HEALTH CARE NEEDS OF OLDER ADULTS: A SURVEY

A THESIS

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Concern for the needs of the aged has become widespread in recent years. The rapid growth of the aging population, along with the problems associated with longevity, have brought into focus as issue which requires planned action to meet the many needs of America's older people.

One of the large areas of need for older people is health care. The seventh, eighth, and ninth decades of life often bring both personal deterioration and social losses which can result in a steady progression toward the "illness" component of the health-illness continuum. The current health care delivery system fails to provide adequate means of meeting the health needs of elderly persons. Eighty percent of the older adults suffer from chronic conditions but are treated in hospitals designed for the acutely ill. Still others of the older population are placed in nursing homes because of impaired functional abilities. The greatest need for meeting the health needs of the elderly lies in providing a continuum of services that will enable the person to function optimally within his own environment.

Home health care has the potential for bridging the gap between acute care and long-term institutional care. It is designed to bring to the home of older and disabled persons the medical, nursing, and supportive services that are needed to promote optimal health, and thus to postpone or prevent the need for care in an institution. In 1975 only 2,254 home health agencies that participated in Medicare existed in the United States (Department of Health, Education and Welfare 1976a). Until these services are made available to all American people, the gap in health care services will continue to exist. It is hoped that this study will be instrumental in discovering health needs of the elderly so that a home health service can be established to meet those needs.

Statement of the Problem

The problem of this study is to determine health care needs of persons 65 years of age and older living within the community which could be met by home health services.

Statement of the Purposes

The purposes of this study are to:

1. Identify the health care needs of older persons in five parameters as follows:

a. health condition
b. ability to perform activities of daily living
c. ability to obtain medical care when needed
d. social isolation
e. service needs, such as ability to obtain meals or transportation.

2. Determine the relationships between health problems and demographic data.

Background and Significance

Throughout the history of mankind, people in need of help during illness and disability have remained in their homes for a great proportion of the time. Even today, with the sophistication of diagnostic and treatment services available to institutions, a great need for health care outside of these facilities still exists (American Public Health Association 1974). The emphasis on promoting health and assisting people to achieve maximal health potential creates even a greater need for a system that provides health care outside of institutional walls.

Longevity, and the problems associated with it, indicates yet another reason for bringing health care into the home. In America in 1972, the life expectancy for the male was 67.4 years and for the female, 75.2 years

(Department of Health, Education and Welfare 1976b). Three years later these figures have risen to 68.5 years for the male and 76.4 for the female (U.S. Department of Commerce 1976). Because people are living longer, the older population is growing proportionately faster than the remainder of the population. During the 1960-1970 decade, the general population increased by 15 percent in contrast to an increase of 34.1 percent of people 65 years of age and older (American Medical Association 1972).

In 1971 the White House Conference on Aging convened to identify needs of older Americans and to make recommendations for meeting those needs. Health of the aged was one of the concerns of the conference members. Not only were physical and mental health considered, but also many health related services.

The report from this conference on physical and mental health of the elderly stated that the United States must guarantee health care as a basic right to all its older people. A quality of life consistent with what Americans expect should be assured to this group. The report stipulated that for health care to be comprehensive and systematic, it must provide:

1. assessment of health
2. education to preserve health

3. appropriate preventive and outreach services

4. all physical, mental, social, and supportive services necessary to maintain or restore health

5. rehabilitation services

6. maintenance and long-term care when disability occurs (White House Conference on Aging 1973 p. 22).

The need for this type of care becomes even more apparent in the health statistics of the elderly. A 1975 report by the Department of Health, Education and Welfare (1976a) revealed that 17.6 percent of older persons have some degree of immobility. Brody (1973) stated that 81 percent suffer from chronic conditions. Only five percent of the aged are in institutions, and Shanas (1974) stated that 12 percent of the older persons at home are homebound or ambulate with difficulty. Two percent of the homebound are bedfast. Many of the infirm are being cared for by family members who, consequently, are unable to seek needed, gainful employment (Shanas 1974).

The Senate Subcommittee on Long-term Care noted that public policy has failed to produce satisfactory institutional care--or alternatives--for chronically ill older Americans, and that older people suffer severe emotional damage because of dread and despair associated with nursing home care. The committee also stated that

long-term care for older Americans stands as the most troublesome component of our entire health care system (Senate Subcommittee 1975).

