutions: about 10% of those over 75 are so placed: by the year 2000 the roll number of those over 65 will have doubled and those of greatly advanced age quadrupled.

The marketing strategy of individual hospitals is governed to providing the highest standard of care with a full range of services which has therefore created the problem of an over-provision of acute care beds in certain parts of the USA to the extent that, over the next decade, there will be a rationalisation of beds, especially where hospitals have concentrated their resources in areas of wealthy social economic groupings.

The traditional pattern of programmes for health care was based on a "fee for services" basis, which meant that there was little control over Health Service expenditure, resulting in an escalation of the cost of health care, well above normal inflation factors.

With the move towards more control of expenditure by the implementation of Prospective Payments Schemes and Diagnostic Related Groups, which has limited the amount of money that institutions would receive, the American health scene has now developed into an era of competition between hospitals, various patterns of community care and centres, where the number of procedures traditionally carried out in a hospital environment are now carried out in surgi-centers and private practices.

This is similar to the initiatives that certain General Practitioners in the United Kingdom have developed, to assist their patients in not having to wait for certain basic, diagnostic procedures to be carried out at a District General Hospital.

According to a 1984 report by the American College of Hospital Administrators, the recent surge in competition can be attributed to these factors:-

1. Major increases in the elderly population.
2. Increased availability of non-acute care facilities.
3. Acute care bed over-capacity - shorter hospital stays.
4. New payment system.

- Corporate employers have begun to take positive action to hold down their health care and insurance costs.

- Many are signing contracts with Health Maintenance Organisations from which comprehensible medical care can be obtained on a lower fixed cost basis.

- Others are beginning to consider Preferred Provider Organisations (PPO's) in which companies can share in a falling discount negotiation with the PPO's.

Health Maintenance Organisations have grown dramatically in the decade between 1973 and 1983, and according to the American College of Hospital Administrators' study, by 1995, Health Maintenance Organisations and Preferred Provider Organisations are expected to increase their impact on the typical hospital's business five fold.

The vast increase in the number of elderly has been detailed earlier in this report. The emergence of Surgi-Centers and other facilities providing care outside a traditional hospital are demonstrated by the Tables on the following pages, and in particular, of developments in this area.

## SURGI-CENTRES AND OTHER FACILITIES

| YEAR | NO. OF NEW SURGICENTRES OPENED | NO. OF OPERATING ROOMS | NO. OF SURGICAL OPERATIONS PERFORMED IN 1983 | 1983 SURGICAL OPERATIONS FACILITES |
|---|---|---|---|---|
| 1970 | 2 | 8 | 7,700 | 3,850 |
| 1971 | 3 | 5 | 2,416 | 805 |
| 1972 | 4 | 9 | 8,868 | 1,664 |
| 1973 | 5 | 10 | 10,792 | 2,158 |
| 1974 | 7 | 25 | 19,273 | 2,753 |
| 1975 | 12 | 39 | 21,471 | 1,789 |
| 1976 | 16 | 55 | 33,703 | 2,108 |
| 1977 | 14 | 38 | 16,475 | 1,178 |
| 1978 | 19 | 60 | 41,494 | 2,183 |
| 1979 | 15 | 45 | 23,293 | 1,552 |
| 1980 | 14 | 46 | 24,403 | 1,743 |
| 1981 | 28 | 83 | 46,398 | 1,657 |
| 1983 | 57 | 182 | 49,665 | 871 |
| 1984 | 65* | 184 | | |

*60 centres are under development or construction as of March 1984 with five having opened prior to March 1984. Five centres are scheduled to open in 1985 and are currently under development. This number is expected to increase significantly.

**Source SMG Marketing Group** **Modern Healthcare May 15, 1984.**

STASTISTICAL DATA BY TYPE OF OWNERSHIP

| | Corporate CHAIN | INDEPENDANT | HOSPITAL AFFILIATED | TOTAL |
|---|---|---|---|---|
| No. of facilities open or under development | 82 | 191 | 80 | 303 |
| % of total | 27.1% | 63.0% | 9.9% | 100% |
| Number of facilities open | 63 | 151 | 24 | 238 |
| % of total | 26.5% | 63.4% | 10.1% | 100% |
| No. of facilities under development | 19 | 40 | 6 | 65 |
| % of total | 29.5% | 81.5% | 9.2% | 100% |
| No. of surgeries | 137,228 | 198,752 | 35,533 | 371,513 |
| % of total | 36.9% | 53.5% | 9.6% | 100% |
| Number of operating rooms | 326 | 504 | 95 | 925 |
| % of total | 35.2% | 54.5% | 10.3% | 100% |

**Source SMG Marketing Group Inc.** **Modern Healthcare June 6, 1986.**

A demonstration of acute bed over-capacity is illustrated by the example of Chicago.

Chicago area occupancy rates have decreased 34% since 1980, the lowest rate since the Chicago Hospital Council began keeping score 17 years ago. A new Medicare system for paying hospitals has affected buyers and providers of health care. Prospective Payment, which bases payment on diagnosis groups, was introduced in 1983, as the Federal Government's method of cutting back the cost of Medicare. Business coalitions which began just a few years ago are expected to have an increasing influence on the delivery system. In short, the dramatic shift in health care delivery has been to conventional market behaviour.

The Good Samaritan Hospital in Phoenix has demonstrated over the past 2 years, a reduction in the average length of patient stay from 7 days to 6.2 by competition among the suppliers leading to increased marketing cost containment and diversity of services - shopping around for the best deal by the buyers, individual patients and businesses - basing their decisions on quality of product and price, with the increased emphasis of short length stay.

There are also lobbies of business people across the States who are alarmed at the number of hospitals that exist with very poor rates of bed occupancy and escalating costs. One of the hospitals I visited had a bed occupancy of less than 60% and the excessive inflation rate associated with medicine, not only in the United States, but in this country has made the Americans realise that while they reviewed the British system as rationing services for their population, there will be a great need over the next decade to rationalise the number of acute beds being provided.

Comprehensive community care such as that established in Britain with a joint approach provided by the National Health Service, local authorities, private and voluntary sector, which are aimed at complementing each other for a total package of facilities for the elderly, is much more fragmented in the United States. As explained earlier, the acute care hospitals concentrate on short stay, quick turn around treatment of the

elderly, similar to the majority of private hospitals in this country. Most hospitals therefore, either own or have affiliations with other facilities to allow people to receive a continuum of treatment outside the acute ward.

There are three main types of institution geared to varying aspects of the continuum of care of the elderly.

1. **Skilled Nursing Facility (SNF)**

   The first level of continuous nursing care services for geriatric patients is known as a Skilled Nursing Facility (SNF). These patients have passed the acute phase of their illness but still require a high degree of nursing care.

   The Medicare legislation covers benefits for short term post acute care, i.e. three days prior to hospitalisation required, for persons needing skilled nursing or rehabilitation services in an in-patient setting. The Medicare SNF Benefit, as mandated by Statute sets specific and relatively stringent requirements regarding the level of skilled nursing necessary for Medicare SNF services.

   In 1980, the average Medicare coverage of SNF stay was thirty days - much less than the average stay of 456 days for all nursing home patients. Medicare services are reimbursed on a retrospective reasonable cost basis subject to limits applied to routine costs, e.g. nursing, meals, laundry. Ancilliary costs, e.g. physiotherapy and drugs, and capital expenses are not included in the limits. A report has been submitted to Congress on converting Medicare Skilled Nursing Facilities to the Prospective Payment System which has been explained in more detail in this report. The Medicare SNF benefit is relatively small, both as a percentage of Medicare expenditure and as a proportion of total nursing home revenues. Medicare SNF expenditure totalled $520,000,000 in the financial year 1983.

2. **Intermediate Care Facility.**

The second level of facility available for the elderly out of an acute setting is referred to as an intermediate care facility which is an institution licensed by a State to provide health related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing facility, but who do require care or services available only through institutional facilities. These facilities may also be known as Supportive Nursing Care facilities or Health Related Facilities. In the British sense, these would best be compared with the Part III accommodation provided by the local authority or range of nursing home and residential homes provided by the voluntary sector. Community services outside a traditional institutional setting are provided under the Medicare legislation. For home health benefit the following types of services are covered:-

Part time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

Physiotherapy, occupational therapy or speech therapy;

Medical social services which contribute significantly to the treatment of patients' health conditions;

Part time or intermittent services from a home health aide;

Medical supplies other than drugs and biological and medical appliances.

The Medicare law limits payment for home health service to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician, confined to their homes and in need of part time nursing care or a physical or speech therapist on an intermittent basis. Home health agencies are reimbursed on a reasonable cost basis subject to limits. Even though home health expenditure constitutes only about 3% of over-all Medicare cost, there is a big growth in this direction. About one third of the Medicare expenditure increases from 1976 to 1980 were due to price inflation. Increases in utilisation accounted for the

bulk of the increase in Medicare expenditure. Other federal programmes also fund long-term care services although the expenditure is small compared to the amount allocated to Medicaid and Medicare. The Veterans Administration funds some nursing homes and personal care for elderly veterans. These are people who have during their career, spent some time in the armed forces of the United States. Nursing home care for non-military service related conditions is limited to six months.

## 3. Nursing Homes

The major provider of long-term care facilities for the elderly in the United States is provided by nursing homes which during the 1970's were the frequent subject of Congressional and State investigations as well as news media exposes. While problems still remain, independant commentators impressionistic evidence suggests that quality of care has improved since the mid 1970's. In general, public perception remains that quality of care is more of a problem in nursing homes than in hospitals.

In general, market forces to ensure quality of care, are weaker in long term care than in an acute setting. Physicians are less involved in nursing home care than in hospital care. In addition, excess demand or shortage of nursing home beds means that providers need not provide good quality care in order to fill vacancies. Medicare and Medicaid funds are only available to institutions that meet federal quality of care standards. Medicare and Medicaid provide funds to help state departments to inspect long-term care facilities. The bulk of the funds are for inspection of institution providers. In addition, the Federal Government requires States to review only the quality of appropriateness of the care given to each and every Medicaid nursing home resident. There is little formal quality shown for non-medical long-term care services.

Areas of concern in nursing homes in general are, recruitment retention, training of nursing home staff, especially nursing aides, over-medication of patients, including over-use of tranquillisers and respect of patients' rights.

Many proposals have been made for reforming the long-term care financing system, most of which are designed to control Government expenditure or to increase the non-institutional long-term care services. Over the past twenty years the number of persons in nursing homes has increased substantially. One reason for this increase is that the population aged 85 years and over has grown rapidly and this group has the highest rate of nursing home use. A proportion of the elderly living in nursing homes however, stabilised in the mid 1970's, following a decade of extremely rapid growth. This growth occurred because eligibility requirements for public payments for nursing home care were liberalised in the mid-sixties, particularly under the Medicare and Medicaid legislation passed at that time.

Also in the early 1970's, many elderly psychiatric patients moved to nursing homes when federal funds became available under, Medicaid for nursing home care but not for care in long-term pyschiatric hospitals. In 1980 twenty billion was spent on nursing home care, with Medicaid providing about half of the financial support for nursing home patients. Because private health insurance does not generally cover nursing home stays, out-of-pocket payments were the second largest source of payment, accounting for 43% of 1980 expenditures. Medicare and private health insurance combined, provided only about 3% support for nursing home patients.

In 1980 about 10% of the population, 75 years and over in the United States were institutionalised in nursing homes. However, there is a four-fold variation among States in the proportion institutionalised. States in the north tend to have the highest rate of nursing homes, seven of the ten States with 12.5% or more nursing homes are located in the north central region, four of the States, Minnesota, North Dakota, South Dakota, and Iowa had the largest percentage institutionalised.

States with high rates of nursing home use, tend to have extremely cold winters which may have an adverse affect on the health of the elderly, and thereby increase the need for nursing home care. The lowest percentages of the elderly in nursing homes are located predominately in southern and western States. In four of these States, less than 6% of the population, 75 years of age and over live in nursing homes, in Florida, Mexico, West Virginia and Arizona.

The low rate for Florida is attributable to the immigration of many retired persons whose health is generally superior to the over-all elderly population. This explanation may also apply to Arizona, along with the fact that Arizona has no Medicaid programme which subsidises many nursing home residents in other States. Reasons for the low rates of nursing home institutionalisation in New Mexico and West Virginia are not clear. An important public policy issue about long-term care for the elderly is whether many nursing home residents could receive comparable but less expensive care in non-institutional settings.

**The United States Department of Health, Education and Welfare, have established helpful guidelines for families selecting a nursing home, this has been reproduced as Appendix 'A' on page 129.**

Dr. Brickner of St. Vincent's Hospital in New York has been at the forefront of advocating this idea since 1973 and has produced a number of papers demonstrating that the traditional role of the nursing home, while essential in certain respects, has, perhaps been over-emphasised to the extent that many patients facing such facilities could more adequately be dealt with outside this setting. Dr. Brickner in his book on 'Home Health Care for the Aged', has anticipated that if American society continues to look to nursing home needs for the elderly population, there will be a need to increase the number of chronic care beds from the 1980 figure of 1.22 million, to 1.69 million in 1990, 2.19 million in 2000, and 2.99 million by 2020. The cost of this bricks and mortar approach would soar to 76 billion by 1990. In 1982 the United States were spending in contrast only 27 billion, therefore, unless it was possible to move towards doubling the stock of chronic care beds, there would be no room at the nursing home, and yet the dollar cost of such an approach is prohibitive.

Large nursing home chains are building new facilities, although, like any organisation, they will tend to concentrate in those areas of the United States where the social economic groupings and funding from individuals, by means of their own resources or comprehensive insurance, suggest that, there is no national movement towards the provision of new facilities. Instead, the large chains that own most of the long-term care facilities will continue to expand, acquiring smaller operators until State governments provide financial incentives to construct badly needed facilities. Because a minimum amount of construction is taking place, a severe shortage of beds will occur in the future as demand continues to exceed supply.

Danial R. Beatty, Executive President of National Medical Enterprises Incorporated, of Los Angeles, has suggested, that if States' construction restrictions are not removed, the bed shortage will become critical and patients will remain in hospitals longer than necessary. Because hospitals are expensive providers of care, this could cost both hospitals and patients billions of dollars a year. Good quality nursing homes are virtually filled to capacity at the present time, and already many hospital patients must be placed on a waiting list before they can be admitted to a nursing home. Nationwide occupancy rates at nursing homes are ranging between 90 to 95%. The expression that the health follows the dollar, is borne out by nursing homes' reluctance to accept Medicare residents because they tend to be sicker and require more intensive services. Instead, facilities tend to accept private paying residents who do not have complicated medical problems before they will take on those requiring expensive care. Part of the reluctance to take on Medicare or Medicaid patients is the result of Government payment rates which are barely enough to cover the cost of average care. If patients require more than an average amount of care, nursing homes often are not reimbursed for providing those services.

Demand for nursing home services will continue to increase because of the changes in the modern family structure, with more women than ever working outside the home. This will result in the elderly being sent to institutions, when in previous years they could have been cared for in the home.

