Utilization of Community Based Health Care Services by the Well Elderly

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UTILIZATION OF COMMUNITY BASED HEALTH CARE SERVICES
BY THE WELL ELDERLY

By

RACHELLE HESSELBERG
KRISTEN WAGNER
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THESIS

Submitted to the Department of Physical Therapy
of Grand Valley State University
Allendale, Michigan
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN PHYSICAL THERAPY

1993
THE PURPOSE OF THIS STUDY WAS TO DETERMINE IF THE
elderly used community based health care services, to which
they had been referred, following discharge from an acute
hospital stay. The sample consisted of twenty elderly
recruited from various senior centers in the West Michigan
area. Of the respondents surveyed, 18 out of 20 were
Caucasian. The average age of respondents was 73 years old.
Of the services surveyed, all were under utilized by our
sample except those in the clinic. An 18-item questionnaire
was developed and distributed to the participants. Results
from the data implied that it was more likely that community
based health care services were under utilized if the
services were not clinically based.

Major Words: Community based health care services, Elderly,
Utilization.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>i</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>vi</td>
</tr>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background to the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Question</td>
<td>4</td>
</tr>
<tr>
<td>Specific Purpose of the Study</td>
<td>4</td>
</tr>
<tr>
<td>2. REVIEW OF RELATED LITERATURE</td>
<td>6</td>
</tr>
<tr>
<td>Need for services</td>
<td>6</td>
</tr>
<tr>
<td>Factors related to utilization</td>
<td>8</td>
</tr>
<tr>
<td>Lack of information</td>
<td>13</td>
</tr>
<tr>
<td>Cost containment measures</td>
<td>14</td>
</tr>
<tr>
<td>Changes in delivery systems</td>
<td>14</td>
</tr>
<tr>
<td>Case management</td>
<td>15</td>
</tr>
<tr>
<td>Informal/formal care</td>
<td>18</td>
</tr>
<tr>
<td>Compliance</td>
<td>20</td>
</tr>
<tr>
<td>Health beliefs</td>
<td>21</td>
</tr>
<tr>
<td>Conclusion</td>
<td>22</td>
</tr>
<tr>
<td>Implications for Study</td>
<td>22</td>
</tr>
<tr>
<td>Statement of Research Question</td>
<td>23</td>
</tr>
<tr>
<td>Definitions</td>
<td>23</td>
</tr>
<tr>
<td>3. METHODOLOGY</td>
<td>27</td>
</tr>
<tr>
<td>Study Design</td>
<td>27</td>
</tr>
<tr>
<td>Study Site</td>
<td>27</td>
</tr>
<tr>
<td>Subjects</td>
<td>27</td>
</tr>
<tr>
<td>Instrument</td>
<td>28</td>
</tr>
<tr>
<td>Procedure</td>
<td>29</td>
</tr>
<tr>
<td>4. ANALYSIS OF DATA</td>
<td>31</td>
</tr>
<tr>
<td>Statistical Techniques</td>
<td>31</td>
</tr>
<tr>
<td>Characteristics of Subjects</td>
<td>31</td>
</tr>
<tr>
<td>Research Question</td>
<td>32</td>
</tr>
<tr>
<td>Response to Research Question</td>
<td>32</td>
</tr>
<tr>
<td>Results</td>
<td>32</td>
</tr>
<tr>
<td>Other Findings of Interest</td>
<td>33</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>5. DISCUSSION, APPLICATIONS,</td>
<td></td>
</tr>
<tr>
<td>AND LIMITATIONS</td>
<td></td>
</tr>
<tr>
<td>Discussion of Results</td>
<td>38</td>
</tr>
<tr>
<td>Application to Practice/ Administration</td>
<td></td>
</tr>
<tr>
<td>/Education</td>
<td>40</td>
</tr>
<tr>
<td>Limitations</td>
<td>42</td>
</tr>
<tr>
<td>Suggestions for Further Research/ Modifications</td>
<td>43</td>
</tr>
<tr>
<td>REFERENCES</td>
<td></td>
</tr>
<tr>
<td>TABLE 1</td>
<td>49</td>
</tr>
<tr>
<td>TABLE 2</td>
<td>50</td>
</tr>
<tr>
<td>TABLE 3</td>
<td>51</td>
</tr>
<tr>
<td>TABLE 4</td>
<td>52</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>53</td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>61</td>
</tr>
<tr>
<td>AUTOBIOGRAPHY</td>
<td>62</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ethnicity</td>
<td>49</td>
</tr>
<tr>
<td>2.</td>
<td>Comparison of Referred Services to Utilized Services</td>
<td>50</td>
</tr>
<tr>
<td>3.</td>
<td>Comparison of Referred Services to services Felt to be Needed</td>
<td>51</td>
</tr>
<tr>
<td>4.</td>
<td>Comparison of Services Felt Needed to Utilized Services</td>
<td>52</td>
</tr>
<tr>
<td>Appendix</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>A. Questionnaire</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>B. Consent Form</td>
<td>61</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

Background to Problem

This study looked at the juncture of two problems, the increased elderly population, and the rising cost of health care in the United States. The United States as well as other countries around the world have faced or will face a dramatic increase in their elderly populations. In 1989, it was estimated that once a person reached 60 years of age, their average remaining life expectancy was 20.6 years. Women had an added life expectancy of 22.7 years and men had an added life expectancy of 18.6 years. At 65 years of age, a person could expect to live an additional 17 years.¹

Demographic data related to the elderly population was summarized in the 1993 Universal Almanac. In 1980, 25.7 million people in the United States were 65 or over, which consisted of 11.3 percent of the United States population. In 1990, 31.5 million people or 12.6 percent of the United States population was 65 and over. By the year 2000, the Census Bureau has projected that more than 13 percent of the United States population will reach age 65 or older and by the year 2030, the elderly population will reach 21.2 percent of the United States population. This means that one out of five Americans will be 65 or over.¹
The cost of health care has steadily increased over the past decades. According to summarized data in the 1993 Universal Almanac, the health care expenditures as a percent of the Gross National Product (GNP) for the United States were as follows: 5.2 percent in 1960, 7.4 percent in 1970, 9.3 percent in 1980, and 12.4 percent in 1990. The percentage of health care expenditures for United States were as follows. Hospital care comprised the largest proportion of the health care expenditures at 38.4 percent, physicians' services were 18.9 percent, nursing home care was 8.0 percent, home health care comprised 1.0 percent and other professional services were 4.7 percent of expenditures.¹

In an attempt to contain the rising health care costs, the government set into place the diagnosis related groups (DRG's) which placed a limit on the amount of reimbursement a facility could receive for a standard diagnosis. Due to rising health care cost and DRG regulations, people are being discharged from hospitals once medical stability is achieved. Therefore, need for community based services has escalated and these services must accommodate the patients continued requirement for care. Community health care services and home health care are integral components in relieving the overburdened health care system by decreasing cost and keeping the elderly out of hospitals and functional within the community. The demographics indicated that a
significant portion of the elderly were below the poverty level established for the general population. In 1990, the poverty rate for elderly 65 years and older was 11.4 percent.¹