The health effort in this country is largely oriented toward a crisis viewpoint--a strategy of diagnosis, treatment, and recovery (or death) for acute episodes (Hammerman 1974 and Brody 1973). While the aged have a need for acute medical care, their major requirement is in the continuum of services for the chronically disabled that will enable them to function optimally. Brody (1973) stated that any health system which continues to be limited to a disease orientation will not meet the needs of the aging community. Many of the health problems of the aging are marked by complex, non-specific etiology, chronicity, and impaired social functioning.

One of the factors responsible for the inadequate services to the aged is the emphasis on institutionalization (Tobin et al. 1972 and Katz et al. 1972). The traditional response to the presence of age and disability in the community has been to establish special institutions such as homes for the aged, asylums, nursing homes, and chronic and mental disease hospitals. The motives for such organizations, according to Katz et al. (1972), have been twofold; one of removing an inconvenience to society, and the other of providing special care.

Older persons fear, dread, and resist institutionalization (Tobin et al. 1972, Lawton 1974, Blenkner 1976, and Markus 1972). A social survey by Shanas (1962) revealed that almost all older people viewed a move to a home for the aged, or to a nursing home, with fear and hostility. They saw the move as a sacrifice of their independence and believed that the move was a prelude to death. Also, the older person interpreted the change as a rejection by his family.

Studies have been done to identify the effects of radical environmental changes on the psychological well-being and physical survival of the aged. Changes from home to an institution, or from one institution to another, have resulted in a sharp acceleration of morbidity and mortality rates (Aldrich and Mendkoff 1963, Blenkner 1967, and Markus 1972). Tobin and Lieberman (1976) demonstrated, through a longitudinal study, that physical and psychological changes begin occurring when an individual realizes the inevitability of institutionalization, and continue to progress for at least three months after entering the institution. After that time the person either begins to cope with the new situation or continues to deteriorate.

Brotman (1974) stated:

> The overwhelming majority of older people can easily manage in the community if society permits. They

> could manage even better if society would encourage such activity through the provision of essential services.

The validity of this statement is demonstrated in a study by Tobin et al. (1972) in which thirty-eight judges from three geriatric agencies determined that only two out of ten persons on a nursing home waiting list needed immediate admission. Recommendations for other types of services in the community were made for the remaining eight persons. A report of a health program for the home bound in New York revealed that at least 85 our of 116 patients were allowed to stay in their own homes as a result of home health care (Brickner et al. 1976).

Katz et al. (1972) did a longitudinal study of chronically ill patients discharged from a rehabilitation hospital who received health care in their homes for two years. The study led to an acceptance of the researchers' hypothesis that patients whose care is regularly supervised in their homes by a public health nurse will more often maintain or increase physical, psychological or social function than will patients whose care is not so supervised.

The need for home health care, with its multiple services, is extensive. Patients needing this service can be found, if sought, in any community. In 1975 the government recognized the need for an expanded system of health

care delivery and attempted to foster its growth by passing an amendment to the Public Health Service Act which included a section on home health services (Public Law No. 94-63 1975). This section provides the availability of grants to establish home health agencies in communities where such service is unavailable, or to expand the services of existing ones. However, unless professional people and others who see the need initiate action to establish such agencies, older and disabled persons will continue to have no choice but to accept institutionalization. As Traeger (1975) stated, institutionalization is being imposed on a far greater number of persons than is acceptable.

Rogers (1970 p. 86) stated:

> Nursing is concerned with people--all people--well and sick, rich and poor, young and old. The arenas of nursing's services extend to all areas where there are people: at home, at school, at work, at play; in hospitals, nursing homes and clinics; on this planet and now moving into outer space.

This perspective of nursing's broad concerns includes home health care for the aged and disabled. This type of health service can help provide the continuity of care that is written of so frequently in nursing literature, and can be a source of enabling chronically ill persons to maximize their health potential while remaining in the home atmosphere.