The long-term care industry in America believes the elderly of the future will have more money. More retirees receive pension payments than in the past and because the elderly population is increasing, it is claimed that, more people will be able to afford long-term care. Paying for long term care however, still poses a problem. In 1983, Americans spent more than 30 billion dollars on nursing home care and that is expected to increase to almost 90 billion by 1990.

Currently, nursing home residents pay for nursing home care until they deplete their savings, then they are eligible for Medicare coverage. Medicare currently pays for 55% of all nursing home care while Medicaid pays for only a small percentage of care, such as, short term acute care. A limited number of insurance companies are offering long-term care insurance. A one year stay in a nursing home can cost as much as 35,000 dollars. The financing issue has become a problem for developers, because Medicaid pay so poorly. To increase profits, nursing home chains tend to cater to private paying residents.

**Future.**

One possible solution would be to encourage insurance companies to offer long-term care insurance plans. The Government could promote the insurance plans by offering a credit to children who buy these insurance plans for their elderly parents. Pre-paid health plans may start to offer long-term care benefits if the burden of care is shifted to the elderly who can afford such plans. Medicare funds could be reserved for patients who could not obtain nursing home care any other way.

Connie Evashwick, Director of the Office on Ageing and Long-Term Care, in an article suggests that, due to the factors enumerated previously, there will be a major role in long-term care for hospitals. During my visit this was very evident, where acute hospitals had developed links with nursing home chains or, such as VillaView Community Hospital in San Diego, planning a construction of their own facility on an acute hospital site. Hospitals are therefore expanding their scope beyond providing acute care, to providing a wide range of other health related social

services, especially comprehensive and continuing care. One of the major forces for this trend is the changing patient population. Hospitals are focusing on the older disabled and chronically ill populations and devising activities to meet the long-term care of these patients.

Several forces have recently been changing the patient mix of short term care in general hospitals:-

1. Advances in medical technology and attention to health promotion have reduced the incidents of acute illness.

2. Advances in treatment techniques have emphasised out-patient procedures and measures that shorten the length of time required for treatment, whereas, less progress has been made in the prevention and treatment of chronic diseases.

3. Advances in therapy have greatly increased the ability to keep very ill or severely ill patients alive.

4. Reimbursement and reference requirements have placed constraints on the use of some in-patient services and have encouraged the use of community services.

5. Practices have changed in response to these forces and have emphasised greater use of community care.

6. Government programmes for financing health, mental health and social services, have produced a fragmented system of care and have frequently changed the services covered, and the population deemed eligible.

7. The demographic composition of the nations changing with the rapidly expanding older population. There is, in consequence, a great deal of competition between hospitals and nursing home chains for the clients of the future. Nursing homes are beginning to develop special units of care for particular client groups. As an example, Hill Haven Corporation plans to open twenty five units for Alzheimer patients. Part of the reason for this initiative is that some experts believe that as many as half the nursing home residents in the United States are afflicted with the disease.

The Alzheimer Disease and Related Disorder Association estimate that 10 to 15% of the U.S. population aged 65 and older, between 2 and 3 million senior citizens have the disease. This is likely to become more and more of a problem as the number of elderly increase, especially those aged 85 or above because they are more frequently afflicted with the disorder.

The number of elderly aged 85 and over is expected to more than double from 2.2 million in 1980 to 5.1 million by the end of the century.

The nursing home industry now realises Alzheimer patients need special care. In the past they have mixed with the rest of the nursing home population, but since staff members and patients did not understand the disease, they tended to discriminate against Alzheimer patients.

Establishing a nursing home unit that caters specifically for Alzheimer and dementia patients may have an advantage over nursing homes because it is more cost effective to increase staffing in only one section to care for the same type of patients. If Alzheimer patients were spread throughout all the nursing homes, staff would have to increase in all areas.

All the hospitals I visited saw the role of establishing adequate facilities for psychiatric in-patients for the elderly, as a vital component. In addition to the basic in-patient facilities they provided, there was also a great marketing strategy to help relatives of patients suffering from some form of dementia.

Guidance based on the excellent book produced by Nancy L. Mace and Peter V. Rabins, both of John Hopkins University School of Medicine entitled "The 36-Hour Day" - 'Caring at Home for the Confused Elderly People', was made available to the relatives of patients suffering from this condition.

In Chicago they had produced their own guidance for care-givers and many had psychologists trained to deal with the elderly. The British version of the book sponsored by Age Concern, published in 1985, is a worthy addition to developing an understanding for caring for this patient client group.

There are organisations who are able to fund initiatives in geriatric care. For example, in San Diego, a study on medication abuse in the eldery has been sponsored by the Crock Foundation. A study of the needs of the

elderly in board and care facilities is also planned. Intuitive programmes are also available for social work graduate students and speech therapists, in addition to which there were sociologists trained in the treatment of the elderly and also the post of recreational therapist who usually has skills in art, music, or training in counselling and motivating the elderly, this post has been recognised as a vital component of the rehabilitive services in an American setting.

* * * * * * * * * * * *

In the following sections on Rehabilitation, various passages are extracts from two excellent pamphlets entitled:-

**'Acute Care Patients Can Stay Active', by Martha A Warnick MA RNC,** which is denoted by the symbol [2].

**'Rehabilitation in Our Ageing Society' by Dr. T. Franklin Williams and Pamela Winters Jones,** which is denoted by the symbol [3].

## REHABILITATION

> [2]The value of providing social interaction, sensory stimulation, recreation and psychological support for residents in long-term care institutions has long been recognised. State regulations require that a programme of activities be provided for every patient in order to ' promote general health, physical, social and mental well-being.' Qualified activity co-ordinators plan and implement activity programmes in all licensed facilities.[2]

The ideas of re-education and re-adjustment have a special meaning for those involved in rehabilitating the elderly and this was well demonstrated in the rehabilitative services offered by all the hospitals I visited, especially in Chicago.

> [3]Rehabilitation is often viewed as the third phase in medical care, the first two phases being prevention and specific medical/surgical care. But successful rehabilitation also involves preventing further disability or related deterioration and aiding on-going medical or surgical treatment.
>
> The simple recognition that ageing and disease are not synonymous will go a long way toward creating an environment in which rehabilitation becomes a routinely applied medical approach. The prejudices and myths about ageing must be attacked and conquered on many fronts, including the field of rehabilitation. The all-too-common point of view that the normal ageing process inevitably results in physical and mental deterioration, much of which is viewed as untreatable, is a notion that must be overcome. This point of view - that a certain degree of functional loss is the **normal** result of 'wear and tear', and since we cannot restore the patient to his or her former state, it is pointless to talk about rehabilitation-leads to a philosophy of inaction.
>
> Research has shown that many of the disabilities experienced by older patients are the result of identifiable and treatable

N.B. [2] and [3].

pathological processes. Even in cases where the disease process can only be controlled, rather than cured, it is a legitimate goal of the clinician to treat the disabled person and to help him achieve whatever degree of productivity his functions will allow.

An increased emphasis on rehabilitation therapy also has an economic basis. The Health Care Financing Administration has estimated that in 1983, $362 billion was spent on health care, with about half of this spending on behalf of older Americans. For many elderly, the alternative to costly rehabilitation therapy is even more costly institutional care. Studies of patients with selected impairments have shown that patients who receive rehabilitation therapy are much more likely to return home and avoid institutionalisation than are patients who do not receive such therapy. It is therefore in the interest of an already over-burdened medical system to invest in rehabilitational measures that will somewhat shift the focus from acute and long-term institutional care, to home and self care.[3]

[2]Some elderly have a high vulnerability to illness. Multiple health problems, chronic disease and compounded socio-economic hardships, impact on the acute condition precipitating hospital admission. Medical emergencies alter delicate homeostatic balance, adding further stress to already compromised bodies.[2]

With the demands on para-medical services within a traditional hospital setting, very often the geriatric patient does not have a fair share of the scarce resources made available.

[2]The elderly fear hospitalisation and will under-report or disguise symptoms to avoid being admitted. Stress of a new environment often causes acute confusion in older adults. *Wolanin and Holloway describe the physiological and environmental factors contributing to confusion experienced by many elderly, one to five days following the traumatic relocation of hospitalisation. **Pomerantz states that cognitive disfunction accompanying acute illness, is a manifestation of pathological processes. Sensory losses contribute to the sensory deprivation and sensory overload experienced in hospital settings, and also result in confusion.

*Wolanin M.O. Holloway J: Relocation confusion: Intervention for Prevention in Burnside I M (ed). Psychosocial Nursing of the Aged. New York McGraw-Hill Book Co. 1980.

**Pomerantz R: Considerations in the Physicians Approach. Geriatric Nursing 1982 3(5): 311-315

N.B. [2] and [3].

Hospital staff is geared to a medical model of care and rapid admission/discharge turnover. The longer hospital stays, seen with some elderly patients, are fraught with fear, anxiety, pain, confusion, loneliness and depression. The high-tech setting is often cold and impersonal. In some cases, staff do not seem to have time for that caring touch or the few extra minutes the elderly need for reassurance and communication.[2]

[3]Several unique features of older patients necessitate changes in the traditional course of rehabilitation therapy. Normally rehabilitation treatment encompasses four activities; treatment of the underlying disease; prevention of secondary disabilities; restoration of functional ability; adaptation of the patient to a different functional level.

Special features of geriatric patients require additional activities. Most older people acquire multiple chronic diseases and disabilities. Although many of these disabilities may be individually controllable, (i.e. osteo-arthritis, hypertension, and diabetes; are examples), the geriatric rehabilitation approach must simultaneously direct attention to a variety of problems.

A second unique feature of older patients-altered presentation of disease - adds another dimension to rehabilitation treatment. The complaints that cause patients to seek medical treatment may not always point clearly to the specific disease or disorder that underlies the symptoms. For example, among the elderly, falls are the most common cause for admission to hospitals but the disorders that result in these falls are not always easy to pinpoint. Stroke, orthostatic hypotension, (sudden low blood pressure) or a neurological disfunction may be the cause of the fall and the patient may have experienced no other symptoms that would be useful in diagnosing the condition.

Another special consideration in treating older patients is that the psychological impact of disability may be out of proportion to the immediate effects of the disability itself. Depression, lowered self esteem and lack of motivation can complicate the treatment programme and may require direct intervention in the form of psychological support, either from the treatment team, the family, or both. Physicians and other health providers must set realistic treatment goals for older patients. For younger patients, a successful return to work is a normal measure of the success of treatment. For older patients, simpler - but no less important - goals may be independance in such activities as household work, walking,

N.B. [2] and [3].

> grooming or similar daily tasks. Realistic goal-setting also includes accepting small gains in function, many of which mean the difference between living at home and living in an institution. The greater susceptibility of older patients to secondary disabilities makes it mandatory to begin rehabilitation immediately. By taking too long to investigate the geriatric patient or ignoring the need for rehabilitation therapy, care providers risk creating additional disabilities for the older patient.[3]

In all the hospitals I visited, the guiding philosophy is, that the older persons in spite of physical decline, illness and increasing dependance, still have the capacity for human growth and self actualisation. Probably in no other setting is an older person's self esteem or security so threatened as than in a hospital environment, where compromised basic physiological integrity becomes the priority concern of care-givers.

> Nursing Administration Manager, Martha A. Warnick, when writing on this subject of activity programmes for the elderly, [2] "suggests that all levels of the hierarchy require nursing intervention simultaneously. Being hospitalised results in a loss of control over every aspect of daily life. Helplessness in institutionalised persons can lead to boredom, apathy and illness, and even death".

The great advantage of having rehabilitation departments actually allocated to geriatric patients helps in avoiding the traditional problem of the stereo-typed attitudes that are held by all levels of staff who come into contact with the elderly. In all the hospitals I visited, the philosophy and aims set by the various authors on this subject were being followed, and demonstrated that much more could be done in this country by increasing the resources for the appointment of more para-medical staff for the elderly. In an age of cost benefit analysis, the following result of a survey on rehabilitation emphasises this point.

The National Research Corporation conducted this survey of United States hospitals offering some type of rehabilitation programme and the results of this exercise were reported in Modern Healthcare in November 1985.

N.B.[2] and [3].

This stated that 83% of a survey of 450 Hospital Administrators conducted for Modern Healthcare, provided some type of rehabilitation programme. These programmes offer medical, social, educational or vocational therapy that addresses the needs of patients disabled physically or psychologically by accidents, illness or other circumstances. Almost half of all hospitals offered two or more services. The Upper Mid-West offer 88% and the West with 87% followed closely. Eighty percent of hospitals in the South-East and 70% in the Mid-West offer rehabilitation services. Physiotherapy services are by far the most common rehabilitive service found in 75% of the hospitals surveyed. These services are more common in larger hospitals. The number of hospitals offering physiotherapy grew by 8% last year, increasing from two-thirds in 1984 to three-fourths in 1985.

Alcohol treatment centres were offered by 25% of all hospitals that were investigated.

## DRUG AND ALCOHOL ABUSE.

A significant number of Americans have a life threatening illness, alcohol dependancy. Although the situation continues to improve, the nation's second largest health problem is far from abating. The National Institute of Mental Health found that 6.4% of Americans over the age of 18 or 10,000,000 (ten million) persons are subject to alcohol dependency or abuse. Many persons suffer from a mixture of alcohol and drug problems, of which nearly 85% are not treated. The loss in national productivity, estimated at $125 billion per year, is severe. The impact on the individual and family is even more disturbing.

All the hospitals I visited, particularly those in California and Arizona, saw a great need to establish programmes to ensure that elderly people, suffering from these conditions, have access to detoxification and behavioural modification and perhaps more importantly, group therapy and support to encourage and reinforce new positive attitudes that replace the old practices that led to alcoholism.

## PSYCHIATRIC SERVICES.

My Travelling Fellowship did not include visits to establishments for psycho-geriatric patients which have traditionally been an area that the Federal Government has played a large part in funding.

Similar to our own country, there is a greater interest in developing a variety of services for this patient client group.

It would therefore be inappropriate for me to comment on the success of American Health Care, for this particular group.

## CONCLUSION

From the preceding description of the various levels of care made available to the elderly, one can see the free market approach to this client group, based on finance.

Many studies have however, shown that many Americans approach old age with trepidation, as with no national health care system the spend-down philosophy for the elderly and their children is very worrying. Naturally, in a culture which has always emphasised the role of the individual to be responsible for all their needs, American society seems more willing to accept this approach to health care.

Employers and employees endeavour, during the period of their working life to put money aside to meet the possibility of ill-health after retirement. There is however, a two-tier system, as many Americans cannot afford insurance. They are then left to be looked after by federal or charitable funds. On balance, while impressed with the access to technology, the British system is preferable from an individuals perspective.