Within a twelve month period, eighty to ninety percent of the elderly population will require one form or another of community based health services which demonstrates the need for these services.² Concern and research were increasing, but little was known about the factors among the elderly that influenced home care use.³ At the time Kempen and Suurmeijer wrote their article, professional home care was under serious study in the Netherlands. As the population ages, there will be a greater need for health services. Many factors play into the need to utilize home health and community services one factor is physical limitations, which can affect an individual's ability to perform activities of daily living. The more limited the individual is, the more services they will require.³ Jackson stated that "Waters (1987) found a trend towards an overall decrease in independence and ability to cope with personal and domestic activities of living post-hospitalization."⁴

The services investigated in this study included outpatient physical therapy, outpatient occupational therapy, outpatient speech therapy, outpatient mental health services, transportation services, visiting nurse services, home health aide, homemaker, meal programs, medical
supplies, and medical equipment. The reasons for lack of utilization included accessibility, awareness of available programs, financial considerations, location, and transportation.\textsuperscript{5}

The demographics indicate that family support systems are decreasing. The number of elderly without family support is expected to increase due to the changing American family structure, i.e., smaller number of children; higher number of single, divorced or widowed persons; and dissolution of extended kinship networks.\textsuperscript{5}

Upon reviewing the literature, the above factors included changing demographics, rising costs, cost containment measures, and apparent need for community based services research on utilization of community based health services by the elderly need to be explored. Also, the reason for use and non-use need to be exposed and dealt with by health care professionals.

\textbf{QUESTION}

What was the utilization of community based health services by the well elderly following discharge from the hospital in 1990, 1991, and 1992?

\textbf{SPECIFIC PURPOSE OF THIS STUDY}

The authors designed this study to find out if the elderly were utilizing the community based health care services that they were referred to at the time of discharge from the hospital. A sample of convenience was used which included the well elderly population in West Michigan from
area senior centers. Senior centers surveyed included the Evergreen Commons Senior Center in Holland, and Senior Neighbors Incorporated Center's including the Downtown and Roosevelt Park centers in Grand Rapids, the Grandville center in Grandville, and the Sparta center in Sparta. Factors that affected the well elderly's utilization of outpatient community based health care services were investigated. A questionnaire was developed and implemented on elderly individuals, 60 years old and older who met the criteria for this study.
Elderly Americans prefer to remain independent and continue to live at home for as long as possible. "For every impaired elder in an institution, there are at least three, to as many as five comparable elders in the community." Community support services must be extensive in order to meet the needs of the elders in the community and support the family. In the past, there has been little focus placed on the need for support of community services by the government. Recently, there has been a push toward development of community based services in order to control rising health care costs. Medicare and Medicaid have tended to tightly control the use of these services for the elderly due to low reimbursement.

There is a definite need to develop community health centers for the geriatric population. This need was made clear in an article by Yeatts, Ray, List, and Duggar due to the rapidly increasing percentage of elderly in the population. "As this change in population occurs the demand will also rise for health care services, including nursing homes, hospitals and community health programs." Communication between agencies and especially agencies that serviced the elderly helped to establish referral networks.
and increase the number of elderly services.  

Tesfa stated in his article that, "home health services are an essential component of the health care system for the elderly. At the present development of home health services in this country is limited by legislative and administrative regulations, problems associated with coordinating home health services, resistance from physicians, resistance from short and long-term facilities and lack of specialty health personnel in gerontology and geriatrics." Providers, consumers, and policy makers have grown increasingly concerned with the growing problem of discharging an increasing number of acutely ill elderly into the community with little access to community based services. In some cases community based health care services have allowed patients to be discharged earlier than might otherwise have been possible. Hospitals, faced with this challenge, intensified their efforts to link older patients with the necessary services upon discharge to avoid unnecessary readmissions. They were concerned about the elderly patients health, safety, institutional liability, and guaranteed third party reimbursement.

Studies have been conducted which report that older patients were more likely to have conditions requiring care from a community based service. "In an American study, patients randomly assigned to receive home care services exhibited greater improvement in their health status and had
fewer readmissions than did patients admitted to extended care facilities.\textsuperscript{11} It was essential that in the health care system structural changes occurred to increase availability and accessibility of community-based services. Also, a wide variety of community-based health services must be developed to meet the increasing needs of the growing elderly population.\textsuperscript{12}

The community services most frequently used by the elderly were visiting nurse services, homemaker or provider assistance, home-delivered meals, medical equipment, and transportation.\textsuperscript{2} According to Moxley and Buzas needs and problems presented by service recipients included shelter, transportation, nutrition, i.e. home-delivered meals, assistance with bills and taxes, utilities, guardianship issues, social support, recreation, respite care, health care, and mental health care.\textsuperscript{13}

Several authors have concluded from their literature reviews that there are several personal characteristics that have contributed to the use or non-use of services by the elderly.\textsuperscript{2,3,7,14} These factors included an individual's history, culture, ethnicity,\textsuperscript{14} residential environment, marital status, the number of informal supporters, risk status, and proximity to death.\textsuperscript{2} Other significant factors included income level, age, education levels, and knowledge of available services.\textsuperscript{3} The coordination of patient care also affected patients' attitudes toward the services they received. Factors that have served either to encourage or
discourage potential users of the geriatric services at community centers were cited in the literature.\(^3\) Yeatts, Ray, List, and Duggar have stated factors related to utilization of community based health services. "These included the center's image, availability of social services, clinical issues, and financing. Factors affecting a positive image of the geriatric program included the clinic's convenience to public transportation routes and parking facilities, atmosphere, socialization (availability of day health and day care programs), easy physical access (ramps, handrails, etc.), satellite sites, bicultural and bilingual staff capabilities, and a positive 'community clinic' image as opposed to a 'welfare image'."\(^7\)

The elderly tended to have increased participation in services if they lived close to where the services were provided. "This makes sense, given the time, energy and transportation costs in making any trip to the doctor."\(^15\) Durham, Beresford, Dieher, Gemboski, Hecht, and Patrick believed that if transportation and other incentives were provided, they may help attract seniors to the programs.\(^15\) One helpful means for increased use was to place health centers in the community to provide increased opportunity for community living options. It then became important to insure that quality was continually monitored.\(^16\)

Regulations governing the various aspects of health care have led to complications in delivery of health care services. Yeatts, Ray, List, and Duggar have stated that
factors reported to cause a negative image and subsequent barrier to service being utilized included clinic location, crowded waiting rooms, scheduling problems, and poor community relations. They also felt that negative feelings toward community based health services could decrease use. Also, some people may not have received the service because they were not aware that the service was available, they did not have health insurance, the strict DRG regulations, they were unable to afford insurance deductibles, or the service was not available in minority communities.

Another factor affecting non use of services is cost. According to Tesfa's article, he felt that the restrictive legislation of medicare and medicaid has prevented the development of home health services. Patients were required by Medicare Part A to be hospitalized for three consecutive days before qualifying for home health services. Under part B, patients were not required to be hospitalized but were required to pay premium costs, deductibles, and co-insurances making it difficult for the elderly to obtain services. The number of visits were limited thus making continuous care impossible. Under medicaid there has been a lack of services for physical, speech, occupational, or hearing therapies. These services are allowed by medicaid legislation but they are restricted to reduce home health service costs. Many times there were no uniform guidelines for interpreting claims and payment, therefore, causing increased anxiety to the patient. Also, reimbursement has
not been made available for preventative and maintenance care. "This exclusion forces the elderly into institutions. While many would prefer home health care, they cannot afford it and must rely on nursing homes and hospitals for proper care." Services have not been coordinated at the Federal, State and Local levels. "The regulations that govern each of the programs; the criteria for eligibility, duration, scope of services covered; and method of reimbursement vary greatly". Historically, hospitals have not monitored their patients following discharge, primarily because there were no compelling monetary, social or legal reasons to do so. However, "Every effort should be made to remove or limit the existing barriers that prevent home health services from becoming an alternative for the elderly who prefer to live in their own homes." A goal of many case management programs was to maintain elderly people in the least restrictive environment while simultaneously, trying to promote their quality of life.