Definition of Terms

For the purpose of this study the following terms were defined:

1. Health care needs - five problem areas which directly or indirectly influence the health of a person:
    a. Health condition is concerned with the subject's reported illness during the past month, disability status, and the place of confinement during illness
    b. Physical functioning is defined as the person's capacity to perform activities of daily living; namely, going up and down stairs, getting out of the house, washing and bathing, dressing and putting on shoes, and feeding self
    c. Accessibility to medical care relates to the individual's ability or inability to obtain the services of a physician at the time of felt need
    d. Social isolation relates to the respondent's interaction with others by telephone contact, social visits, or participation in formal group activities

e. Service needs are related to the subject's ability to obtain meals and transportation (Managan et al. 1974)

2. Older persons; elderly - persons 65 years of age or older

3. Living within the community - residing in their own homes or in the homes of relatives or friends; residing outside of institutions

4. Home health services - an array of health care services provided to individuals in their places of residence for the purposes of preventing disease and promoting, maintaining, or restoring health, or minimizing the effects of illness and disability (National League of Nursing 1974).

Limitation

A limitation which may influence this study is: responses given by the subject will be accepted as fact.

Delimitations

The following delimitations were selected for this study:

1. The sample subjects will be 65 years of age and older

2. Persons in institutions will not be included in the sample

3. Only subjects who are able to answer the questions will be utilized in the study

4. The population will be selected from a three year old list of older persons, obtained from the County Clerk's office.

Assumptions

The following are assumptions relative to the study:

1. Old age is not an illness; it is the final stage in the cycle of life

2. Old age increases the susceptibility to illness and disability

3. The administration of health care in the home may prevent or delay admission to an institution

4. Older persons who dread institutionalization will remain healthy longer in their own homes.

Summary

This chapter introduced the difficulties older people have in obtaining health care that will maximize their health potential and yet allow them to remain in their own homes. It also discussed the government's concern for the aged and the steps the government has taken to encourage provision of home health care. The problem to be studied, the purpose of the study, definitions of terms used, selected delimitations, and assumptions were included.

Chapter II, Review of Literature, discusses the physiological and psychosocial aspects of aging and their influences on older people. Five health parameters, physical condition, functional ability, accessibility to medical care, social isolation, and service needs are developed in relation to their effect on older people and the nursing implications inherent in each parameter.

The third chapter describes the design, method of data collection, population and setting, and the plan for analysis of data. Analysis and interpretation of the data are found in Chapter IV; and summary, recommendations, implications, and conclusions are in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Aging is a natural process in the human organism; it is one more phase in the life cycle. Old age follows former stages in human development, and each stage offers frustrations, problems, and difficulties, as well as satisfactions, challenges, and opportunities. Each stage in the life cycle presents the common problem of caring for the body, maintaining mental health, and coping with the sociocultural environment (Youmans 1973). The aging process involves the individual in his totality; each person ages biologically, psychologically, and socially. Biological age refers to a position along a continuum from birth to death. Psychological age encompasses adaptive capacities and ability to learn, remember, and respond effectively to the environment. Social age refers to habit systems and social roles (Birren 1977).

Old age is not a disease, nor is it an acute crisis. It usually enters slowly and therefore is almost imperceptible in its coming. Actually, old age is one of the developmental phases in the life span of the human

being. Weinberg (1970) stated that it is developmental in the sense that it is not a static phenomenon which comes at the end of a person's existence; rather, it is a "fluid state influenced by one's physiology and psychology, and the socio-economic and cultural environments in which one lives" (p. 682).

Butler (1974 p. 9) also considered old age as a developmental phase and assigned to the phase a task: "...the major developmental task in old age is to clarify, deepen, and find use for what has already been obtained in a life-time of learning and adapting." The ability of the older person to perform this task is contingent upon his physical health, personality, earlier life experiences, and the societal supports he receives. To accomplish normal, successful aging, as described by Butler, it is imperative that older people continue to develop and change in a flexible manner.

Society has enveloped the aged and the aging process with myths and stereotypes. One such myth is that the aged are all alike. However, many authors stress the fact that people over 65 years of age belong to a very heterogenous group (Verwoerdt 1973, Maddox 1973, Butler 1974, and Palmore and Maddox 1977). Butler stated that the aged are at least as heterogenous as any other age category spanning thirty-five years. Aging proceeds not only at

different rates in various individuals, but also at different rates in various systems of the same person (Verwoerdt 1973 and Weg 1976). Aged persons are not alike in personal needs, health status, or social conditions; these vary as much among the older population as among young people.