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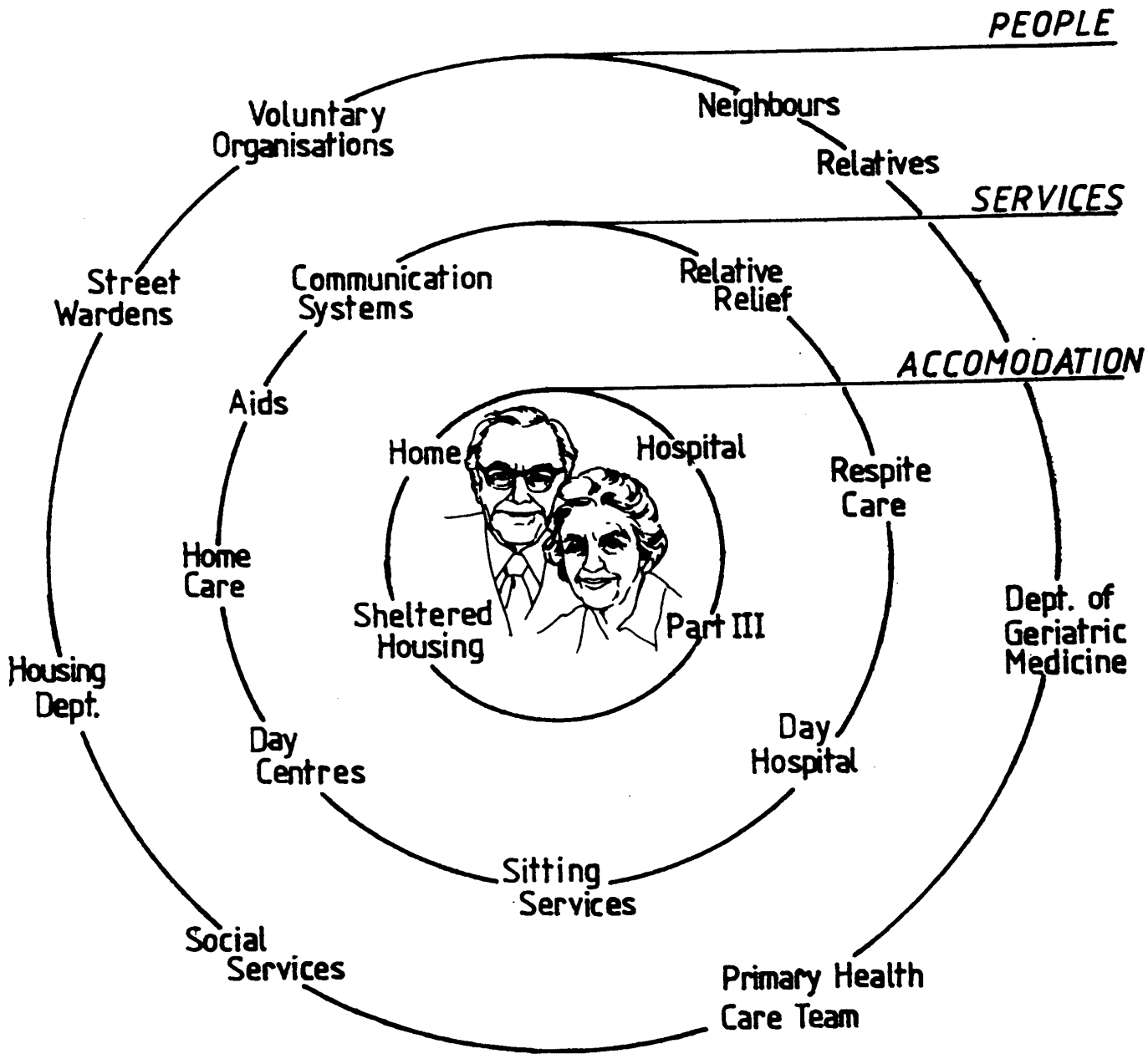
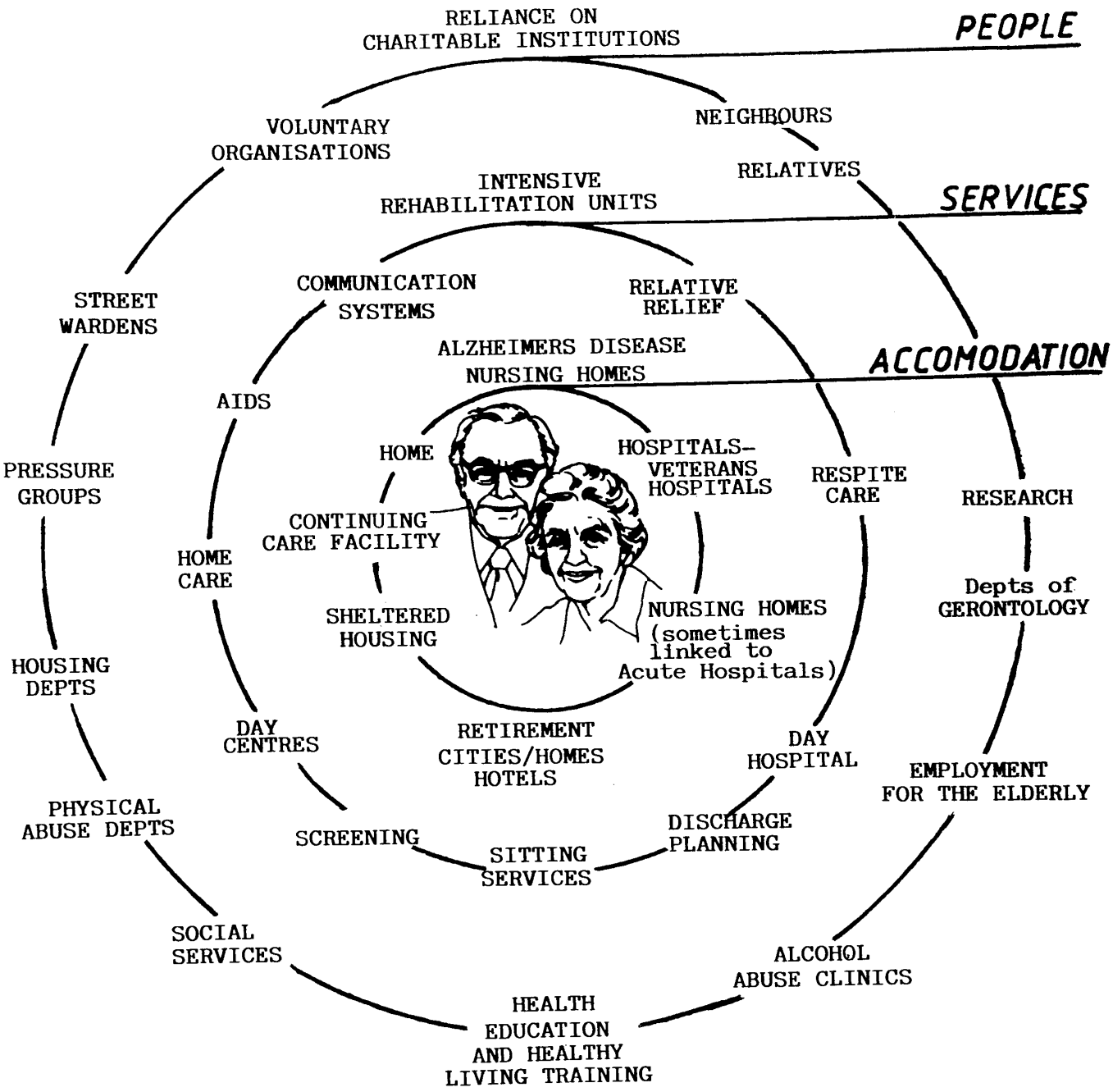



# EZEKIEL'S WHEEL (10,7)

*Model of Community Care.*




Comparisons of EZEKIEL'S WHEEL with the
American pattern of care for the Elderly
which varies throughout individual States and Communities

## STRATEGIES

The preceding chapters have been an introduction to the pattern of geriatric services presently provided in the United States. I now intend to expand on the initiatives that are being developed within the United States to meet the particular needs of that society. Many of the ideas may not easily be translatable into a British setting.

### 1. Preventative Health Service Programmes.

Preventative programmes usually include three levels of activities.

a) Primary prevention - reduces the likelihood of the development of a disease or disorder.

b) Secondary prevention - interrupts, prevents or minimises progression of disease or irreversible damage from a disease at an early stage.

c) Tertiary prevention - focuses on progression of damage in a disease, emphasis is on measures to alleviate disability and slow progression of established diseases.

All three measures of preventative health service will be developed.

i. Primary prevention may be offered across a particular catchment area. Examples of the type of activities offered to the programme would include exercise classes, swimming, screening programmes, medication information, hearing tests, non-smoking classes, widower's meetings, grief counselling, pre/and retirement counselling.

ii. Secondary prevention includes Hypertension education, Glaucoma, partner information exchange, Stroke information exchange, Arthritis, Parkinson's, Alzheimer's, Care-givers meetings, Cardiac information, smoking and diet control, Diabetic classes, and senior emergency alert system.

iii. Finally, tertiary prevention includes Colostomy training, Incontinence training, patient and family education during hospitalisation.

2. Health Promotion

As previously stated, there are a number of nationally recognised private sector initiatives. This approach, which seeks to strengthen non-public voluntary financing mechanisms includes private long term care insurance, life care communities and home equity conversion. Life care communities are financially self sufficient settings for the elderly that combine residential living, with the availability of medical nursing and social services in specialist facilities on the premises.

Home equity conversion plans convert assets in home equity into a lifetime stream of income that can be used for long-term care. Such a pattern of services has been developed by various local authorities in the United Kingdom, to fund people needing accommodation in local authority provided facilities for the elderly. These approaches, it has been speculated, have the effect of reducing surgical expenditures, by meeting the needs of middle class disabled elderly, to private financing mechanisms rather than from Medicaid. British Government initiatives of allowing resources from public funds to offset the cost of elderly going into private nursing homes or residential establishments, follows the same pattern.

Another proposal is the long-term care block plan. This option would convert federal long-term care programmes into an indexed block grant. Under this proposal, Medicaid entitlement to long-term care services would end. States would be given flexibility on how to spend the funds. This approach was part of the Reagan Administration's 1982 proposal to federalise Medicaid. In addition to Medicaid, some proposals would fold in long-term care, services funded from the social services block grant, the Elderly Americans Act and other federal programmes. A more limited block grant option would retain Medicaid coverage and nursing home care, but would impede grants from non-institutional services.

3. Federal Long-Term Care Insurance

This option would establish a federal long-term care insurance programme as an addition to Medicare. This would be a federally administered individual entitlement programme covering an array of medical and social services. One version of this option would establish a voluntary programme analogous to Medicare supplementary medical insurance, in which government would subsidise much of the cost of insurance purchased from carriers, but also require beneficiaries to contribute to the cost of premiums.

4. Additional Geriatric Services.

In considering the range of services available either by means of federal legislation or voluntary effort for the elderly in the United States it should be borne in mind that while there is no National Health Service system, 40% of the total health care expenditure is in fact provided by central government. There is a complexity of government agencies at federal, state, county and city level who provide anti-poverty programmes, welfare officers and Department of Health offices for ageing and planning boards, ensuring that the development of services required for the community have proper approval.

Social services agencies provide visiting nurse services, settlement houses, state hospitals, housing. Congregate housing for older adults that includes access to continued support services, providing apartment units with kitchen facilities for the elderly who are in need of only intermittent support services, such as occasional meals, socialisation opportunities and transportation. The development of congregate housing for low income elderly was promoted by the federal government through the 1978 Housing Act. Similarly, in Britain, there is a well established system of private enterprise for

developing apartments, houses and other accommodation geared to the elderly.

Reference has already been made to the town established in Arizona specifically for the elderly, which at the present time has a population of 80,000. This experiment has been found so successful that a similar town intended to cater for a similar number of people is to be established at Sun City West, approximately eight miles from the existing town. The types of housing available are, special apartments and hotels geared for the elderly, the development of foster care and life care communities, which guarantee that the person, after paying a certain sum, will be ensured accommodation of various grades dependent upon disability, for the rest of their years.

5. Home Care for the Elderly

Social policy in the United States has supported long-term institutional care rather than maintenance of the elderly in their own homes. In January 1973, St. Vincent's Hospital in New York City started a programme to bring professional health services to home bound isolated elderly people living in the Chelsea and Greenwich Village sections which surround the hospital. The goals of the programme, known as The Chelsea Village Programme, are to keep patients:

a). in their own community;
b). out of institutions;
c). in adequate housing;
d). in the best possible state of health;
e). at the maximum possible level of independence.

The experience of this programme is that people who would otherwise be forced into institutions, can be maintained at home thereby reducing costs. In order to provide the necessary services

St Vincent's Hospital and Medical Center.

St. Vincent's Hospital and Medical Center is an 813-bed facility founded in 1849 and is one of the oldest and largest voluntary non-profit hospitals in New York. The only full-service hospital on Manhattan's lower West Side, it is a major affiliate of the New York Medical College and is also affiliated with New York University-Bellevue Medical Center, Downstate Medical Center and the New York Eye and Ear Infirmary.

Special Programmes: The hospital operates the innovative Chelsea-Village Programme for the isolated and home-bound elderly; undertakes health education programmes in area schools; and provides clinical services to residents of welfare hotels, nursing homes, drug abuse centers and shelters for the elderly.

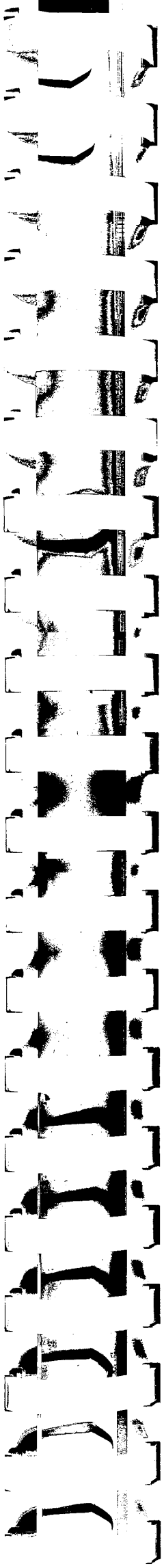
to the home bound, a multi-disciplinary team was established consisting of co-ordinator, physician, nurse and social worker. Their combined skills are often sufficient to provide practical assistance to clients in situations where any one health worker would fail.

A Home Maker is an important additional staff member of the programme which in Britain would equate to some form of nursing assistant or home help. The co-ordinator is the contact with the patient or the referring community agency. Most referrals come by telephone. The co-ordinator confirms and makes appointments, answers enquiries, participates in team conferences, schedules visits, maintains charts and functions as a central source of information for patients and programme members.

The social worker is concerned with obtaining concrete services for patients such as Medicaid eligibility, home makers, changing housing and the initiation of meals-on-wheels. After the initial contact, a counselling session is often arranged by the social worker.

The nursing aspect of the programme is carried out almost entirely by one person, a member of the Sisters of Charity who has worked full time for the programme since its beginning. This nurse knows every patient and is the most consistent source of contact between patients and staff. Physicians are recruited in part, from hospital residents who volunteer time outside prescribed duties. Others are paid by the hospital for their time in the programme.