Raschko stated, "community mental Health centers throughout the United States have traditionally underserved persons 60 years of age and older in proportion to their percentage of the general population." "Cognitive and emotional problems are primary among difficulties experienced by the elderly..." Elderly individuals most at risk do not present themselves to agencies that are available to help them because: The elderly have been forced to accept "...societal stereotypes about aging in
which coping problems and problems of living are viewed as the normal and irreversible results of senility and growing older, and the exaggerated self-reliance ethos of our society.\textsuperscript{19} These individuals fear exposure of their deficits, nursing home placement, feeling like they are "going crazy", and further loss of mastery and control of their own lives.\textsuperscript{18} This has caused elderly patients to conceal any potential illnesses, for as long as possible, thus making it difficult to identify the elderly who are most at risk that would benefit from community based health services.\textsuperscript{7} "The fortunate elderly are referred to services by concerned relatives or significant others, but agencies often further fragment the problem by using specialized services."\textsuperscript{20}

The foregoing paragraph indicated that targeting the elderly at risk was essential. It is especially important for the elderly with chronic illnesses. "The ailments of the elderly are chronic, therefore, services addressing chronic needs must be sustained over time, not provided for a few weeks and than stopped."\textsuperscript{5} A successful "long-term home care program included a large variety of coordinated medical and social services provided along a continuum of care, to individuals in their homes".\textsuperscript{5} "The National Center for Health Statistics reports that 81 percent of all persons over age 65 have chronic conditions that impair their ability to function independently".\textsuperscript{5} This means that the elderly will face ups and downs and sometimes will require
The obvious benefits of a continuum of care, both for social work departments and hospital administrators, include better data about client needs and problems, the functioning of community services, and discharge planning interventions.10

According to an article by Eustis and Fischer many elderly felt that they did not have enough information about home health care. "There was also evidence of clients having little understanding of how home care was arranged and supervised."21 In this day and age, the elderly and their families want more health information than the health care system has provided in the past. The elderly and their families are more willing to expend time and energy finding the services best-suited for their needs.22

To acquire needed services, skilled coordination of service by providers is essential with a focus on older people who are caught in this complicated service delivery system.23 Patients and their families should ask or be told the answers to their questions such as "What is the cost?", "What services are available?", "Are there government or community agencies that can be contacted for help and advice?", "Is there a special type of care or rehabilitation therapy required?, and if so, "Where is the best place to look for it?", and "Are there local institutions where further help might be found?". These are just a few of the questions that need to be asked and answered.22 With the
use of a geriatric case manager, the coordination of and access to services increases for the elderly individual.

Wood, Hughes, and Estes felt the demand for non-acute care was likely to increase as the government continued cost containment measures. Also, the prospective payment system is expected to increase the demand for community services. At the time their article was written, there was a disproportionate payment for inpatient care over ambulatory care.  

Changing times have affected the way health care costs were met in the United States. Economic factors and affordability of fees were very important to the elderly in the seeking and use of, mental health services, as well as other services. Most people have exhausted their emotional and financial resources and their families after having tried to obtain in-home services. Despite expressed enthusiasm for in-home support options, states have spent very little money on these options for older adults, and have instead primarily invested in institutional and congregate care. "Medicare and Medicaid expenditures on home health service totalled approximately $356 million, compared to $5.6 billion for institutional care." If third party payers, hospitals, and consumers were willing to pay for short-term intervention at the time of critical need, the need for sustained long-term care might have been alleviated in some cases and the quality of life of older persons and their families improved.
This major shift in the health care environment has promoted new service delivery models. The changed reimbursement patterns and health care financing structures have strengthened hospitals interest in systems that contributed to greater control over hospital length of stay. This allowed patients to be discharged safely and at the earliest possible point.27

However, the lack of monitoring of the elderly by hospitals has changed because case managers have started to assume the role of patient follow up.23 Due to the decreased private and public funding for social services and complicated medical systems a case manager is needed to access community services. A lay person, regardless of age, would have difficulty negotiating the complicated and constantly changing health and social care arena without significant difficulty.23 O'Brien and Wagner stated that "...all individuals are dependent on others to provide them with information channels through which help or direct first hand aid can be secured in the face of need."28

According to several authors, case managers assisted elderly in obtaining the proper services while at the same time decreasing the cost of health care.10,13,16,29,30,31 Reimbursement changes must be developed to enable the case manager to intervene with community based services during times of critical need to avoid a long term placement in an institution. "A case manager can be with a free standing facility or a specific service providing care, but case
management must be allowed to conduct a comprehensive assessment, to complete a formalized care plan, arranging formal and informal services included within the plan, and conducting ongoing case monitoring that included formalized assessment.".\(^{16}\) Robert Applebaum felt case managers were a critical component of the community-based long-term care system.\(^{16}\) The educational level required for case managers was a baccalaureate or a master's degree in social work. Training needs for the case manager according to this article are as follows. The case manager must understand the elderly client and have "knowledge of health and disability limitations, morbidity and mortality patterns, and mental health needs"\(^{16}\) that affect the elderly. The case manager must also understand the environment: "awareness of service providers, eligibility criteria, and service unit costs; methods of negotiating with and monitoring providers; working with physicians and other medical professionals; and knowledge of support mechanism for informal care givers."\(^{16}\)

During the past decade, human services and health care providers have increasingly adopted case management practices to improve the long-term coordination of community-based services. Case management was offered as a way of coordinating a fragmented service delivery system. The most fundamental component of the case management model was that families and other primary groups provided the bulk of care for individuals in need of assistance. The primary
goal of case management, therefore, was to integrate formal supports with family caretaking systems.\textsuperscript{10}

Many elderly people have faced a lack of choices when forced to deal with the health care service system.\textsuperscript{32} However, case management has attempted to maintain the elderly in the least restrictive environment while simultaneously trying to improve the elderly’s quality of life.\textsuperscript{13} This made hospital-based case managers logical links between discharge planners and community service providers.\textsuperscript{23} The fragmentation of services has led to many older adults not receiving the services they need because they are unaware of the services or they are unable to negotiate the complicated bureaucratic system.\textsuperscript{30}

In an effort to deal with identification of at risk elders the Dallas Area Agency on Aging (DAAA), conducted a study which had a legislative responsibility to develop a comprehensive and coordinated delivery system of supportive services for the elderly individual. The DAAA was aware that elderly patients were falling between the cracks with the community care system after discharge. With the DAAA's funding, the Parkland Social Work Program provided an opportunity to expand the continuum of care for the elderly.\textsuperscript{30}

The DAAA's program goals were to prevent unnecessary hospital readmissions and prevent unnecessary institutionalization in long-term care facilities. To achieve these goals, a program was implemented to support
and improve non-institutional long-term care. The program activities focused on the coordination of case management and discharge planning for elderly patients returning to the community with difficult problems. The coordination of these care services by the case manager prevents duplication of effort and ensures the most efficient use of scarce resources. Sizemore, Bennet, and Anderson felt that home based services reduced the demand for costly institutionalized care while maintaining the elderly in non-institutional community environments. Inspite of programs like the one listed above, community and home-based long-term care and in-home support services were the two main health care and supportive service needs of elders, now and in the future, that were currently not being met.