Since the aged do differ greatly among themselves, Busse and Pfieffer (1977a) divided the elderly into two groups in their writings: the younger aged (65-75 years) and the older aged (over 75 years). The incidence of disabling conditions is far greater among those over 75 than in the younger aged group. Also, in contrast to the younger aged, those over 75 are in poorer health, are hospitalized more often, are more isolated and lonely, are rarely employed, and have less income (Managan et al. 1974, Shanas et al 1968, and Hain and Chen 1976).

Not only are differences prevalent among the age groups, they also exist between the sexes. Women live longer than men--almost eight years longer, according to the 1975 statistics of the U.S. Census Bureau (U.S. Department of Commerce 1976). Consequently, more women than men are widowed. Widowed women tend to live with their children or relatives, while widowed men are more likely to live alone or in an institution (Shanas et al. 1968). Men

appear to cope with their environment in abstract and cognitive terms; in contrast, women become increasingly affective and expressive in their terms. A far greater number of men than women commit suicide in old age, usually from depression (Busse and Pfieffer 1977b).

Because the aged are so varied in their needs, values, and reactions, they present a great challenge to the health care team, as well as to other helping professions. As Palmore and Maddox (1977) stated, in planning for the elderly there can be no simple, sovereign solution.

Physiology of Aging

The process of aging seems to elude definition, for a review of literature revealed no explicit, concise definition. Busse (1977), in writing of the problem of defining the term, pointed out the differences of opinions among biologists. Some define aging as a progressive loss of functional capacity after an organism has reached maturity, while others contend that aging begins with the process of differentiation. Still others believe that a definition of aging is not useful or possible.

The biological processes of aging are usually associated with a decline of efficiency and functioning that eventually results in death. Since the human body is so complex, biological aging can be studied from many

levels. Consequently, many theories have been postulated; none have gained widespread support. Only a few theories will be described here.

The wear-and-tear theory holds that the organism simply wears out from constant use. In this view, aging is the result of the gradual deterioration of the various organs necessary for life, and when a vital organ no longer functions, life ceases (Atchley 1972).

Tha autoimmune theory maintains that as age increases, mutations cause some of the cells of the body to produce proteins which are not recognizable as "self" and thus are responded to as if they were foreign substances. The body reacts to foreign substances by producing antibodies which attempt to neutralize the effect of the foreign substance. This phenomenon is called an immune reaction. When antibodies respond to mutations within the body, an autoimmune reaction occurs. Rheumatoid arthritis is known to be caused by autoimmune reactions (Atchley 1972).

The homeostatic theory, as described by Kimmel (1974), proposes that the efficiency of homeostatic mechanisms which maintain vital physiological balances in the body (such as pH and blood sugar levels in the blood) is central to the process of aging. It has been demonstrated that older subjects readjust to normal equilibrium after

stress at a lower rate than do younger people. Therefore, the theory maintains that the self-regulating feedback mechanisms decrease in efficiency with age so that when they are no longer able to maintain the necessary equilibrium, the organism dies. Because of this homeostatic inefficiency, the emotional stresses that accompany aging (loss of spouse, environmental changes, etc.) are more likely to increase the risk of death for the aged than for the young. This theory, according to Kimmel, describes the clearest link between social, physiological, and psychological aspects of aging.

Selye (1976), in his book The Stress of Life, added momentum to the homeostasis theory. His research had demonstrated that stress causes certain changes in the structure and chemical composition of the body which can be accurately assessed. Some of the changes are signs of damage, others are manifestations of the body's adaptive reactions, its mechanism against stress. Selye terms the totality of these changes the "general adaptation syndrome". Each person has inherited a genetically determined amount of adaptation energy. Throughout a lifetime this reserve of adaptive energy is utilized at a rate dependent upon the amount of stress one experiences and the person's ability to cope. Deficits in adaptive energy add up to what is called aging. True age depends on the rate of

wear and tear on the body processes, for life is essentially a process that gradually spends the inherited amounts of adaptation energy. Likewise, failure to adjust effectively to life situations is at the very root of disease producing conflicts. Since reactions to stress are rarely evenly distributed over the entire body, one particular organ will succumb to depletion of energy sooner than another. When this depletion occurs in a vital organ, death ensues.