Some physicians in private practice volunteer their services. As Dr. Brickner has said, the idea that institutions must inevitably be the setting for the care of aged people/disabled people, has been taken for granted. The real financial price of such care has not been questioned deeply. The cost must be measured and compared with that of other initiatives that could be developed for community care for geriatrics, in addition to the proposals for mental illness and mental handicap.



6. Long-Term Home Health Care Programme

New York State enacted legislation in the 1970's to initiate in long-term home health care sponsored by Senator Lombardi Junior, which is considered to be the most viable alternative to institutional care in the nation. Because Medicare is the largest payer of institutional long-term care, the 'Nursing Home Without Walls Programme' was designed to reduce this massive public expense. This pioneering programme provides and co-ordinates the delivery of home services for the chronically ill or disabled, who are determined to be medically eligible for placement in a skilled nursing facility or health related facility. Providers of care are certified by the Department of Health; the local Department of Social Services works with home care services. Patients qualify for long-term home health care programme, if they are eligible for Medicaid, or pay privately.

Services provided directly by St. Vincent's include medical and nursing care, social work, voluntary work and nutrition counselling. They also provide physiotherapy, occupational, respiratory and speech therapy, personal care, housekeeping and home health aids service through contract arrangements. In addition to in-home respite care, an emergency alert system and home maintenance service are also provided.

7. Emergency Response System

An emergency alarm and response system designed for functionally impaired persons living in the community, particularly the elderly, has been well developed by local authorities in this country and in many instances has now received joint financing between the health service and local authorities. A range of similar systems have been developed in the United States. This usually includes an electronic communication unit in the home which is easily activated when there is an emergency. A central emergency station located in a

hospital or similar facility, is responsible for receiving incoming calls, identifying the client and sending help when required.

8. Incentives for Family Care

A variety of options for encouraging family care-givers have been proposed. One of these would expand public financing of respite services for family care-givers beyond the very limited respite services currently available under Medicaid Home and Community based long-term care waivers. Respite services enable family members to take periodic time off from the demands of caring for elderly relatives and may approach institutionalisation by alleviating excessive stress on family care-givers. Such a pattern has been well established in many parts of the United Kingdom, and in my own district there has been an initiative developed by the local authority and the health authority, to provide a facility for the disabled to be accommodated in a short stay establishment, to enable their relatives to have respite care.

Another option would give families tax deductions or credits if they maintain severely disabled family members at home rather than placing them in an institution. Arizona, Idaho, Oregon and Iowa currently do this in a limited fashion.

9. Classes for Care Givers, Research and Training

As part of the marketing strategy of many of the hospitals I visited, there is a great emphasis on developing local initiatives for screening of the elderly and the provision of classes to ensure that people are better able to cope with the changes that come about through the process of ageing. Family and patient education is regarded as a vital component and there is no shortage of seminars and courses organised by individual hospitals and also the production of many detailed articles of guidance for the elderly or their next of kin. Such topics covered are maintenance, educational programmes

for hospital employees, patients, nurses and physicians and are directed at raising consciousness about normal ageing, sensory decline, functional impairment ability and disability in the aged.

Courses include such topics as death and dying, nutrition, family support, crisis intervention, counselling for the elderly, utilising both internal expertise and outside authorities in the geriatric field. Community education programmes are directed at general audiences as well as middle aged and senior citizens. A wide range of interesting topics are available for community educational outreach activities. Some programmes are co-sponsored by community agencies in order to increase the public's knowledge of individual hospitals.

The Johnston R. Bowman Health Centre in Chicago, have established a 'Speakers Bureau' with a very comprehensive programme of topics relating to every conceivable avenue in the care of the elderly. The following is an article taken from their Handbook:-

The Speakers Bureau of the Johnston R. Bowman Health Center for the Elderly is designed to communicate the most current geriatric and gerontological knowledge to diverse audiences and organisations.

Speakers representing the interdisciplinary team of the Bowman Center and Rush-Presbyterian-St. Luke's Medical Center will, either solely or in combination, address concerns of senior citizen organisations, business and labor, educators, social service agencies, as well as health care professionals.

The establishment of The Speakers Bureau formalises a community activity the Bowman Center has pursued since its opening in 1976. Speakers from the Bowman staff have participated in retirement planning seminars, interdisciplinary workshops, in-service education, and presentations to professional and lay audiences.

Representatives from the following disciplines are readily available for presentations; however, special arrangements can be made for inclusion of other disciplines or sub-specialities upon request:

Administration
Audiology
Dietary
Gerontological Nursing
Medicine
Occupational Therapy
Pastoral Care
Pharmacology
Physiatry
Physical Therapy
Psychiatric Nursing
Psychiatry
Psychology
Recreation Therapy
Rehabilitation Nursing
Social Work
Speech Pathology
Surgery

Topics listed below are examples of available presentations. Bowman speakers will also tailor programs to the needs of specific audiences upon request.

* Physiology of Ageing
* Clinical Nutrition for the Elderly
* Sex after 65
* Development Tasks of Ageing
* Nursing Management of Common Health Problems of the Aged
* Middle-Aged Children and Ageing Parents
* Retirement Planning
* Interdisciplinary Approach to Health Care
* Alternatives to Nursing Home Placement
* Use and Misuse of Drugs
* Organisation and Management in Geriatric Facilities
* The Dying Patient and His Family
* Therapeutic Uses of Music, Art and Photography
* Ageism
* Rehabilitation after Stroke
* Adapting the Environment for Physical and Psychological Deficiencies
* Nursing Care of the Chronically Ill
* Preventive Approaches to Health Care
* Residential Apartment Living in a Hospital Setting
* Volunteerism with the Elderly.

**TO ARRANGE A SPEAKER - CONTACT-**
**THE BOWMAN SPEAKERS BUREAU**
**(312) 942-7156**

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10. Detection and Prevention

All the hospitals I visited saw their role beyond the confines of their own wall, with Health Promotion being one of the major strategies for the elderly in America.

Consumers are more aware of the relationship between lifestyle and health status. Those who choose to change harmful habits are seeking high quality programmes to help them achieve this goal. Until recently, little attention was given to health promotion or preventive health services for the elderly. Preventive and health maintenance services are justified on many grounds especially because 80% of people over 65 have one or more chronic illness.

A study carried out in America illustrates that although the prevention, early detection and effective management of chronic diseases lacked the drama of open heart surgery, their positive impact on health is great. Similar approaches have been adopted in certain districts of this country, such as my own, where the establishment of geriatric health visitors has been aimed at promoting a healthy lifestyle. The variety of topics detailed for individual hospitals I visited are related either to general health and well-being or to disease control. Disease control topics include arthritis, diabetes, cancer, eye disorders, heart disease and hypertension, weight control, stress management and safety programmes. Health screening for hypertension, glaucoma and skin cancer is also well developed.

Individual health counselling sessions conducted by nurses are also available. Other programmes offered include, **'Living with Low Vision', - 'Caring for your elderly relatives', - 'Changes which occur with age', - 'Coping with changes in the senses, hearing, sight, smell, taste, and touch', - 'Compensating for sensory changes', - 'Caring for one-self', - 'Managing your health and health care', 'Relaxation and exercise', - 'Resources and services available', - 'How to be your own**

**advocate', - 'Getting and giving service', - 'The problem of memory loss and confusion', - 'Practical approaches to dealing with the problems of memory loss and confusion'.**

11. Outreach Programme

An important component of all the geriatric programmes I was able to study, is the development of an outreach programme conducted by nursing and social services. These usually consist of a geriatric nurse practitioner and social worker who are appointed to identify potential community sites with a significant at-risk geriatric population, conduct clinical programmes for on-site clinical and psychological assessments for the geriatric population, develop plans for these patients, and when appropriate arrange referrals to the hospital arranging the outreach programme. Another component is the system of case management which involves the assessment, treatment, planning, referral and follow up which ensures the provision of comprehensive services and the co-ordination of payment and reimbursement for care. A Case Manager acts as a client advocate, often performing assessment and referral and monitoring the progress of the individual through the system.

12. Case Management

This option represented by the Department of Health and Human Services would use case management organisations to perform needs assessment and co-ordinate non-institutional services for the severely disabled at risk of institutionalisation. Some legislative proposals would entitle certain low income persons to receive a wide range of publicly funded services prescribed in the care plan developed by the assessment team.

13. Admission and Assessment Documentation

Many of the hospitals I visited provide a standardised comprehensive evaluation of the elderly client prior to admission. The

documentation identifies physical and psychosocial problems that are used in the development of the patient care plan.

14. Special Care Unit

In VillaView Community Hospital in San Diego, the six bed acute geriatric medical/surgical service has operated since 1985. A modified environment with specialist patient care procedures promotes and maintains the functional abilities of the hospitalised elderly. Preliminary statistics indicate discharges to skilled nursing facilities are down by 30% and that patients admitted to the units, within three days of hospitalisation are routinely profitable.

Currently a computerised system for tracking the statistical data from this unit is being developed in conjunction with a local university.

15. Links with Universities

Maintaining links with universities through collaboration is considered to be an important part of the geriatric service. An example of joint collaboration was the assignment of a student nurse to a local university who, following her secondment, was able to produce a volunteer's guide to working with geriatric/psychiatric patients. The guide was then brought into use, in the geriatric behavioural programme. Additional collaboration with the universities has been going on through involvement.

16. Out-Patient Services

As part of the total package offered by individual hospitals, many of them feel it is necessary to offer out-patient services not within the confines of their own hospital, but in areas which ensure easy access for the elderly. These range from geriatric clinics, psycho-social

counselling, psychiatric services, rehabilitation, adult day care and day hospitals.

17. Adult Day Care

This programme provides a combination of health and social services to older adults during the day time hours. Services include comprehensive assessment, health monitoring, occupational therapy, personal care, meals and transportation. Some programmes also provide a primary health care and rehabilitation service. These equate to a typical British day hospital or day centre provided by a local authority. In Chicago, the Parkside Human Services Corporation have had funding from a national charity to provide a day centre for the elderly, this is partly offset by the provision of a day nursery facility which is run on a full profit basis. There are also sessions devoted for part of each week whereby the elderly and children mix, as it has been claimed that such an interchange has therapeutic value for the elderly.

Parkside also has a communication system, known as Communi-call, for the home-bound patient. This is a 24-hour contact system with a support centre, advanced computers and telecommunications equipment on a voice-to-voice basis.

In addition, they provide a geriatric consultative service that provides a comprehensive in-home evaluation of the psychosocial, functional and medical status of older adults. This is a multi-disciplinary team approach for care plan development.

18. Elder Crisis Centre

Sixteen States in America have passed legislation that now mandate the reporting of elderly abuse. It has been estimated that 2.5 million old people are abused and neglected each year in the United

States. As the population of individuals living to advanced old age increases, so does its vulnerability to abuse. Abuse and neglect have been defined as follows:-

Abuse

Active intervention by care-taker, such that un-met needs are created or sustained, with the resultant physical, psychological or financial injury.

Neglect

Failure of care-taker to intervene, to resolve a significant care need, despite awareness of available resources.

A profile of a typically abused elderly person reveals an individual, 75 or over, female, dependant on others for protection and care.

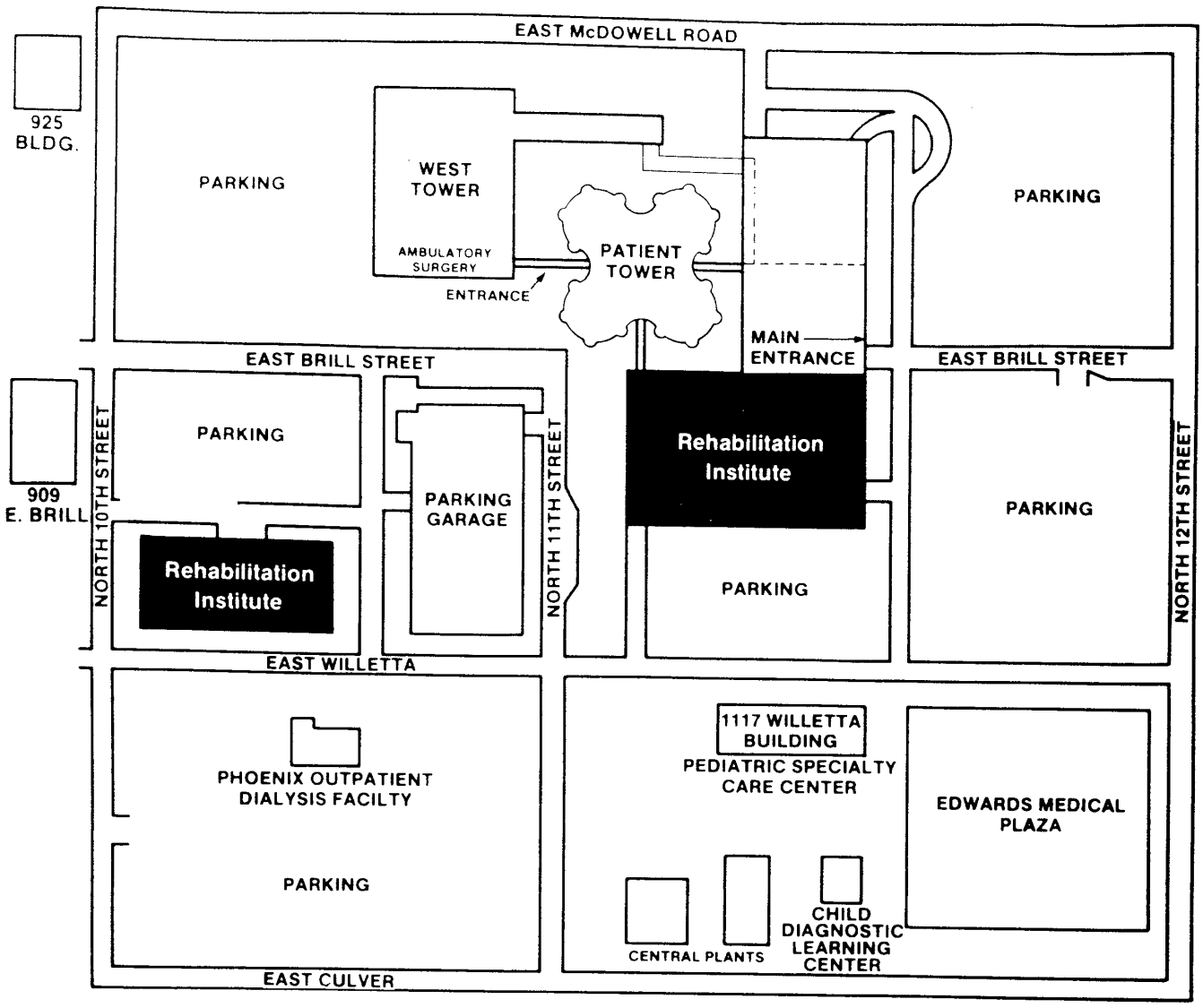
BLOCK AND SINNOT 1979.

Current thoughts on causes of elder abuse include emphasis on the possible pathological nature of the care-givers, the stresses of caring for an impaired elder, family crisis and existence of trans-generational violence.

OMALLY TNA 1983.