Jamieson, Campbell, and Clark in their study cited an example of community based services in their study of the St. Anthony Park Block Nurse Program. This community-based program, drew upon the professional and volunteer services of local residents to provide nursing and other services to elderly neighbors who might otherwise have been admitted to nursing homes. Older people, who may have been admitted to institutional care in the past, may now live in their own homes or in alternative community settings through the use of personalized case management services.

Most people who successfully resolve their problems do so by first drawing on some type of aid from informal sources: family, friends and neighbors. These informal
sources are backed up by needed, available, additional aid from formal agencies and organizations.\textsuperscript{28} It was found that "...where formal care predominated, the level of total care is significantly lower than it is where informal care predominates".\textsuperscript{2} However, there existed a point beyond which families could no longer provide informal services, and formal care was clearly needed.\textsuperscript{2}

Morris and Morris felt formal services should be complementary to informal services and not replace the informal support system.\textsuperscript{2} It would not be advisable to develop a system totally dependent on formal services because this would reduce informal support. Most elderly people living in the community received informal support from one source or another.\textsuperscript{21} The primary helper in most cases was the elders' spouse. Other informal helpers included children, other relatives, and friends. Only a small portion of the elderly population could not identify at least one informal helper.\textsuperscript{2} "Canadian studies indicate that home services do not decrease family involvement with elderly relatives, a reflection of the substantial contribution families make towards enabling their elderly members to remain at home."\textsuperscript{35}

Typically, however, users of community based services had a narrower social support system. Even when informal support was in place the care giver needed a respite and if they were unaware of available community services it could be difficult to obtain the needed relief.
The argument that formal services, when appropriately targeted, can reduce the risk of high-cost institutional placements goes as follows: The risk of impairment status is buffered, informal supporters do not become overburdened or disillusioned, and the overall reality of the individual support network is extended over a wider array of supporters.2

Here the term "compliance" will be used and defined as the extent to which an individual chooses behaviors that coincide with a clinical prescription.36 In addition, to perceived susceptibility, severity, efficacy, barriers and modifying factors, internal (somatic) or external (social or cultural) cues must be present and strong enough to trigger an individual to act.37 The most well established health care regimens are worthless if a patient chooses not to comply with the recommendations of the health care system. To some individuals, compliance is a non rational choice on the part of the patient to yield to the tyrannical dictates of medicine. The alternative term "adherence", has been suggested by those contending it has less of an authoritarian tone and implies a willingness on the part of the patient to participate with the prescribed regimen.36

Compliance was related to the readiness to take action. The state of readiness to take action resulted from perception of the health threat and health motivation. Health threats consisted of the belief in personal susceptibility to a disease and the belief that it would
have a moderately severe effect on some aspect of their life.\textsuperscript{36}

According to Redeker these modifying factors, included demographic variables, sociopsychological variables, and structural variables (i.e. knowledge about the disease). Psychosocial adjustment to illness, health locus of control, self-concept, social support, and various aspects of the "doctor-patient" relationship are a few of the sociopsychological variables. These variables influence an individual's readiness to take action.\textsuperscript{36}

Health beliefs are an individual's perception of the relationships between wellness and disease and the actions taken to maintain or restore wellness \textsuperscript{35}. These beliefs have influenced the elderly's perceptions of the necessity for community based services. Attention has been given to community based services at this time in an attempt to control increasing health care costs, prevent hospital admissions and facilitate early discharges. A study was done by M. Jackson which examined the use of community support services by elderly patients discharged from geriatric medical and general medical wards of an acute care hospital. This study looked at the types of community support services, the length of time these services were used and the level of patient and family satisfaction with the services provided.\textsuperscript{35} The types of services explored in Jackson's study included: district nurse, homemaker services, meals-on-wheels, hospital day centers,
warden/community visitor service, physical therapy, physician visits, families and others, abuse, and medications. Other than studying similar community based health care services, this research done by Jackson took a different direction than did our study. Jackson researched the length of time community based health care services were utilized by the elderly.

Upon reviewing the literature the authors found that there was an abundance of information on compliance, case managers, and case management related to health care for the elderly. There was some information on the need for services for the elderly, factors affecting utilization of services by the elderly, cost containment measures for health care expenditures, informal and formal care services for the elderly. With extensive searching the authors found that information was very limited on the subject of utilization of community based health services and home based services by the elderly. Therefore, the authors felt that more research needed to be done on the elderly's utilization of community based health services and home based services.

**IMPLICATIONS FOR STUDY**

The authors of this project expected to support their research question that the elderly were not utilizing community based health care services at the same rate as
they were referred to the services following discharge from the hospital.

If services were under-utilized, the impact on the elderly population would be negative. More elderly would be admitted to hospitals, become dependent on family members and eventually end up in long term care facilities. Also the cost for symptomatic care would continue to increase. There was a possibility that a service was not being utilized because the elderly were unaware of the services' existence. Results from a questionnaire about utilization of community based health care services may indicate that the elderly are unaware of services available to them or do not know where to go for services on their own. Hospitals, case managers, doctors, senior centers, health care services, and the elderly community would benefit from reviewing this study or other similar studies.

STATEMENT OF RESEARCH QUESTION

The well elderly utilized community based health care services less than they were referred to these services.

DEFINITIONS

WELL ELDERLY = "They are vigorous and competent men and women who have reduced their time investments in working or homemaking. They are relatively comfortable financially, relatively well-educated and well-integrated members of their families and their communities"
COMMUNITY BASED HEALTH CARE SERVICE= a health service provided in the community for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.  

HOME CARE= a health service provided in the patient's place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. Service may include such elements as medical, dental, nursing care, speech and physical therapy, the homemaking services of a home health aide, or the provision of transportation.

PHYSICAL THERAPY= assists clients with musculoskeletal problems using various modalities.

OCCUPATIONAL THERAPY= the use of purposeful activities with individuals to maximize independence, prevent disability, and maintain health.

SPEECH THERAPY= treatment of abnormalities of speech and with disorders that affect normal oral communication, and information processing.