Despite the many unproven theories and their inability to define the process of aging, biologists do agree that, for the majority of older persons, there is a steady, gradual decline in a number of functional capacities--in cells, tissues, organs, and therefore, the whole person. However, the nature of these changes are such that the great majority of persons over 65 years of age remain mobile and are able to cope with the demands of every day life.

Weinberg (1970) and Busse (1977) considered aging as a dual process comprised of primary and secondary aging. Primary aging is a process of change moving toward the eventual death of the organism and it is accomplished by functional decline. This type of aging is rooted in heredity and encompasses the inborn and inevitable detrimental changes that are time related but independent of stress,

trauma or disease. The secondary phase, which is of most concern to sociologists and psychologists, is a speeding up of the primary process. It is a result of environmental deficiencies and stresses imposed on an organism at a time when coping mechanisms are at a low ebb. Primary aging may be called normal senescense; secondary aging is a pathological process.

A number of structural and functional changes that occur in the body can be labeled primary aging or senescense. These changes occur early in the aging process for some people and later for others. Some of the physiological changes will be described below.

The skin of older people tends to be wrinkled and dry and is less elastic than younger skin. Spots of dark pigment are often seen. The skin becomes more vulnerable to bruises because of fragile blood vessels, loss of hair, and malignancies. It heals slowly and sweating is considerably reduced. The older person tends to be bent over and stooped, primarily due to weakening of muscles, decrease in elasticity and calcification of ligaments, and compressed spinal discs (Atchley 1972 and Rockstein 1976).

A common manifestation of senescence is a decrease in muscle strength, endurance and agility. The wasting of muscle is reflected in the decreased number of muscle fibers, since muscles lose their ability to regenerate.

Muscles in arms and legs reduce in size and are flabby in appearance (Rockstein 1976).

The role of the nervous system as coordinator of muscles, glands, neurons, and blood is altered with aging. Conduction of the nerve impulse decreases and thus activities of daily living, such as walking, lifting, bathing, and cooking, are affected. This decrease of conduction also causes reduced reaction time (Weg 1976). Rockstein (1976) stated that there is a loss in the total number of brain cells with advancing age, aside from hardening of the vessels of the brain in very advanced age. In general, there is a gradual failing of memory capacity.

A decrease in the senses occurs with time. Proprioception, perception of one's position and relatedness to space, also appears to be impaired and may relate to balance and coordination. Touch sensitivity, perception of vibration and temperature, appear to decline and the pain threshhold increases. These changes contribute to a decreased response capacity and a consequent decrease in adaptation to the environment (Weg 1976).

Increased aging also results in a measureable reduction in the efficiency of respiration. This response is characterized by decreases in maximum breathing capacity, residual lung volume, vital capacity, and basal oxygen

consumption. There is likewise a reduction in the total number of alveoli, as well as reduction in expandibility of the lungs, caused by changes in elastic fibers of the bronchioles (Weg 1976 and Rockstein 1976). There is a decreased capacity to cough, caused by rigidity of the thoracic wall combined with reduced strength of expiratory muscles (Goldman 1971).

In the aged, cardiovascular function alters, even in the absence of pathology. The aging heart becomes less capable of responding to extra work by acceleration and increased stroke volume (Agate 1970). Renal blood flow decreases, and peripheral resistance, circulation time, and systolic blood pressure increases (Weg 1976).

Gonadal harmones decrease in time in both men and women, accompanied by slow, involuntary genital tissue changes and functional consequences. This decline eventually leads to loss of fertility without an inevitable loss in libido (Goldman 1971 and Weg 1976).

In the aged individual, recovery from stress, whether physical as in exercise or emotional as in excitement or fear, is slowed. Thus, homeostasis is less easily maintained in older persons and increased time is needed to return to pre-stress levels (Selye 1976, Kimmel 1974, and Weg 1976).

From this picture of diminishing homeostatic and functional capacity, it is apparent that aging includes a gradual increase in vulnerability to disease. However, the aging process alone does not cause disease and disability. The aged person's ability to adjust, adapt, repair, and restore are modified but they are not lost (Chinn and Robins 1970). Although aging cannot be reversed, medicine and nursing are challenged to deal with diseases and their consequences through prevention, treatment, and rehabilitation. The aim of these professions working with the aged should be directed toward achieving the maximum function and the maximum physical and social effectiveness of which the individual is capable.