In analysing these studies, Selina Atwell found that local state departments or social services were usually designated as the agencies responsible for implementing the mechanisms for reporting abuse. In more than half the states, legislation failed to establish a registry for case report systems, to document incidents of elder abuse and the cases that were reported, were poorly developed.

Dr. Georgia Hall, the Director of Gerontology and Geriatrics at the Good Samaritan Medical Center in Phoenix, Arizona, as part of that hospital's commitment to the ageing population, established a counselling service for individuals who were experiencing difficulty in coping with transitions in the later years, in addition to those who




Good Samaritan Medical Center.

Rehabilitation medicine started at Good Samaritan in 1963 as a one-man operation. Carl R. Bjorklund MD., was a pioneer rehabilitation physician in Phoenix whose leadership enabled the facility we know today. It has grown from these early beginnings to a 120-bed, five-storey facility located on the campus of Good Samaritan Medical Center, a 770-bed regional referral center. Its growth has realized many milestones.

The Institute has enjoyed measurable growth since the completion of the new Good Samaritan Medical Center and its three-storey ancillary building. The new facility has provided expansion for out-patient services such as physical and occupational therapy, speech pathology and audiology services.

may be depressed, abused, exploited in crisis or isolated and/or lonely.

While necessitating a full commitment from the local community, Dr. Hall arranged to fund a full time social worker who is assigned to the accident and emergency department to assist in the identification of such elderly and also to assist them in the social problems that need to be resolved. The social worker is required to effectively evaluate and treat the abused and/or neglected person.

In Britain, the number of elderly attending accident and emergency departments, who are regarded as social, rather than clinical problems, do not have the luxury of a social worker available to assist staff awareness to a growing problem of elder abuse.

Such a reporting system for young children has been developed for many years in British society and while I have not done any major research in terms of a feed back from my local community nursing colleagues, it would be niave to believe that such a problem, in some shape or form did not exist within the British society.

19. Home Delivered Meals

A number of programmes that provide meals on a daily basis, Monday to Friday, to home bound elderly who are not able to provide or prepare meals for themselves, have been developed similar to the Meals-on-Wheels service arranged by the Local Authorities in the United Kingdom.

20. Nutrition Consultation

In addition to detailed guidance for acute episodes of illness where a patient's diet may have a contra-indication when receiving certain medications or clinical procedures, a great deal of advice is available in terms of ensuring people follow the best dietary

strategy available from their resources. The Health Education Council in this country does some of this work and many districts also produce their own guidance for the general public and the elderly, in addition some of the large scale agencies in this country, such as major food producers also produce guidance on correct dietary patterns which are subsidised for the elderly.

21. Congregate Meals

The Older American Act provides federal funding to provide meals on a group basis to older adults.

22. Journals

A number of the hospitals that I visited were pleased to show me the journals they produce to foster good ideas in geriatric medicine.

For example, in New York, St. Vincent's have for four years produced the 'Pride Institute Journal of Long-Term Health Care', which is published quarterly to report on emergent service and policy issues in the field of long-term health care. In addition, it offers communication, information, technical assistance, enhanced understanding and education to its readers.

The Good Samaritan Medical Center also produce a publication about their hospital for the people of Arizona which is produced by their Public Relations Department. Their Chief Executive Officer, Richard Uhrich has for the past three years, adopted the motto 'Excellence in Caring' to describe the hospital's commitment to providing the finest possible health care for their patients. He was the moving force behind the establishment of a gerontology/geriatrics department at the hospital. The first value is the personal quality that is needed for everyone involved in delivering service, compassion for people in need; the second value is the expectation of the requirements for employment at The Good

Samaritan, capability and skills; the third value is required employee behaviour at Good Samaritan Hospital, respect for others, for others' differences, for others' ideas and points of view; the fourth value is basic performance standard, responsibility in duties; the fifth value is the standard of action that is required, to be perceived by all people who are served - that includes patients, physicians and the general public and that action is, courtesy to all. The employees of Good Samaritan Medical Center and others who provide services there, take values quite seriously and this was well demonstrated during my visit.

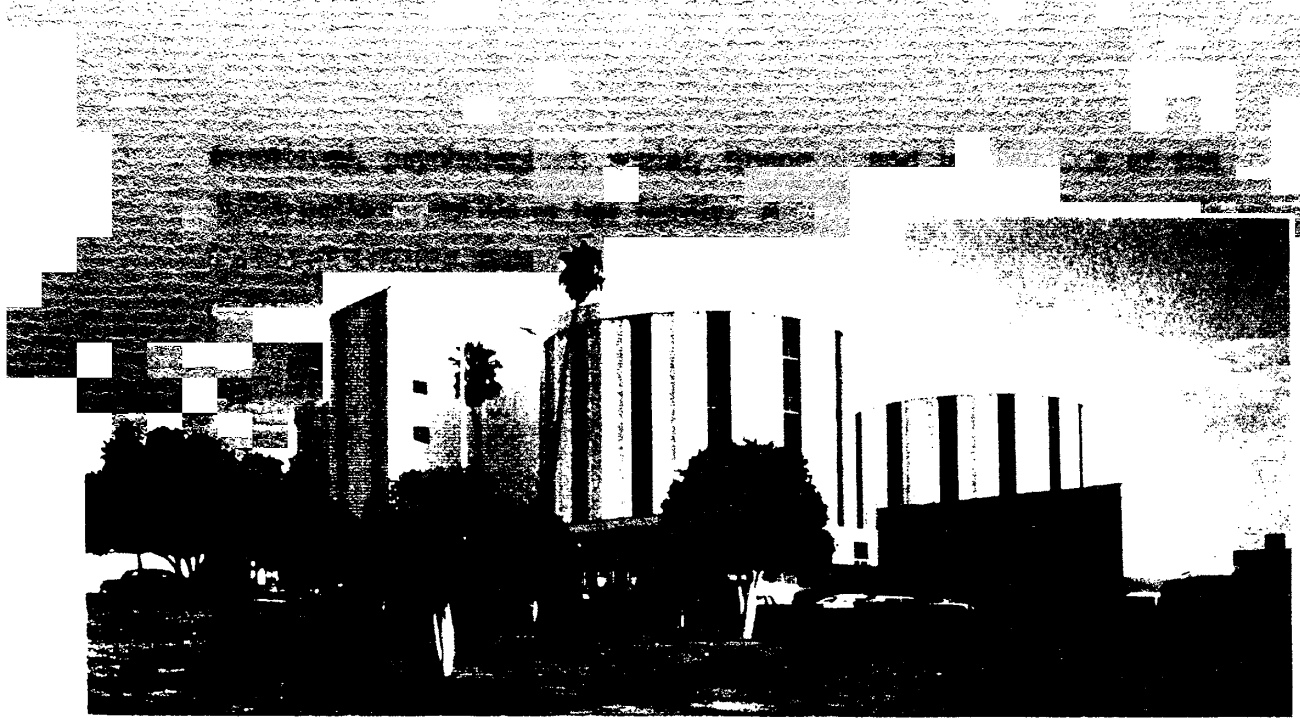
23. Library Services

Each of the geriatric departments I visited made it one of their priorities, to catalogue all literature or periodicals that are held within their institutions related to the ageing process. Each department facilitates the addition of books and periodicals related to particular aspects of geriatric care. For example, nursing, nutrition, cardiology, neurology, immunology, etc. The emphasis is on making available to all professionals, information on ageing. The departments of geriatrics, distribute up-dated information on library holdings on the subject of ageing, to all relevant hospital departments periodically.

Appendix 'B' on page 134 is an example from The Good Samaritan Medical Center, of books held by individual hospitals.

24. Hospice Care

The development of Hospices in the past ten years in the United Kingdom, has mainly come from funds provided by the voluntary sector. Similar facilities are available in the United States and as mentioned earlier, some payment from federal funds are appropriate for certain patient client- groups. Their role is similar to that in Great Britain, that the care addresses the physical, spiritual,



"Dedicated to Excellence"

Walter O. Boswell Memorial Hospital.

The Boswell Memorial Hospital is recognised as one of the nation's premier adult health care centers, with special focus on diseases and conditions related to the ageing.

Sun City where the hospital is situated has the largest retirement community in the nation, where the average age is 72, while the hospital provides care to a patient population of which 85% is aged 65 or older.

The Boswell Biogerontology Research Institute affords unparalleled opportunities for the clinical investigation of basic biological aspects of ageing and age-related pathology.

emotional, psychological, social, financial and legal needs of the dying patient and his or her family. A Hospice is not a place and is not a particular type of service - it is a non-traditional way of delivering assisting services.

25. Senior Volunteers

I have already referred to the impressive number of volunteers assigned to the Walter M. Boswell Hospital in Sun City, Arizona. Many other hospitals I visited in America also thought it important to appoint senior volunteers in an effort to make their skills available and in certain instances, to be trained as peer counsellors for older adults.

**NOTE:** The majority of the text between ** and ** is reproduced with grateful thanks to the Handbook **"MONTEFIORE",** published by the **Montefiore Medical Center.**

26. Initiatives at the Montefiore Medical Center.

** Montefiore Hospital, which is situated in the Bronx part of New York City has long been a leader and innovator in providing health services that meet the special needs of their catchment population. It is estimated that 50% of the aged population in The Bronx will be 75 and older within the next two years, significantly higher than the national average. There are already more than 18,000 people over 85 living in that part of New York. The hospital currently serves the highest proportion of Medicare patients of any major acute-care hospital in the United States of America.

Treatment of physical problems alone is not sufficient to restore and maintain the elderly person's well being. Hospitalisation for an acute medical problem is but one stage in a continuum of

programmes to improve and maintain good health and a meaningful life.

A number of initiatives have been developed by their Department of Geriatric Medicine; for example, elderly volunteers are themselves helping to find answers to the problems of the aged.

At the Montefiore Medical Group, over 100 people between 75 and 85 years old are participating in the Bronx Ageing Study. Designed to identify risk factors in this age group, the programme offers volunteers complete physical examinations, neuropsychological testing and 24 hour electrocardiograms each year for five years. Each year's results are compared to previous tests to identify changes and their causes. The knowledge gained from this study will help to establish the parameters of normal physical and mental health for people this age. Researchers hope the study results will also suggest strategies for preventing dementia.

The pattern of assessment and rehabilitation is very similar to that found within a District Health Authority in this country. After the acute stage of hospitalisation an assessment is made of the mental status and functional level of selected elderly hospitalised patients to develop comprehensive health care plans designed to enable these patients to return home whenever possible.

After the acute stage some patients are referred to the hospital's Geriatric Nursing Unit for specialised nursing care. Here, nurse and patient work together to develop and follow a plan designed to restore as much functional capacity as possible before the person is discharged from the hospital. Other patients go to a centre for nursing and rehabilitation; although people of all ages are admitted, most of the patients are elderly, the unit being staffed completely by registered nurses. The centre offers intensive nursing care and rehabilitation, including physiotherapy and occupational therapy to those who no longer need acute care but are not ready to go home.

A multi-disciplinary approach is arranged between the Division of Ageing and Geriatric Psychiatry to focus on mental health concerns. Its Geriatric Family Diagnostic and Treatment Service offers evaluation and treatment for people with Alzheimer's disease and other dementing disorders and with depression and other psychiatric problems of the elderly. Equally important are the support facilities provided to family members because caring for an impaired loved one can be profoundly stressful for them and this is being well documented within British society.

Montefiore has been delegated by the Robert Wood Johnson Foundation with the administration of their 6.5 million dollar programme for Hospital Initiatives in Long-Term Care. This project will provide grants to selective hospitals around the country to develop a comprehensive programme of institutional and home-based services to meet the health care needs of the elderly.

Another initiative developed by the hospital, is the link between High Schools in the community which is designed to enhance relations between teenagers and the elderly.

Each participating teenager is matched with an elderly person hospitalised at Montefiore. The young person visits the senior citizen in the hospital and after the patient is discharged, becomes an escort for clinic visits and shopping trips as well as a companion. For the elderly person who has become isolated and lonely, this scheme provides a young friend who can help make it possible to remain in the community. For the teenager this scheme is an experience in giving, and for a young person whose home life is unhappy, the older person becomes a role model to look up to and an anchor to cling to.

Montefiore also has links with other hospitals within their chain.

Beth Abraham Hospital which has been established to provide long term care facilities has 504 beds and is classified as a skilled nursing facility. This hospital admits people over the age of 16 who require long-term rehabilitation, nursing and medical care. The overwhelming majority are wheelchair-bound and many are elderly. Their problems range from slow degenerative disorders such as, Multiple Sclerosis, Cerebral Palsy, Parkinson's Disease and Alzheimer's and other dementing disorders, to deterioration brought about by Diabetes, Heart Disease and Stroke.

The objective of this hospital is to care for those people who need more skilled nursing care and medical attention than can be delivered in the home or even in the average nursing home, yet do not require the complex technology and specialised services of an acute care hospital. The goal is to help each person achieve his or her maximum potential for self-sufficiency and meaningful activity by providing the necessary level of nursing, medical and specialised rehabilitation services. Similar to many mental illness hospitals in this country, workshops are provided for training in such jobs as hand assembly, mailing preparation and packaging of hard and soft goods.

The chronic care management programme is similar to the range of facilities either provided by the community services or as required by the legislation which requires local authorities to provide meals-on-wheels, home helps and day centres. Day Hospitals have also been developed for nursing and medical attention, rehabilitation therapy, social services, recreational activities, a nutritious meal and returned to their own homes at the end of the day.

Again, very similar to this country is the idea of establishing facilities outside the hospital environment. Montefiore is providing apartment buildings for senior citizens which are designed to provide many functional, recreational and aesthetic amenities that will make it possible to meet the social as well as the physical needs of the elderly.

A Hospice has also been provided with 16 places at Montefiore which established the first hospital-based homecare department in 1947. In 1979, the New York State legislation established the "Nursing Home Without Walls Programme", allowing Montefiore to extend its home health services to 200 additional patients. Over 86,000 home visits were made by Montefiore staff in one year, for more than 2,500 patients in these programmes.

Recognising the social economic grouping in which Montefiore is based, it was accepted that good housing is critical to the health of the community. The hospital therefore created an independant organisation to improve housing and other conditions in the area around their hospitals. A need to strengthen the local economy to assist the community has also been recognised. The hospital has therefore established an independant corporation called 'Bronx Community Enterprises' to concentrate on commercial and industrial development in the area. The aim being, to develop businesses which will provide additional jobs and income to residents of the community.

The Montefiore Medical Center is also carrying out numerous other research projects, some of which will benefit the elderly patients which the hospital serves. As an example: The Department of Cardiology has long had a tradition of developing the technique of transvenous pacing of the heart and was the original developer of this technique in 1958. Since 1958 about 7,000 pacemakers have been implanted and about 250 first time implants are carried out each year. Until recently, there was no technology capable of stimulating the heart to enable it to restore the normal sequence in which it pumps blood - atrium, ventrical, atrium, ventrical. Pacemakers could stimulate the heart's pumping mechanism only by keeping the ventrical beating rhymically. The heart then had to work harder to circulate blood through the body, resulting in a limited tolerance for exercise and other physiological problems which can sometimes be helped by medication or diet but can never be totally corrected.