MENTAL HEALTH= treatment of mental disorders.
SKILLED NURSING= provision of "patient assessments, administration of medications and change of dressings". 11

HOME HEALTH AIDE= provides personal hygiene care to clients. 11

HOMEMAKER= provide services such as light housekeeping, grocery shopping, doing laundry and performing other errands. 9

MEAL PROGRAMS= the delivery of prepared meals to people in their home. 11

COMPLIANCE= The extent to which a person's behavior coincides with health care advice. 42 The regimen must be achieved through negotiations between the health care professional and the patient. 43

LONG-TERM CARE= Consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and non-institutional health settings, including the home, with the goal of promoting the optimum level of physical, social and psychological functioning. 12
ADULT DAY CARE= A structured, comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day, but less than 24-hour care. It assists the participants to remain in the community, thus enabling families and other care givers to continue caring for an impaired member at home. The ultimate goal of rehabilitation in adult day care is to promote the participant's highest level of independence and functional ability.44
CHAPTER 3

METHODOLOGY

STUDY DESIGN

The research design of this study was retrospective and descriptive in nature. A polling of 20 well elderly individuals who were participants of area senior centers was done. The senior centers included in the study were Evergreen Commons in Holland, the Downtown and Roosevelt Park Senior Neighbors in Grand Rapids, Grandville Senior Neighbors in Grandville, and Sparta Senior Neighbors in Sparta. Selection of individuals from these sites represented a sample of convenience.

STUDY SITES

The senior centers used in this study, provide a full range of services for their members. Social activities, health prevention and screening activities comprise the major services provided by the senior centers.

SUBJECTS

The population consisted of 176 questionnaires collected from the respondents. However, the sample size was limited to twenty questionnaires that fulfilled the inclusion criteria for this study. The participant sample consisted of well elderly individuals 60 years of age and older. Sixty years of age is the age at which an
individual may become a member at the Evergreen Commons senior center and Senior Neighbors Incorporated. Individuals were eligible to complete the questionnaire if they were age 60 or over, had been hospitalized for at least two days sometime during 1990, 1991, or 1992, and had been referred to at least one community based health care service by an authorized referral source. Twenty respondents met the above criteria and thus completed the questionnaire.

**INSTRUMENT**

A pilot study was conducted as a pretest for the questionnaire. Some clarifications were required to insure a proper response by the individual surveyed. Therefore, the necessary revisions were made on the questionnaire. The devised questionnaire (appendix A) was an 18-item instrument that surveyed the use of community-based health care services by well elderly individuals. Questions were designed with yes, no and check all that apply response options. The questionnaire was designed to use recognition instead of recall when referring to services used. The use of recognition, was used in an attempt to combat possible memory problems of respondents when referring to types of services received.

The research project methodology is replicable because a questionnaire was used. The use of a statistically valid pilot study would assist in determining the degree of validity and generalizability of the questionnaire.
PROCEDURE

The authors of this project developed a questionnaire that looked at the elderly's utilization of community based health care services. Approval was received from committee members and the Grand Valley State University Human Resources Review Board. Experts in the field of geriatrics in West Michigan were consulted about appropriate sites for questionnaire distribution. Recommended sites were contacted by telephone and letter to obtain permission to use the facility as a questionnaire distribution resource. Verbal and written contact with the director of the facility allowed any questions regarding the study to be answered by the authors. Verbal consent from each senior center director was obtained. The project was announced in Evergreen Commons Senior Centers' newsletter, which was distributed to the centers' members. The listing included the date the authors would be at the appropriate senior center, what the project was about and the request for participants to answer a questionnaire. The directors at each Senior Neighbor Incorporated facility introduced the project verbally to their members prior to questionnaire distribution. Letters were mailed or phone calls were made to the director of each center prior to the date the questionnaire was distributed. This process confirmed the dates and times the questionnaires would be distributed at
the center. In January and February 1993, questionnaires were hand distributed and collected at the specified senior centers. The benefit of hand distribution of the questionnaires was that it enabled the participants to address any questions about the study or the questionnaire directly to the authors of the project.

Individuals willing to participate in this study were asked to sign an informed consent form (appendix B). This form preceded the first page of the questionnaire, and stated the release of information and the right to confidentiality of the respondents. The consent forms were not attached to the questionnaires. Also, the names of the respondents were not placed on the questionnaires, therefore, names were not used in the study. As subjects agreed to participate, each questionnaire was assigned a study number. The purpose of this was to ensure confidentiality.
CHAPTER 4
TECHNIQUES

The services of a statistical consultant were obtained to aid in statistical analysis and data compilation. It was determined through discussion with the statistical consultant that summary statistics were appropriate for data analysis. The consultant determined that statistical inferences were not appropriate secondary to small sample size and a non-random sample. For a statistical test such as a Chi-square to be applied, a sample must be larger than 30 and random.

CHARACTERISTICS OF SUBJECTS

Well elderly in the West Michigan area from the Senior Neighbors Senior Centers in Grand Rapids, Grandville and Sparta were surveyed for this study. Data was also gathered from the Evergreen Commons Senior Center in Holland. A total of 20 people completed a questionnaire for this study. Our demographic categories included gender, age, race, education level and facility. Elderhostel Inc., and the facilities surveyed require a person to be 60 years of age or older. The inclusion characteristics for our subjects were set at 60 years of age or older, hospitalization for at least 2 days sometime during 1990, 1991, or 1992, and referral to a community based health service as a result of the most recent hospitalization.
Analysis of gender indicated that of the 20 respondents, 14 were female, which comprised 70% of the respondent sample and 6 were male, which comprised 30% of the respondent sample. Analysis of age revealed that the average age of the respondents was 73.6 years of age.

The questionnaire categories of race included Caucasian, Black, Hispanic, Asian, American Indian and Other. Results from the survey data indicated that 90% of the respondents were Caucasian and 10% were Black. The West Michigan area was not as ethnically diverse as the United States population according to the 1990 Census. (Table 1)45,46

**QUESTION**

What was the utilization of community based health services by the well elderly following discharge from the hospital in 1990, 1991, and 1992?

**RESPONSE TO THE RESEARCH QUESTION**

The well elderly utilized community based health care services less than they were referred to these services.

**RESULTS**

Services identified as necessary, by a health care professional, to meet the needs of the patient at discharge were compared to actual utilization of services by the respondents. Summary statistics were used to analyze the results. (Table 2) Clinical physical therapy, clinical occupational therapy, clinical speech therapy, and clinical mental health services were utilized at the same rate that
they were referred for the sample. All other services that were looked at were not used at as high a rate as they were referred.

Services to which a patient was referred were compared to services a patient felt were necessary at the time of discharge. (Table 3) Summary statistics were used to analyze the data. Data implied that it was likely that categories of home physical therapy, clinic occupational therapy, and clinical speech therapy were identified as needed as often as they were referred for the sample. The remaining services were not felt to be needed as often as the respondents were referred to the services.

Services a patient felt were necessary at the time of discharge for recovery were compared to services utilized following discharge. (Table 4) For the sample surveyed, the following services were utilized as often as they were felt needed, these include clinical occupational therapy, clinical mental health, home health aide and other.

OTHER FINDINGS OF INTEREST

Results from the questionnaire indicated that while in the hospital, a health care professional was present at the time of admission or shortly after to help with discharge planning and post-hospitalization care 70% of the time.

When referred services were compared to services utilized the following trends were found for the sample. Clinically based services were utilized at the same that they were referred. Statistics for clinical physical
therapy were four out of four, clinical occupational therapy were two out of two, clinical speech therapy were one out of one, and clinical mental health were two out of two for the studied sample. The services not utilized at the same rate to which they had been referred included all home services studied. Home physical therapy was utilized one out of three times, transportation three out of four times, skilled nursing services seven out of eleven times, home health aide three out of five times, homemaker services two out of six times, meal programs two out of three times, and medical supplies and equipment four out of five times. Home occupational therapy was not utilized, however, it was referred two times. Home speech and home mental health were not referred nor utilized. One person out of sixteen who indicated they had not been referred to clinical physical therapy utilized the service.