Because proper functioning of the ventricals is essential to life, cardiologists and their patients have been grateful for this less than perfect therapy. Recently however, at Montefiore, with guidance from their pacemaker specialists, pacemaker manufacturers have developed a dual chamber which stimulates the heart to pump in normal sequence. About 100 dual chamber pacemakers have been implanted at Montefiore and patients who have them are being followed very closely in the continuing effort to refine pacemaker technology.

Another initiative is related to implantable defibrillators. Some people have potentially lethal abnormal heart rhythm - fibrillations, which cannot be controlled by pacemakers or with medication but require an electrical shock directly to the heart, - a technique known as defibrillation. Using a still largely experimental technique, the cardiologists are now implanting defibrillators in such people. Montefiore is the only medical centre in New York, and one of a handful around the country now working this device.

Researchers are also experimenting with substances which, when injected into a coronary artery during a heart attack, dissolve the clot that caused the attack and thus prevent any further damage to the heart muscle.

The availability of such technology within the British health care system, is viewed in America by people I spoke to, as a system of rationing such services, especially to the elderly. **

Montefiore Medical Center and the
Albert Einstein College of Medicine.

The Montefiore Medical Center and the Albert Einstein College of Medicine have a symbiotic relationship which benefits health care in the region and contributes to advances in medicine generally.

Situated in the North Bronx, in a neighbourhood that has one of the highest concentrations of elderly in New York City, it is in a unique position to understand and respond to the increasing demands of the elderly.

In 1982, the medical center began to plan and implement a many-faceted program in the division of Geriatric Medicine. This expanded swiftly to include service, research and educational commitments and in 1985, a second site on the campus of the Albert Einstein College of Medicine was added.

NOTE: **The majority of the following information is provided with grateful thanks to The Cedars-Sinai Medical Center of Los Angeles and The Johnson R. Bowman Health Center for the Elderly.**

26. Initiatives at the Cedars-Sinai Medical Center.

Cedars-Sinai Medical Center of Los Angeles is a 1,120 bedded Medical Center with 5,600 employees, 1,200 volunteers and more than 2,000 attending physicians to fulfill the community's faith in the future of Cedars-Sinai.

The Medical Center is now one of the leaders in patient care, not only within the United States, but internationally and while my visit was not to see the high standard of accommodation and research departments that existed within the hospital, it was evident that patients being referred there could be ensured the highest level of patient care with access to all the latest technology available for treatment.

At the time of my visit, there were many clinicians who had an interest in the elderly. A strategy for care of the elderly as a separate patient/client group could only be looked at in a fragmented way. Although the hospital realised that the local population looked to them to provide services, it was necessary for them to develop initiatives in the local community so that the elderly could receive treatment and advice outside the hospital's boundaries.

Consequently, I visited a number of Out-patient Clinics which had been established for the hospital, many of which were not in purpose-built buildings but very often in small buildings which had allocated accommodation for a few days per week.

The full range of medical, nursing and para-medical staff therefore, went out to see patients in the community, to assess their conditions

and where necessary, refer them to the Medical Center when a more intensive treatment needed to be carried out.

Already established, was a Rehabilitation Center to treat patients who have strokes, brain injuries (and associated neuropathies), spinal cord injuries, multiple fractures, joint replacements, amputations as well as neuromuscular diseases. In addition, they offer a special pain management programme to help those experiencing chronic pain.

Each patient is given an individualised programme of care developed by their multidisciplinary team of health care professionals.

Emphasis is placed on active, one-to-one therapy with the primary therapists and nurses.

The team is led by a physiatrist (a physician who specialises in physical medicine and rehabilitation). The Rehabilitation Team meets regularly to plan, co-ordinate, adjust and monitor each patient's programme. The patient and family are also considered active members of this team because, once the patient is discharged, they become "the team".

As with other aspects of the rehabilitation programmes, discharge planning is made according to each patient's personal and medical needs. This begins on admission and continues as a team process throughout the patient's stay.

An estimate of the duration of this stay is made during the initial team conference, which is held the week following admission. This estimate is discussed further (and adjusted if needed) during subsequent team conferences. Upon discharge, the social worker arranges any follow-up therapy, in-home assistance or equipment that is recommended by the Rehabilitation Team.

Prior to my visit, they had produced a strategy for the care of the elderly based on the principle that adults over 65 are admitted to the hospital 3 times as frequently as younger adults and their length of stay, on average, is longer. Moreover, people over 75 use by far the highest proportion of health care services and based on data provided elsewhere in the report is also the fastest growing age group.

In their strategic document, reference was made to the American Hospitals Association projection that there would be a 15% increase in patient days between 1980 and 1989. Of the increase, 89% is attributed to the older population, with about half due to greater numbers of older people and about half due to more intensive use of sophisticated technologies. The hospital therefore thought it was important for the future, that there should be a better understanding about the clinical differences in the diagnosis, treatment and goals of care for the frail elderly.

Elsewhere in the report, mention is made of the continuum of care that is provided in the United States of America, which demonstrates the different kinds of services that are provided for the varying degrees of intensity of care. As stated in their planning document, many of the services deliniated in the continuum of care, were already being offered at the Medical Center, but it was still thought that a Geriatric Planning Task Force consisting of representatives from Administration, Medicine, Rehabilitation, Nursing, Psychiatry and Medical Social Services be appointed to develop a proposal for the establishment of a more co-ordinated approach to this client-group.

Having established a Geriatric Advisory Committee and a Geriatric Programme Management Team, their next phase of development was to establish a Geriatric Support Team.

This inter-disciplinary team would be comprised of clinical specialists in geriatrics from the areas of medicine, pyschiatry, rehabilitation, nursing, Medical Social Services, pharmacy and nutrition. The team would have a consultation and referral function to assist medical staff in assessing the unique and multi-faceted problems of the elderly. The team would evaluate physical, functional, mental, behavioural, social, nutritional and environmental status and suggest a comprehensive plan for patient care to the patient's physician.

The Geriatric Support Team was initially a pilot programme for a specific number of patients.

An audit of the Team's activities, impact upon patient care, interventions, cost effectiveness and analysis of the physicians's acceptance of the Support Team's services would be conducted by the Programme Management Team. Once the audit findings had been determined and any required modifications made, the implementation of a hospital-wide programme would be possible.

The Strategic Document took into account that there already existed extensive networks of geriatric provider and consumer groups in the Cedars-Sinai Medical Centers catchment area. Therefore, the development of a committee consisting of representatives from these existing groups would provide the input and collaboration necessary to co-ordinate a continuum of geriatric care at Cedars-Sinai.

The role of this committee would be two-fold. First it would bring the different community groups closer to Cedars-Sinai. The committee would provide the vehicle with which to develop relationships, referral arrangements, partnerships and joint ventures with the existing service groups within the community. These relationships would assist the Cedars-Sinai in making available to its patients a full continuum of geriatric services.

The committee could also provide a mechanism for giving and receiving follow-up and feed-back from the community groups on the different geriatric services provided by the hospital.

Secondly, the committee would bring the Cedars-Sinai's services and its commitment to the elderly closer to the community.

An important component of the Geriatric Programme would be the development of an outreach programme conducted by nursing and social services. It would consist of a geriatric nurse practitioner and a social worker who would identify potential community sites with a significant at-risk geriatric population; conduct clinical programmes for on-site physical and psychosocial assessments for the geriatric population; develop care plans for these patients and when appropriate, facilitate referrals to Cedars-Sinai primary care physicians. Similarly to many of the other hospitals I visited, they saw the need for an education programme for the staff working within the hospital and the community.

Other long-term aims of the geriatric programme would consist of the potential development of the following components:-

1. Transportation Programme
2. Satellite Ambulatory Care Centers
3. Respite Care Centers
4. Skilled Nursing Facility
5. Congregate Housing
6. Community Based-Case Management

Other parts of the document dealt with an analysis of the population that was being served, indicating a total of 126,270 discharges and 1,217,799 patient days.

The remainder of the document went into great detail on the marketing strategy for initiatives that the hospital hoped to develop to improve the number of patients looking to Cedars-Sinai as a "center of excellence" for the geriatric services as demonstrated by the aforementioned resume.

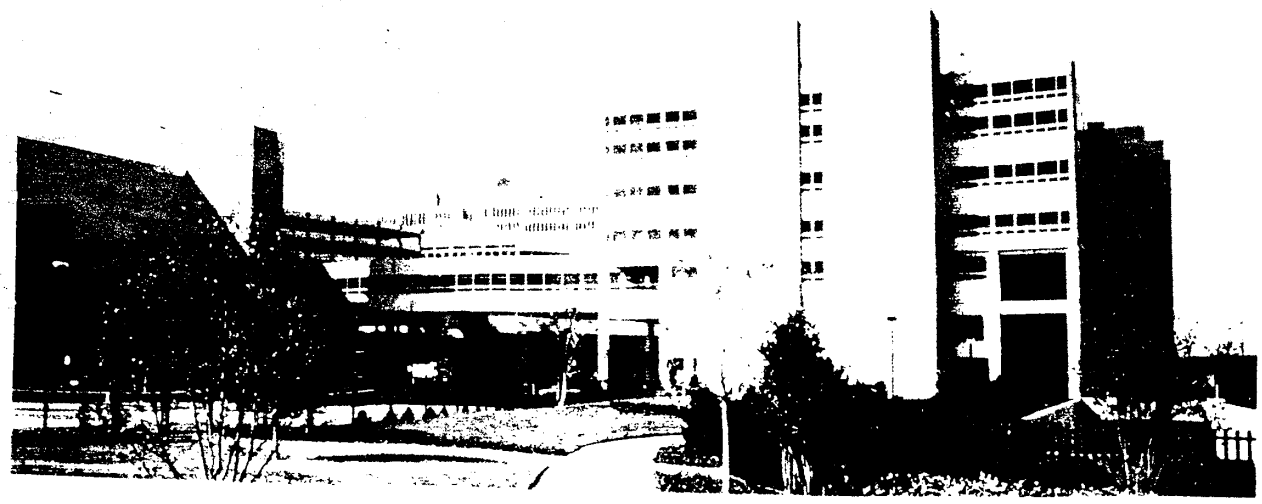
While Cedars-Sinai is at the forefront of technology for in-patients and research projects, they have not considered a major strategy for the elderly as a separate entity to the other mass of in-patients they were dealing with.

One of the services at the Cedars-Sinai Hospital in Los Angeles relates to biofeedback which uses electromyographs (EMG), electrodermographs (EDG/GSR) and thermographs to ascertain physiological changes that have been produced within a patient. The information is fed back by use of a meter, lights, audible tones or even computerised graphs.

The suggested benefits of biofeedback, is still a relatively new methodology. There are, it is claimed, many areas where bio feedback is shown to be very effective. These include tension headaches, migraine headaches, ulcers, colitis, peripheral vascular problems, neuro-muscular difficulties such as spasticity or chronic muscle spasms, insomnia, respiratory problems, cardio-vascular conditions, such as angina and hypertension and menstrual cramps.

Since my return, I have discussed with nursing and other para-medical colleagues the loan and hire services for various aides that assist those staying within their own homes. There is nothing in their list which is not provided by one of the statutory bodies or voluntary organisations in this country.

**A list of appliances available for rental as produced by Cedars-Sinai, can be found in Appendix 'C' on page 143.**



Rush-Presbyterian-St Luke's Medical Center and the
Johnson R. Bowman Health Center for the Elderly.

Rush-Presbyterian-St Luke's Medical Center is one of Chicago's oldest and most distinguished health-care institutions. Located on the near west side of the city, it is an academic center offering programmes in health care, education and research. One of its principal components is the Johnson R. Bowman Health Center for the Elderly, a 176-bed facility and a national model for hospital-based geriatric care.

The Bowman Center was established in 1976, a 10-storey building designed specifically to meet the needs of the older patient. In addition to the comprehensive range of in-patient and out-patient services, the Center also offers modern apartments for older residents capable of independant living. These residential units occupy the top two floors of the Center.

27. Initiatives at the Johnson R. Bowman Health Center.

The Johnston R. Bowman Health Center for the Elderly, is a Geriatric Unit which forms part of the Rush-Presbyterian-St. Luke's Medical Center. A multidisciplinary team of Geriatric Specialists provides medical, nursing, rehabilitative and other services in a setting designed specifically for elderly patients. In addition, patients have access to all the services and specialties at Rush-Presbyterian-St. Luke's Medical Center. Patient-services are organised into various units, each structured towards the patient's individual care plan.

1. The acute medical unit: This provides diagnostic assessment and treatment for patients who are in an acute stage of illness and in need of hospital services, similar to the role carried out by a District General Hospital in this country.

2. The Rehabilitation Unit provides restorative services and therapies to help patients with physically disabling conditions and with the objective that patients attain the highest possible level of functioning.

3. The Geriatric Psychiatric Unit provides in-patient diagnosis and treatment for elderly patients experiencing acute psychiatric problems.

4. The skilled Nursing Units' role is to provide restorative nursing and progressive physiotherapy, following a patient's acute hospitalisation, to up-grade function, prior to returning to their own homes.

5. The Out-patient Department covers the full range of services that one would find in a British setting. Also, provided on the same site, is a residential apartment complex for the elderly patients who are able to care for themselves. The apartment complex provides bi-weekly transportation for grocery shopping and a variety of recreational and cultural activities. These apartments are furnished and rented on a daily basis for short-term needs. This is the bricks and mortar aspect of this specialised unit, but they are also involved with many of the other aspects of services for the elderly, such as:- discharge planning, education, research, community services, nursing home liaison and personal emergency response system.

These services are similar to those developed by a number of joint financing schemes between Local Authorities and Health Authorities in this country.

Publications are provided for people who have had hip joint replacements and the precautions patients need to follow after such surgery. These publications include special techniques on the use of adaptive equipment to accomplish daily activities safely and independently, it also provides the phone number of the Occupational Therapy Department who can give further advice.

Their Psychiatric Unit issues a publication for relatives to deal with persons with Alzheimers disease, or related dementias. Another publication of the Occupational Therapy Department deals with home safety - this contains advice for the older people and those with handicaps, as well as commonsense ideas for every home.

An abundance of literature is also provided to assist people on their discharge.

As part of their marketing strategy, (similar to the majority of the hospitals I visited), they produce glossy brochures on the facilities they offer, which includes case studies of patients who have been admitted - and - rehabilitated and who return to the community within a short space of time.

NOTE: **The majority of the following text is provided with grateful thanks from leaflets supplied by the Yavapai Regional Medical Center, Prescott, Arizona.**

28. Initiatives at the Yavapai Regional Medical Center.

Although the Yavapai Regional Medical Center is one of the smaller establishments that I visited, their initiatives in the area of Peer Counselling was impressive.

They have two schemes. Understanding the reluctance of the elderly to seek counselling in hospitals, the West Yavapai Guidance Clinic was set up with a Senior Peer Counselling Programme.

The counsellors - - Older adults volunteer their time, from 3-10 hours per week, to be trained and supervised as peer counsellors. Under training and supervision of professional mental health workers, each is matched with one or more elderly clients. Weekly visits or phone calls to clients are focused upon support, mutual caring, and problem solving.

The clients - - Seniors in need of a supportive, adult relationship are referred to the program by physicians, human service agencies and family members. Often clients are isolated due to physical impairment or loss of family. In many cases, peer volunteers compliment the medical and counselling services offered by professional staff.

## ADULT PEER COUNSELLING

Traditional methods of addressing adverse psychological consequences of ageing - - loneliness, depression, fear - - have had only modest success. In spite of great need, the elderly are often unable or unwilling to seek counselling and related mental health services in conventional settings - - hospitals, private counsellors or mental health centers.

Referrals come from Physicians, Human Service Agencies and family members and the volunteers provide weekly visits or phone calls, especially where the clients have no family support or have physical impairments.

## MOUNTAIN AIR REHABILITATION CENTER FOR HEALTH
## M. A. R. C. H.

Their second programme is called Mountain Air Rehabilitation Center for Health, (M.A.R.C.H.). This title was selected in the hope that it would be adopted as a collective name for rehabilitation. The rehabilitation team is multidisciplinary, involving Pharmacy, Dietary, Physical (Physio) Therapy, Occupational Therapy, Respiratory Therapy, Nursing, Social Services, Cardio-pulmonary Lab, Education and Medical Staff. Currently, the services available under the name M.A.R.C.H. include programs for cardiac and pulmonary rehabilitation.....both in-patients and out-patients. Pulmonary or cardiac rehabilitation may be ordered by the patient's personal physician. Following the physician's order, the rehabilitation team members begin responding to the needs of each particular patient.

It is important to include the patient's family in the care and teaching, and by involving the family, a better understanding of the disease, a teaching regime and 'whole' person caring is developed, the goal being fewer hospitalisations and better health.

There is no fee. The project is funded in part by Block Grants Administration, Arizona Department of Economic Security.

To make a referral or learn more about the Adult Peer Counselling Programme, call WYGC at 445-7730.

**WEST YAVAPAI GUIDANCE CLINIC, INC.**

505, South Cortez Street, Prescott, Arizona 86301

(602) 445-7730

Community Mental Health Services Since 1966.

## PULMONARY REHABILITATION

If rehabilitation is ordered for a patient with chronic respiratory disease, the various disciplines will meet with the patient to determine the patient's learning needs. For instance; the dietician will instruct the patient in proper nutrition. The pharmacist will visit to provide medication instruction and information. If the physician desires, the nursing staff will evaluate the patient for exercise and introduce the patient to a program using the exercycle, the treadmill or a walking program. Respiratory therapy will provide important information concerning equipment and breathing techniques. The therapist may perform an Oxygen evaluation and/or pulmonary function studies. Occupational Therapy will advise concerning activities of daily living, energy conservation, relaxation, and/or special needs in the home. Physical Therapy may be required for patients with special musculo-skeletal limitations. Social services will provide the pathway to follow-up care if needed through discharge planning. The patient and family are provided with instructional materials for future reference.

Phase 1 is for the hospitalised patient. Phase 11 is an out-patient program.

## CARDIAC REHABILITATION

If cardiac rehabilitation is ordered for the hospitalised patient, he or she will be visited by the various disciplines for information and education. The dietician will provide nutritional instruction and answer questions. The Cardio-pulmonary lab will present a slide show which helps the patient and family to understand exactly what the cardiac problem means. The pharmacist may discuss medication regimes, medication actions and side effects. Occupational Therapy and Physical Therapy may consult for patients with special needs. Social Services will provide information and access to follow-up care if needed.

The patient may be referred at a later date to the out-patient program known as Phase 11, which is a personalised exercise program designed to enable the individual to work toward improved cardio-vascular fitness. The individual may have cardiac monitoring during the exercise period. Phase 111 is an on-going independent, yet supervised exercise program.

## Conclusion

The pattern of initiatives nationally vary from one community to another, but the role of the American Hospital Association as a fosterer of collecting and disseminating information to a wider audience, is only matched in this country by reports from the Health Advisory Centre and 20 Demonstration Centres most of which are not known to the majority of people dealing with the elderly. A wider distribution of good practices and new initiatives are important for the major organisations dealing with the elderly to address themselves to.

Similar to the Health Authorities in this country, they produce strategic documents as to how they can best cater for the elderly within their catchment area. This takes into account the type of principles looked at in this country, such as the economic and demographic trends.

With the privatisation of services for the elderly in this country, by means of various D.H.S.S. grants, (which has encouraged many Health Authorities to come to agreements with the private sector), there is every possibility that similar schemes for providing facilities adjacent to District General Hospitals and Long Stay establishments might be a type of strategy for the future in the United Kingdom.

With the reduction of finance in the Health Service and the limits on capital expenditure, it is more likely that the private sector will be looking for such collaborative arrangements, as they have the resources to develop such initiatives in this country.

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## TECHNOLOGY

The access to technology for the elderly in the United States was well demonstrated by the range of facilities provided by each of the hospitals I visited. Their view of the British health care system was, that there was an unwritten rule, that much of the technology available for diagnosis and treatment - and the treatment that was required after diagnosis, was very often not available due to the long waiting list and an unwritten rule that where there was a shortage of technology or high cost treatment, that the elderly should be disregarded.

Comparisons around the world for certain sophisticated procedures and not compared just with the United States, seem to indicate that the British Society was not as well developed in terms of the type of treatment that can be given to patients, due to the trend within Western Europe to reduce public expenditure on health care.

In all the hospitals I visited, the Gerontology Departments were primarily there to provide assessment and diagnosis and they had arrangements with all specialities that patients requiring even a most sophisticated and expensive treatment, should be referred to them, to improve their lifestyle. The availability of heart by-pass operations for the very elderly was a good demonstration of what could be done.

In this country, even in teaching hospitals, the number of operations tend to be limited, because of the cost of implanting cardiac pacemakers to this specialist group of patient.

Many of the hospitals had research departments specifically geared to identifying areas of technology which could assist elderly patients. Possibly they had the financial incentive to move in this direction as a means of marketing the products that they produced.

The continued growth of genetic engineering applications would have a profound affect on health care, for instance Streptokinase, a blood clot

dissolver would revolutionise cardiology treatment when it could be injected in a vein and travel directly to a clot in the heart.

With regard to disease prevention, cancer and other life threatening illnesses may become preventable with advances in genetic engineering. Monoclonal antibodies would be part of the regular treatment programme within five years, based on statements made in the "Meditrends Physician" opinion survey, sponsored by the American Hospitals' Association. At the same time it is projected that more patients will benefit from the type of surgery that will extend their productive lives.

1. Polyners Long Chain Molecular Weight Molecules, such as protein rubber or Polyesters used in clothes are being used to make much smaller synthetic blood vessels than it has been possible to make in the past.

2. New bone substitutes are being produced that may greatly reduce the painful process of transplanting a bone from one part of a person's body to another.

High technology home care services were being used by hospitals of all sizes interested in cutting the length of stay due to the DRG Regulations, saving money and ensuring the proper treatment of patients. Territory Care Hospitals were the first to refer patients to high technology home care on a regular basis. These hospitals treat the largest number of acutely ill patients who can benefit most from sophisticated care in the home.

But as more physicians have been educated about home care services and as the technology has been adopted for use by more patients, hospitals of all sizes have begun sending patients home to high-tec care. The components that are used at the present time are:

i) Total parenteral nutrition - the intravenous infusion of nutrients to patients who are unable to digest food.

ii) Entronutrition - infusion of nutrients in traditional format to functioning portions of the patients digestive tract.

iii) Intravenous antibiotic therapy - a method of treating infections of tissues that do not absorb blood quickly.

iv) The continuous intravenous chemotherapy infusion of cancer fighting drugs.

v) Other infusion, including pain relief drugs used after surgery and fluids for dehydrated patients.

These home-care options still require the services of a skilled nurse to supervise the therapy at home. Many of these services are provided in a British setting by District Nurses and Health Visitors and the most difficult aspect of extending a similar service to the British setting is the lack of resources that are permitted to the development of this strategy.

It is not intended that this report be anecdotal but an example of the difference in culture between the United States and Great Britain has been the willingness of the elderly to travel many hundreds of miles to receive the latest technological treatment which can be provided in one hospital as opposed to another.

A good example of this was explained to me in my visit to Sun City in Arizona where I was advised that two elderly patients who could not receive treatment in Boswell Hospital were able to ascertain that more advanced technology was available in a hospital in Tuson, Arizona some 300 miles distance and were visiting this Hospital as out-patients on three days a week in order that they could have access to the latest technology.

On a more basic level, the range of technology available in each of the Hospitals that I visited made many of the District General Hospitals in this country appear to be far behind the United States.

A system of regional specialities being centred on particular sites and the move towards rationalisation of even some of these units into London Teaching Hospitals mitigate against local population having easy access to the range of technology which is available.

In conclusion, I would suggest that, while it is unfair to make comparisons of our two societies based on the level of expenditure between the United States and the United Kingdom, I could not help but conclude that if you are an elderly person in the United States of America your chances of being treated with the latest technology to improve or sustain life, far outweighs the facilities presently available through the National Health Service in the United Kingdom.

## GLOSSARY OF LONG-TERM CARE TERMS

**Long-Term Care** - CARE NEEDED BY PERSONS WHO, BECAUSE OF PHYSICAL AND/OR MENTAL CONDITIONS, ARE UNABLE TO COPE WITH TASKS OF DAILY LIVING WITHOUT ASSISTANCE FOR AN EXTENDED PERIOD OF TIME.

### Adult Day Care Service

This program provides a combination of health and social services to older adults during daytime hours. Services include comprehensive assessment, health monitoring, occupational therapy, personal care, a noon meal and transportation. Some programs also provide primary health care and rehabilitation services.

### Adult Day Health Service

Service is provided for a part of a day and in a congregate setting to individuals who can benefit from care, but do not require institutionalisation. Such service may include health service, physical and/or vocational rehabilitation, provision of meals, personal care and recreation and educational activities. (See Adult Day Care Service).

### Adult Foster Care

Service offered in a private home that is owned and occupied by an individual or family offering a place of residence to an unrelated adult(s), meals, housekeeping service, minimal surveillance and personal care.

### Boarding Home

Facility which provides room and board services only. It is not licensed as a health care facility and in most states is not subject to licensure.

### Case Management

A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive services and the co-ordination of payment and reimbursement for care. A case manager acts as a client advocate often performing assessment and referral and monitoring the progress of the individual through the system.

### Comprehensive Assessment Service

An interdisciplinary service providing a comprehensive assessment of the health, mental health, functional, social and financial status of older adults, resulting in a plan for comprehensive treatment and referral to

appropriate providers. A comprehensive assessment service can be a part of an in-patient or ambulatory care setting (also see Geriatric Comprehensive Assessment In-patient Unit).

## Comprehensive Long-Term Care

Comprehensive long-term care consists of those services designed to provide diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services for individuals (and their supportive families) who have chronic and/or mental impairments+ this care is provided in a variety of settings, including the home. The goal of the comprehensive long-term care system is to promote the optimal level of physical, social and psychological functioning.

## Congregate Housing

Facility providing a sheltered living environment for residents, possibly including such services as housekeeping, dining, social activities, protective oversight, assistance with personal care activities and intervention in a crisis situation. The general term "congregate housing" includes facilities known in various states as custodial care facility, domiciliary care facility and supervisory care facility. This scope of services to residents ranges from very limited personal services in an independent living environment to a full service supportive living environment.

## Congregate Meal Service

Meal or snack service provided to an elderly population in such congregate settings as senior centers, socialisation/nutrition sites and congregate housing.

## Day Hospital

A hospital-based program that provides intensive medical, nursing and rehabilitation services to individuals who spend the day at the hospital and return home in the evening and who would need to be in the hospital, were the day program not available. Services provided are more intensive in nature than those commonly provided by adult day care programs (see definition above).

## Discharge Planning

Discharge planning assists older patients and their families in arranging for services that they will need after discharge from a hospital.

## Emergency Response System

An emergency alarm and response system designed for functionally impaired persons living in the community (particularly the elderly). The system includes: an electronic communication unit in the home which is easily activated when there is an emergency; a central emergency station

located in a hospital or similar facility that is responsible for receiving incoming alarms, identifying the client and sending help when required; and individuals chosen by the user who have agreed to respond to specific calls for help.

## Enriched Housing/Sheltered Housing/Board and Care Facility

Housing with some services for semi-independent older adults. Services provided include meals preparation, housekeeping, laundry, personal care and shopping. In addition, social or recreational activities and/or counselling are offered by some facilities. Individual apartment units usually do not include kitchen facilities. This type of supportive living environment promotes independence for residents to the maximum extent possible.

## Friendly Visiting

Personal, regularly scheduled visitation to homebound or socially isolated individuals for the purpose of assuring continuing contact with the community.

## Geriatric Comprehensive Assessment In-patient Unit

An in-patient unit designed to comprehensively assess elderly patients' medical and psycho-social problems as well as functional status to determine placement and often to provide therapy and rehabilitation. Geriatric assessment/rehabilitation units utilise a multidisciplinary team of professionals including physicians, nurses, social workers and rehabilitation therapists. Some geriatric units focus on comprehensive assessment and short-term treatment of acutely ill patients without providing extensive rehabilitation therapy. Others provide less extensive comprehensive assessment but do not provide prolonged rehabilitation (also see comprehensive assessment service).

## Gerontological Nurse Practitioner

The gerontological nurse practitioner is a registered nurse, educationally prepared to assume an expanded role in providing primary health care to older adults and their families, one who possesses in-depth knowledge of physical assessement and can manage stable, chronic and minor acute illnesses or conditions afflicting older adults. The gerontological nurse practitioner collaborates with other health care professionals to provide optimal care to older persons, (American Nurses Association).

## Group Home

An organisationally sponsored living arrangement shared by several older adults. Tenants or residents are jointly responsible for food preparation, housekeeping and recreation. Group homes usually are not licensed and do not provide health care or personal care services.

## Home Delivered Meals

A program that provides meals on a daily basis Monday through Friday to homebound older adults who are not able to provide or prepare meals for themselves.

## Home Health Care

Care provided to individuals in their homes for the purpose of promoting, maintaining or restoring health or of minimising the effects of illness and disability in order to enable the individual to maintain an independant lifestyle at home. Such a service is authorized by a physician and may include nursing, speech, physical, occupational and rehabilitation therapy, physician services, social work or counselling.

## Home Visitors

Hospital volunteers who provide companionship on a regular basis to older people, especially those who live alone.

## Homemaker Service

Provision of non-medical service such as cleaning, laundry, meal preparation and shopping to an idividual living at home but unable to perform these tasks. This program also may be known as Chore Service. It may be distinguished from personal care by its providing services to enhance the physical environment. Personal care and homemaker services may be provided concurrently and by the same health worker or a volunteer.