The data was suggestive that even though a patient felt that home physical therapy was necessary, three out of four times it was not utilized by our sample. Data on physical therapy in a clinic suggested that in three out of four cases the respondent indicated that the service was necessary at discharge and was utilized after returning home. Clinical occupational therapy data suggested that if the respondent did not feel the service was needed it was not used and if the respondents felt it was necessary the service was utilized. The data suggested that four out of six respondents utilized transportation and two out of three
three utilized meal program services if they felt the service was needed. Skilled nursing services data suggested that a respondent utilized this service five out of six times if they felt it was necessary. The Home health aide data suggested that respondents used this service four out of four times when they felt it was needed. Homemaker data suggested that two out of four respondents utilized the service if they felt it was required. Home occupational therapy and home speech therapy data suggested that no one felt the need for the services and these services were not utilized. Clinical mental health data suggested the one respondent used this service the time they felt it was necessary. Three out of six times, medical supplies were utilized by individuals when they felt the service was necessary.

A comparison was made between what services were identified to meet a patient's needs and what services the patient felt were needed at discharge. Overall, the majority of the respondents agreed with the assignment of services. The categories of home speech, and home mental health were neither identified as being needed nor felt to be needed by the respondents. Home occupational therapy was not felt to be needed by any of the respondents.

Respondents were asked if they still received the services they utilized. There were slightly less than half who indicated that they no longer received the services and
slightly more than half indicated that they did still receive the service.

Of the 19 respondents who indicated they were no longer using services, two which was 10.5% of the people did not respond to why they were not using the service any longer, five or 26.3% of the respondents felt they no longer needed the service, three which was 15.8% lacked funds, 5.3% of the referrals or one respondent was discontinued by the physician. Health care providers discontinued treatment in 15.8% or three of the cases, and five which is 26.3% of the respondents indicated other as the reason for no longer using a service.

If a person was referred by a health care professional to a service and never used it, approximately a quarter of the people who responded to this question indicated lack of transportation and financing. Approximately three quarters of the respondents felt the service was unnecessary.

When asked whether care was received from a non-health care professional, approximately two thirds of the people (n=20) indicated that they had received care from a non-health care professional and approximately one third (n=20) indicated no non-professional care was received. The respondents were asked who provided the non-professional care that they received. The spouse provided care in 25% of the cases. In the rest of the cases 15% responded daughter, 10% son, 5% friend, and 15% other. Thirty percent of the respondents did not mark this question. When asked if the
non-professional care giver received formal training, 30% of the respondents indicated yes and 35% indicated no. The other 35% did not indicated a response to this question.

When asked whether the responsibility of the non-professional care had changed from one person to another, 35% indicated no change. Of the 65% of the respondents that indicated yes, 5% stated the change was due to time constraints, 55% indicated exhaustion, and 5% indicated health problems of the care giver as the reason for a change in the non-professional care giver.

The respondents indicated that in 20% of the cases non professional care decreased when professional services began. Thirty-five percent of the respondents indicated that non professional care did not decrease, 10% indicated that this question did not apply to them, and 35% of the respondents did not answer this question.
CHAPTER 5
DISCUSSION

The pilot study conducted only consisted of 4 surveys, which did not meet criteria for statistical validity due to the limited number. A sample of 20 or greater is required for statistically valid analysis to be performed using a Fisher exact test (1-tail). A sample of 30 or more respondents is desirable for a survey of this nature to decrease the likelihood that the probability of chance would influence the results.

The respondents were not as ethnically diverse as was desired for this study. This is due to the fact that the west Michigan population is less ethnically diverse than the national population. (Table 1) The participants who responded to our questionnaire were predominantly white.

The Jackson research article mentioned in the literature review looked at the types of health services used and the family satisfaction with community support services by the elderly. The patients had been discharged from geriatric medical and general medical wards of acute care hospitals. In comparison, Jackson researched the length of time services were utilized following discharge while in our study, we limited our focus to whether or not services were utilized following discharge.
Our findings related to informal caregivers were similar to those identified in an article by Morris and Morris. In the article they noted that only a small portion of the elderly were unable to identify at least one informal caregiver.²

The definition of utilization in this study was based on the use of services to which a person had been referred. Therefore, clinical based services looked at in our study were utilized at the same rate that they were referred and the other services were under utilized. The services that were under utilized by our sample were home setting physical therapy, home setting occupational therapy, transportation services, skilled nursing services, home health aide services, homemaker services, meal programs, and medical supplies and equipment. If the person felt that they needed the services to which they had been referred, there was still under utilization of the services. The exceptions were clinical occupational therapy, and home health aide, which were both utilized at the same rate the respondents felt services were necessary. When services were under-utilized, this may have been due to the fact that the person was not referred to the service and therefore was unable to utilize that service.

The trends found in this study suggested that services based in a clinic were more likely to be utilized than home services. Trends also implied that clinical mental health services were only used when the patient felt they were
they were needed. This supports Raschko's theory that there is a stigma that is associated with mental health services.¹⁸

There was some variance in the services a person was referred to and the services they felt were needed. This could influence the utilization of services. A feeling by the respondent that the service was not needed was the most frequently indicated reason for not using a service to which they had been referred. If a person does not feel that they need a service, they will be less likely to use that service. This is related to the health belief that an individual has which was discussed by Jackson.³⁵ Other reasons stated by the respondent for not using a service included lack of transportation, and lack of financing.

After reviewing our results, we determined that our research statement was highly likely to be supported for services other than clinically based services. This study revealed that there was inconsistency in utilization of the community based health services by the elderly population.

APPLICATION TO PRACTICE/ADMINISTRATION/EDUCATION

As a result of this study there were applications drawn that would enhance the field of practice, administration, and education. It became clear that there was a need for education of allied health professionals as well as physicians and nurses in the area of Gerontology. The health care system needed to focus on prevention rather than treatment of symptoms. Also, physicians would benefit from
education about various services that community health care services can provide. The elderly need to be educated about services that are available. A way to accomplish this would be to have health care professionals speak to seniors in the community and provide literature on available services.

One application to administration would be the need for a change in the reimbursement system. Reimbursement has been focused toward institutional care in the past and many elderly would benefit from increased reimbursement for home and community based health services. The information gleaned from a research study of this nature if implemented would allow for administration to allocate funds for home and community based health services based on the communities that would benefit most from the funds. Also funds could be targeted toward services that would be most beneficial to the community.

Due to under utilization of services, an application to practice would be the development of a follow up program for seniors to assure that they are receiving appropriate services for their needs. More research needs to be done on factors that affect the elderly's utilization of home care and community based health services in order to educate health care professionals about the factors affecting utilization.

A tool that community based health services could use to educate the community about available services would be the development of a service handbook. This type of a
resource could also be of use to health care professionals who are responsible for discharge planning for elderly clients.

**LIMITATIONS**

The limitations found in this study included a small sample size that was not a representative distribution of ethnic groups found in the United States, and was non-random. According to an authority in Geriatrics it has been perceived that a lower percentage of the population in the West Michigan area used alcohol and tobacco than in the general population which could decrease the incidence of health problems. The demographics in the area of study were primarily rural. West Michigan was not considered to be an economically diverse area, but the poor in this area have a higher standard of living than in other areas of the country according to an expert in the field of Geriatrics.

A design flaw in the study due to the setup of the questionnaire was present. There was a possibility that respondents had varying interpretations of questions on the questionnaire. A sample of convenience was utilized, which was non-random. Also, there was a loss of data secondary to the unwillingness of some seniors to sign the consent form. The use of Evergreen Commons Senior Center also biased our study because it is a model site. A limitation was that a limited pilot study was conducted. Another limitation is that the sample size was small, making statistical analysis beyond summary statistics inappropriate. Therefore,
implications could not be generalized to the population as a whole. Another factor that could possibly limit this study is that the respondents may not have marked services that they felt they needed due to the fact that there was no initial referral to that service from a health care professional.

SUGGESTIONS FOR FURTHER RESEARCH/ MODIFICATIONS

After working through the process of developing a research project, some modifications that would improve the quality of this study are as follows. The results from this study would be generalizable to the overall population if a random sample of elderly participants were surveyed through mailings. This would broaden the scope of the study to include a sample that is ethnically diverse. In the design of the questionnaire, persons should be allowed to continue with the questionnaire even if every question is not applicable to them. To validate the responses to the questionnaire, it would be beneficial to access hospital records. This would allow the researchers to document exactly what services were recommended to the patient following discharge. A modification that should be made for clarity would be to change the word Caucasian to White on the questionnaire because some respondents were confused by this term. A way to help clarify the questionnaires would be to personally interview each respondent and address each question to ensure completeness and accuracy of the responses.
Research provides a catalyst for further research. This study raises many questions and opens doors for research in a variety of areas. Some suggestions for further research include:

1. Look at specific age groups within the elderly population to see if there are differences in the utilization of services.

2. Mail out questionnaires to target the population of elderly that may still be homebound and using or not using community based services.

3. Contact physicians and determine their knowledge about community based health services that are available.

4. Research to explore services available in the community for the elderly.

5. Obtain hospital records about community based health care services referred to either independently from the questionnaire or as a supplement to the questionnaire.

6. Look at people requiring services who were not hospitalized.

7. Investigate the insurance packages that elderly people have and the compensation received for community based health services.

8. Investigate how services such as occupational therapy and physical therapy as well as other community based services go about educating the public about their services.

9. Investigate the type of care given by informal caregivers.

10. Design a longitudinal study investigating the elderly populations use of health care at various periods in life.
REFERENCES


31 Schneider B. Care planning, the core of case management. *Generations*. Fall 1988:16-18.


Table 1

ETHNICITY

<table>
<thead>
<tr>
<th>RACE</th>
<th>West Michigan (Kent &amp; Ottawa Co.) (N=688,399)</th>
<th>United States (N=250,410,000)</th>
<th>West Michigan (Our Sample) (n=20)</th>
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</tr>
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<table>
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<th># (%) Referred to Service (n=20)</th>
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<td>Home Physical Therapy</td>
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<td>Clinic Physical Therapy</td>
<td>1 (6.25%) out of 16</td>
<td>4 (100.00%) out of 4</td>
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<td>Home Occupational Therapy</td>
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<td># (%) Referred to Services</td>
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<td>Home Health Aide</td>
<td>1 (5.88%) out of 17</td>
<td>3 (60.00%) out of 5</td>
</tr>
<tr>
<td>Homemaker</td>
<td>0 (0.00%) out of 16</td>
<td>4 (66.67%) out of 6</td>
</tr>
<tr>
<td>Meal Program</td>
<td>1 (5.56%) out of 18</td>
<td>3 (75.00%) out of 4</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>2 (11.76%) out of 17</td>
<td>4 (80.00%) out of 5</td>
</tr>
<tr>
<td>Other</td>
<td>1 (5.00%) out of 20</td>
<td>0 (0.00%) out of 1</td>
</tr>
<tr>
<td>Services</td>
<td># (%) Who Felt Service Unnecessary (n=20)</td>
<td># (%) Who Felt Service Necessary (n=20)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Home Physical Therapy</td>
<td>0 (0.00%) out of 16</td>
<td>1 (25.00%) out of 4</td>
</tr>
<tr>
<td>Clinic Physical Therapy</td>
<td>2 (12.50%) out of 16</td>
<td>3 (5.00%) out of 4</td>
</tr>
<tr>
<td>Home Occupational Therapy</td>
<td>0 (0.00%) out of 20</td>
<td>0 (0.00%) out of 0</td>
</tr>
<tr>
<td>Clinic Occupational Therapy</td>
<td>0 (0.00%) out of 18</td>
<td>2 (0.00%) out of 2</td>
</tr>
<tr>
<td>Home Speech Therapy</td>
<td>0 (0.00%) out of 20</td>
<td>0 (0.00%) out of 0</td>
</tr>
<tr>
<td>Clinic Speech Therapy</td>
<td>0 (0.00%) out of 18</td>
<td>1 (50.00%) out of 2</td>
</tr>
<tr>
<td>Home Mental Health</td>
<td>0 (0.00%) out of 20</td>
<td>0 (0.00%) out of 0</td>
</tr>
<tr>
<td>Clinic Mental Health</td>
<td>1 (5.26%) out of 19</td>
<td>1 (100.00%) out of 1</td>
</tr>
<tr>
<td>Transportation</td>
<td>1 (7.14%) out of 14</td>
<td>4 (66.67%) out of 6</td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>2 (14.29%) out of 14</td>
<td>5 (83.33%) out of 6</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>0 (0.00%) out of 16</td>
<td>4 (100.00%) out of 4</td>
</tr>
<tr>
<td>Homemaker</td>
<td>0 (0.00%) out of 16</td>
<td>2 (50.00%) out of 4</td>
</tr>
<tr>
<td>Meal Program</td>
<td>0 (0.00%) out of 17</td>
<td>2 (66.67%) out of 3</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>2 (14.29%) out of 14</td>
<td>3 (50.00%) out of 6</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0.00%) out of 19</td>
<td>1 (100.00%) out of 1</td>
</tr>
</tbody>
</table>
APPENDIX A

Questionnaire for the "well" elderly

Personal Information:

Sex: 1. Male _____ 2. Female _____

Age: _____

Race: 1. Caucasian _____
2. Black _____
3. Hispanic_____ 
4. Asian _____
5. American Indian _____
6. Other_____.

Highest Education Level: 1. Elementary School _____
2. Junior High School _____
3. High School _____
4. Vocational Training _____
5. College _____

Job at time of retirement (please state)__________________.

Facility: 1. Evergreen Commons _______.
2. Downtown Center _______.
3. Grandville Senior center_______.
4. Roosevelt Center________.
5. Sparta Senior Center_______.

1. Were you hospitalized for a period of two days or longer during 1990-1992?
   _____1. Yes
   _____2. No If No, do not go any farther. Please turn in questionnaire.

2. In what year was your most recent hospitalization?
   _____1. 1990
   _____2. 1991
   _____3. 1992
3. Did a health care professional refer you to outpatient community based health services such as:

1. Physical Therapy
2. Occupational Therapy
3. Speech Therapy
4. Therapeutic Recreation
5. Skilled Nursing services
6. Transportation services
7. Home Health Aide services
8. Meal Programs
9. Medical supplies and equipment after discharge?