## Hospice

A program which provides palliative and supportive care for terminally ill persons and their families. The family is considered the unit of care and care extends through bereavement. Emphasis is placed on symptom control and pain control for the terminally ill person, support for the patient before death and support for the family before and after death. Major hospice services include home care, in-patient care, bereavement services, counselling and education.

## Hospital-Based Skilled Nursing Facility

Provides medical and continuous nursing care services to patients who are not in the acute phase of illness and require primarily convalescent, rehabilitive, and/or restorative services. May be located on or off-campus but must meet the following three criteria: hospital and nursing home are governed by a common governing board, hospital and nursing home must file a common cost report, and the nursing home must utilise more than half of its service from the hospital.

**Information and Referral**

A special program for older adults or their family to provide information about and referral to services available in the community.

**Intermediate Care Facility**

An institution licensed by a state to provide health related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing facility but who do require care or services available only through institutional facilities. These facilities may also be known as supportive nursing care facilities or health related facilities.

**Life Care/Continuing Care Community**

A program through which older adults commit to reside in a community for the remainder of their life. The community has the physical facilities and services to provide care ranging from freestanding apartments to nursing home care. The concept has insurance features in that an initial payment ("entry fee") is required. The fee guarantees residents a specified package of health and long-term care benefits (over Medicare covered services), co-payments and deductibles also are part of the benefit package.

**Long-Term Care in an Acute Care Setting**

Services provided in an acute care setting to patients whose disability requires care and supervision of an extended duration. Such service, although long-term, is provided in the regular acute care units of an institution, not in a designated long-term care unit.

**Mental Health Liaison Services** (sometimes referred to as psycho-social counselling)

Counselling provided by a psychiatrist, social worker, clinical pyschologist, nurse or other health professional for the purpose of helping an older adult to deal with emotional and mental problems related to hospitalisation.

**Multidisciplinary Team**

An approach to caring for the elderly that involves professionals representing multiple disciplines with the goal of providing comprehensive, integrated care. The team includes a physician, nurse and social worker, working closely together and, depending on the patient's needs, may also include occupational, physical and other therapists; a psychiatrist or psychologist.

**Multipurpose Senior Center**

Community centers that emphasise social, recreational and educational programs for older adults.

## Passive Monitoring

Any number of monitoring systems which involves activation of an alarm by the person in need of assistance.

## Personal Care Facility

An institution providing personal care services, including assistance with activities of daily living such as bathing, toileting, eating, transferring and ambulation.

## Preferred Provider Organisation (PPO)

PPO is a concept (rather than a specific entity) that refers to a negotiated arrangement between a buyer and seller of health care services. It provides services at any price and under any circumstances to which the parties agree. In many respects a PPO falls midway between a Health Maintenance Organisation and a conventional insurance plan and shares features of each.

## Respite Care

An in-patient or ambulatory service that takes care of older adults for a short period of time allowing the family or care-giver a rest from providing care.

## Satellite Clinics

Out-patient clinics or centers which are located in the community and provide health and related services to older adults. Common locations are senior centers, day care centers or senior housing.

## Senior Volunteers

A hospital volunteer program making particular efforts to recruit and involve older adults.

## Skilled Nursing Facility

A facility that provides medical and continuous nursing care services to geriatric patients who are not in the acute phase of illness and require primarily convalescent, rehabilitive and/or restorative services. It may include, but is not restricted to, Medicare/Medicaid certified skilled nursing facilities. (Also see hospital-based SNK).

## Social/Health Maintenance Organisation

A Health Maintenance Organisation providing comprehensive care to older adults. A single provider entity assumes responsibility for providing enrollees with a full range of benefits to include health and social services delivered on an acute and long-term basis (i.e. primary medical care, hospital care, nursing home, home health and personal care services).

Elderly persons are voluntarily enrolled through the marketing efforts of the provider. Once enrolled, these individuals receive all covered services through the designated provider. There are currently four S/HMOs established under a Medicare demonstration project. Other Medicare HMOs are being established under TEFRA, Section 114. These programs can expand benefits to include long-term care.

## Telephone Reassurance

Interaction with a client by telephone for the purpose of reducing social isolation and insuring health and safety, determining if special assistance is required, providing psychological reassurance or notification of a contact person if the person called does not respond.

## Transportation Service

Organised service providing conveyance of an individual from one location to another for an identified service population of the elderly or handicapped.

## APPENDIX 'A'

### EVALUATING LONG-TERM CARE FACILITIES

Carry this checklist when you visit nursing homes. It will help you compare one with another. As a rule of thumb, the best home is the one for which you check the most "yes" answers. However, remember that different kinds of homes offer different types of services. You should compare skilled nursing homes with skilled nursing homes, and residential homes with residential homes.

If the answer to any of the first four questions is "no", do not use the home.

| | | YES | NO |
|---|---|---|---|
| 1. | Does the home have a current license from the State? | ____ | ____ |
| 2. | Does the administrator have a current license from the State? | ____ | ____ |
| 3. | If you need and are eligible for financial assistance, is the home certified to participate in government or other programs that provide it? | ____ | ____ |
| 4. | Does the home provide special services such as a specific diet or therapy which the patient needs? | ____ | ____ |

### PHYSICAL CONSIDERATIONS

| | | | |
|---|---|---|---|
| 5. | Location | | |
| | a. Pleasing to the patient? | ____ | ____ |
| | b. Convenient for patient's personal doctor? | ____ | ____ |
| | c. Convenient for frequent visits? | ____ | ____ |
| | d. Near hospital? | ____ | ____ |
| 6. | Accident Prevention | | |
| | a. Well-lighted inside? | ____ | ____ |
| | b. Free of hazards underfoot? | ____ | ____ |
| | c. Warning signs posted around freshly waxed floors? | ____ | ____ |
| | d. Handrails in hallways and grab bars in bathrooms? | ____ | ____ |
| 7. | Fire Safety | | |
| | a. Meets Federal and/or State codes? | ____ | ____ |
| | b. Exits clearly marked and unobstructed? | ____ | ____ |

| | YES | NO |
|---|---|---|
| c. Written emergency evacuation plan? | ____ | ____ |
| d. Frequent fire drills? | ____ | ____ |
| e. Exit doors not locked on the inside? | ____ | ____ |
| f. Stairways enclosed and doors to stairways kept closed? | ____ | ____ |
| **8. Bedrooms** | | |
| a. Open onto hall? | ____ | ____ |
| b. Window? | ____ | ____ |
| c. No more than four beds per room? | ____ | ____ |
| d. Easy access to each bed? | ____ | ____ |
| e. Drapery for each bed? | ____ | ____ |
| f. Nurse call bell by each bed? | ____ | ____ |
| g. Fresh drinking water at each bed? | ____ | ____ |
| h. At least one comfortable chair per patient? | ____ | ____ |
| i. Reading lights? | ____ | ____ |
| j. Clothes closet and drawers? | ____ | ____ |
| k. Room for a wheelchair to manoeuvre | ____ | ____ |
| l. Care used in selecting room-mates? | ____ | ____ |
| **9. Cleanliness** | | |
| a. Generally clean even though it may have a lived-in look? | ____ | ____ |
| b. Free from unpleasant odours? | ____ | ____ |
| c. Incontinent patients given prompt attention? | ____ | ____ |
| **10. Lobby** | | |
| a. Is the atmosphere welcoming? | ____ | ____ |
| b. If also a lounge, is it being used by residents? | ____ | ____ |
| c. Furniture attractive and comfortable | ____ | ____ |
| d. Plants and flowers? | ____ | ____ |
| e. Certificates and licenses on display? | ____ | ____ |
| **11. Hallway** | | |
| a. Large enough for two wheelchairs to pass with ease? | ____ | ____ |
| b. Hand-grip railing on the sides? | ____ | ____ |
| **12. Dining Room** | | |
| a. Attractive and inviting? | ____ | ____ |
| b. Comfortable chairs and tables? | ____ | ____ |
| c. Easy to move around in? | ____ | ____ |
| d. Tables convenient for those in wheelchairs? | ____ | ____ |

| | YES | NO |
|---|---|---|
| e. Food tasty and attractively served? | ____ | ____ |
| f. Meals match posted menu? | ____ | ____ |
| g. Those needing help receiving it? | ____ | ____ |
| 13. Kitchen | | |
| a. Food preparation, dishwashing and garbage areas separated? | ____ | ____ |
| b. Food needing refrigeration not standing on counters? | ____ | ____ |
| c. Kitchen help observe sanitation rules? | ____ | ____ |
| 14. Activity Rooms | | |
| a. Rooms available for patients activity? | ____ | ____ |
| b. Equipment (such as games, easels, yarn, kiln, etc.) available? | ____ | ____ |
| c. Residents using equipment? | ____ | ____ |
| 15. Special Purpose Rooms | | |
| a. Rooms set aside for physical examinations or therapy? | ____ | ____ |
| b. Rooms being used for stated purpose? | ____ | ____ |
| 16. Isolation Room | | |
| a. At least one bed and bathroom available for patients with contagious illness? | ____ | ____ |
| 17. Bathrooms | | |
| a. Convenient to bedrooms? | ____ | ____ |
| b. Easy for a wheelchair patient to use? | ____ | ____ |
| c. Sink? | ____ | ____ |
| d. Nurse call bell? | ____ | ____ |
| e. Hand grips on or near toilets? | ____ | ____ |
| f. Bathtubs and showers with non-slip surfaces? | ____ | ____ |
| 18. Grounds | | |
| a. Residents can get fresh air? | ____ | ____ |
| **Sevices** | | |
| 19. Medical | | |
| a. Physician available in emergency? | ____ | ____ |
| b. Private physician allowed? | ____ | ____ |

| | YES | NO |
|---|---|---|
| c. Regular medical attention assured? | ____ | ____ |
| d. Thorough physical immediately before or on admission? | ____ | ____ |
| e. Medical records and plan of care kept? | ____ | ____ |
| f. Patient involved in developing plans for treatment? | ____ | ____ |
| g. Other medical services (dentists, optometrists, etc.) available regularly? | ____ | ____ |
| h. Freedom to purchase medicines outside home? | ____ | ____ |
| 20. Hospitalisation | | |
| a. Arrangement with nearby hospital for transfer when necessary? | ____ | ____ |
| 21. Nursing Services | | |
| a. RN responsible for nursing staff in a skilled nursing home? | ____ | ____ |
| b. LPN on duty day and night in a skilled nursing home? | ____ | ____ |
| c. Trained nurses' aides and orderlies on duty in homes providing some nursing care? | ____ | ____ |
| 22. Rehabilitation | | |
| a. Specialists in various therapies available when needed? | ____ | ____ |
| 23. Activities Program | | |
| a. Individual patient preferences observed? | ____ | ____ |
| b. Group and individual activities? | ____ | ____ |
| c. Residents encouraged but not forced to participate? | ____ | ____ |
| d. Outside trips for those who can go? | ____ | ____ |
| e. Volunteers from the community work with patients? | ____ | ____ |
| 24. Religious Observances | | |
| a. Arrangements made for patients to worship as they please? | ____ | ____ |
| b. Religious observances a matter of choice? | ____ | ____ |

| | | YES | NO |
|---|---|---|---|
| 25. | Social Services | | |
| | a. Social worker available to help residents and families? | ____ | ____ |
| 26. | Food | | |
| | a. Dietician plans menus for patients on special diets? | ____ | ____ |
| | b. Variety from meal to meal? | ____ | ____ |
| | c. Meals served at normal times? | ____ | ____ |
| | d. Plenty of time for each meal? | ____ | ____ |
| | e. Snacks? | ____ | ____ |
| | f. Food delivered to patients rooms? | ____ | ____ |
| | g. Help with eating given when needed? | ____ | ____ |
| 27. | Grooming | | |
| | a. Barbers and beauticians available for men and women? | ____ | ____ |

**Attitudes and Atmosphere**

| | | | |
|---|---|---|---|
| 28. | a. General atmosphere friendly and supportive? | ____ | ____ |
| 29. | Residents retain human rights? | ____ | ____ |
| | a. May participate in planning treatment? | ____ | ____ |
| | b. Medical records are held confidential? | ____ | ____ |
| | c. Can veto experimental research? | ____ | ____ |
| | d. Have freedom and privacy to attend to personal needs? | ____ | ____ |
| | e. Married couples may share room? | ____ | ____ |
| | f. All have opportunities to socialise? | ____ | ____ |

APPENDIX 'B'

# GERONTOLOGY/GERIATRICS

## HEALTH SCIENCE LIBRARY RESOURCES

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GERONTOLOGY/GERIATRICS

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## APPENDIX 'C'

## RENTAL LIST

### WHEELCHAIRS AND ACCESSORIES

Standard Folding Model
Standard/Detachable Arm Model
Semi-Reclining Model
Full-Reclining Model
Lightweight Model
Heavy Duty, Extra Wide Model
A-Bec Motorised Wheelchair
Motorised Wheelchairs, Other Styles
Elevating Leg-rests
Wheelchair Trays
Portable Wheelchair Ramps
Wheelchair Safety Belts
Guerne (Wheelchair Stretcher)

### HOSPITAL BEDS

Standard Two-Crank
Vari-Hite
Vari-Hite with Motorised Spring
Completely Motorised Bed

### HOSPITAL BED ACCESSORIES

Sliding Safety Side Rails
Exercise Bar - Patient Helper
Exercise Bar - Free Standing
Bedside Commode Chair
All-Purpose Commode Chair
Patient Lift
Overbed Table
Bedboard - Folding
Intravenous Stand
Linen Cradle

### TRACTION EQUIPMENT

Overhead Frame
Traction Stands - includes Water
Weight Bag & Spreader Bar

### EXERCISE EQUIPMENT

Bicycle Exerciser
Rowing Machine
Treadmill Jogger, Manual
Inversion Traction Exerciser
Ergometer Cycle

## EXERCISE EQUIPMENT

Massage Tables
Motorised Treadmill
Pulse Monitor

## OXYGEN THERAPY EQUIPMENT

Oxygen Concentrator
Oxygen H Cylinder Contents Only
Oxygen E Cylinder Contents Only
Cylinder Stand
Regulator Humidifier and Cannula
Yoke Needle Valve and Cannula
Hand Cart - E Cylinder

## RESPIRATORY CARE EQUIPMENT

Bennet AP.5 Respirator
Bennet AP.4 Respirator
Portabird Respirator
Monaghan 515 Respirator
TV2P Respirator
Mark V11 with Regulator
Ultrasonic Nebulizers
Pulmo Aide
Ventilators
Aspirators
Apnea Monitors
Liquid Oxygen
Aerosol Therapy
Accessories

## WALK AIDS

Crutches - Adjustable
Crutches - Forearm Adjustable
Walkaid - Without Casters
Wheeled Footpieces for Above
Quad Canes

## ELECTRICAL EQUIPMENT

Air Purifier
Alternating Pump
Lapidus Airfloat System
Water Therapy Pump and Pads
Aspirator - Portable with Suction Catheter
TENS Pain Control Unit
Infra-Red Lamp
Whirlpool Bath
Breast Pump