_____1. Yes
_____2. No If No do not go any farther. Please turn in questionnaire.

For the following questions please respond with your most recent hospitalization.

4. While you were hospitalized what rehabilitation services (listed below) were you receiving in the hospital? Please mark each one that applies.

_____1. Physical Therapy
_____2. Occupational Therapy
_____3. Speech Therapy
_____4. Therapeutic Recreation
_____5. Skilled Nursing Services
_____6. Counseling
_____7. Other (please list) ________________________________.

5. Was there a person assigned to you in the hospital who was responsible for advising you about your discharge and post-hospitalization care?

_____1. Yes
_____2. No
_____3. Do not know
6. At the time of admission or shortly after was there a health care professional to help you with discharge planning and post-hospitalization care?

1. Yes
2. No
3. I do not know

7. What services were identified to meet your needs after discharge? Please mark each one that applies.

1. Home setting Physical Therapy
2. Physical Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
3. Home setting Occupational Therapy
4. Occupational Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
5. Home setting Speech Therapy
6. Speech Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
7. Home setting Mental Health services
8. Mental Health Services in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
9. Transportation services
10. Skilled Nursing Services
11. Home Health Aide
12. Homemaker
13. Meal programs such as meals on wheels
14. Medical supplies and equipment
15. Other (Specify)
8. What services did you feel you needed at discharge? Please mark each one that applies.

___1. Home setting Physical Therapy
___2. Physical Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
___3. Home setting Occupational Therapy
___4. Occupational Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
___5. Home setting Speech Therapy
___6. Speech Therapy in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
___7. Home setting Mental Health services
___8. Mental Health Services in Clinics (Hospitals, Hospital satellite sites, private practices, etc.)
___9. Transportation services
___10. Skilled Nursing Services
___11. Home Health Aide
___12. Homemaker
___13. Meal programs such as meals on wheels
___14. Medical supplies and equipment
___15. Other (Specify) ________________________________
9. Before your release from the hospital who contacted the agencies to provide services for you after discharge? Please mark each one that applies.

1. Discharge Planning Nurse
2. Social Worker
3. Family Member
4. Client(yourself)
5. Case Manager
6. Other (please specify)_________________________.

10. Once at home what services of those identified by the health care professionals as being needed did you utilize? Please mark each one that applies.

1. Home setting Physical Therapy
2. Physical Therapy in Clinics(Hospitals, Hospital satellite sites, private practices, etc.)
3. Home setting Occupational Therapy
4. Occupational Therapy in Clinics(Hospitals, Hospital satellite sites, private practices, etc.)
5. Home setting Speech Therapy
6. Speech Therapy in Clinics(Hospitals, Hospital satellite sites, private practices, etc.)
7. Home setting Mental Health services
8. Mental Health Services in Clinics(Hospitals, Hospital satellite sites, private practices etc.)
9. Transportation services
10. Skilled Nursing Services
11. Home Health Aide
12. Homemaker
13. Meal programs such as meals on wheels
14. Medical supplies and equipment
15. Other(specify)____________________________.
11. Do you still receive these services? Please circle appropriate response either home or clinic. Please mark each one that applies.

Yes  No

___  1. Outpatient Physical Therapy (Home/Clinic)
___  2. Outpatient Occupational Therapy (Home/Clinic)
___  3. Outpatient Speech Therapy (Home/Clinic)
___  4. Outpatient Mental Health services (Home/Clinic)
___  5. Transportation services (Home/Clinic)
___  6. Visiting nurse Services
___  7. Homemaker
___  8. Home Health Aide
___  9. Meal programs such as meals on wheels
___ 10. Medical supplies and equipment
___ 11. Other (specify) ________________________.

If you marked No in any part of question #11 please go to question #12. Otherwise go to question #13.

12. If you are not still using services, mark all the reasons for discontinuing.

___ 1. did not feel you needed the service any more.
___ 2. lack of funds to continue service.
___ 3. referral discontinued by physician.
___ 5. treatment did not appear to be helping.
___ 6. transportation is no longer available.
___ 7. Other (specify) ________________________.
13. If you were referred or suggested by health care professionals to a service and never used it please state the reason why the service was not used? Please mark all that apply.

____ 1. lack of transportation
____ 2. financial consideration
____ 3. felt service was unnecessary
____ 4. services unavailable in the area
____ 5. waiting list
____ 6. prefer care provided by a non-professional care giver.
____ 7. Other(Specify)______________________________________.

The rest of the questions on the questionnaire refer to care given by non-professionals.

14. Have you received care from individuals who were not health care professionals?

____ 1. Yes
____ 2. No  If No do not go any farther. Please turn in your questionnaire.

15. Who provided the non professional care that you received or are currently receiving?

____ 1. spouse
____ 2. daughter
____ 3. son
____ 4. other relative
____ 5. friend
____ 6. Other(Specify)____________________.

16. Was the person indicated in question 15 given any formal training by health care professionals in the care they gave to you?

____ 1. Yes
____ 2. No
____ 3. I do not know
17. Has the responsibility of your non professional care changed from one person to another?

____1. Yes (If yes please mark why.)
____2. No

Why the non professional care giver changed.

____1. lack of time  
____2. exhaustion  
____3. relocation  
____4. health problems  
____5. Other (Specify) _______________________.

18. If you received community based health care professional services has the non professional care you received decreased since you began receiving these services?

____1. Yes  
____2. No  
____3. Does not apply

PLEASE RECHECK THE QUESTIONNAIRE TO MAKE SURE ALL YOUR ANSWERS ARE CORRECT AND THAT ALL OF THE QUESTIONS WERE ANSWERED. THANK-YOU FOR PARTICIPATING IN OUR STUDY.
APPENDIX B

CONSENT FORM

Description of Study:

This study is being conducted for partial fulfillment of the requirements for the degree Master of Science of Physical Therapy at Grand Valley State University. The title is: Utilization of Community Based Health Services by the Well Elderly.

This is a study designed to evaluate the utilization of community based health services by the elderly. It is also to make providers of community services aware of the positive and negative factors that affect utilization of services by the elderly population.

I understand:

1. The purpose of this research project.

2. If I agree to participate in the study I will agree to fill out a eight page questionnaire.

3. All information will be kept confidential and identification of individuals will not be possible.

4. There is no mental or physical risk associated with answering the questionnaire.

5. Information from this study may be published in a scientific journal.

6. I am free to ask any questions regarding the study.

7. I am free to withdraw from this study at any time without any prejudice directed toward myself.

I acknowledge that I have read and understand the above information, and that I agree to participate in this study.

______________________________  ______________________________
witness  Participant's signature

______________________________  ______________________________
date  date

___I am interested in receiving a summary of the study results.
Rachelle Hesselberg attended Washtenaw Community College from September 1986 to May 1989 with a Presidential Honor Scholarship. At Grand Valley State University she received a Bachelor degree in Health Science in May 1991. She will receive her Master of Science in Physical Therapy in May 1993 from Grand Valley State University.

Kristen Wagner received her Bachelor degree in Health Science from Grand Valley State University in 1990. She will graduate with a Master of Science in Physical Therapy in May 1993.

Yolanda Zimmerman received her Bachelor degree in Health Science from Grand Valley State University in 1991. She will graduate with a Master of Science in Physical Therapy in May 1993.