Psychosocial Aspects of Aging

The aging process not only has biological consequences but it also influences the psychological and social patterns of older persons. Research by sociologists in the past two decades has resulted in two major opposing theories: the disengagement theory and the activist theory. Cumming and Henri's (1961) disengagement theory holds that aging is an inevitable process of mutual withdrawal of aging persons and society from each other, resulting in decreased interaction between them. The process may be initiated by the individual or by others in the situation. Withdrawal from some classes of persons may be marked while

remaining relatively close to others. The withdrawal is often accompanied at the beginning by a preoccupation with oneself. When aging is complete there is a greater distance and an altered type of relationship between the older persons and society.

In contrast, the activity theory holds that the maintenance of physical, mental, and social activity is important to most people as a basis for deriving and sustaining satisfaction, self-esteem, and health. Consequently, a reduction in activity results in a reduction of these three components (Busse 1977). A longitudinal study by Palmore (1968) supported the activity theory and is believed to present contrary evidence to the disengagement theory. In the study 127 aged persons were observed for changes in activities and attitudes over a ten year period. From the findings it was concluded that, while many of the aged may disengage or reduce activities in some areas, the majority tend to compensate by increasing activities in other areas.

A third prominent theory, the continuity theory, is promoted by developmental psychologists. This theory, as described by Atchley (1972), contends that in the process of becoming an adult, the individual develops habits, attitudes, commitments, preferences, and many other dispositions that become part of his personality. As the

individual grows older, he is predisposed toward maintaining continuity in these dispositions. The person's reaction to aging is dependent on interactions among personal preferences, biological and psychological capabilities, situational opportunities, and experience.

Research by Neugarten et al. (1968) supported the continuity theory. Personalities of the aged were studied as they related to extent of social role activity and degree of life satisfaction. Eight patterns of aging emerged from the study which suggested to the researchers that neither the "activity" nor the "disengagement" theories of aging accounted for their findings. They concluded that people age according to a pattern that has a long history and that maintains itself, with adaptation, to the end of life.

The psychosocial needs of older people are much like those of their younger counterparts. Older persons need to enjoy friendships and social contacts, to be busy at work and leisure activities in keeping with their capacities, and to be in reasonably good health. As people progress through the various phases of life they are able to adapt more or less successfully to the changes that occur in themselves and in their lives. Indeed, the stresses of life are often useful, for they promote and

engender growth. Verwoerdt (1973 p. 52) stated "a certain amount of stress and conflict are probably desireable in that they stimulate growth and maturation through crisis."

Although all phases of the life cycle present challenges for personal growth and integration, probably no other age group experiences changes in life situations to the extent that persons over 65 do. Each change involves stress and adaptation in varying degrees for each individual. Loss of a job, retirement, death of a spouse, loss of friends and relatives, decrease in income, change in living arrangements, and loss of former physical capacities are only some of the changes that encroach upon older people. These changes can be cataloged under one word: loss. Loss, described in the social context by Bengston and Manuel (1976), involves a decline in three areas: interpersonal support, a valued position in the social structure, and economic status.

For the older person, losses are frequently encountered in rapid succession. Coping ability is greatly taxed at a time when capacities for adaptation are diminishing (Busse and Pfieffer 1977b and Verwoerdt 1973). The fact that change is more difficult for the older person is supported by a study by Muhlenkamp et al. (1975). Using the Social Readjustment Rating Scale devised by Holmes and Rahe, the researchers asked 41 persons between the ages of

65 and 84 to rank life change events and rate them according to the magnitude of adjustment that they perceived necessary for each. It was found that the ranking order of the subjects was not significantly different than the normative group. However, the magnitude assigned to the change events was significant in 27 of the 43 items.

Many factors, biological and experiential, contribute to whether a person will be adaptive or maladaptive in old age. Busse and Pfieffer (1977b) stated that the history of adaptation in younger years is probably one of the best predictors of adaptation in later life. Satisfactory adaptation to the stresses of old age will probably be made by those who had basically trusting relationships with others, who developed a sense of autonomy and a clearly defined, positive-valued identity, who had satisfactory relationships in marriage or in the work situation, and who previously confronted adversity successfully. Good health, intelligence, membership in intact families, adequate food, shelter, and clothing, good education, and orderly careers can have a helpful influence on coping ability. Deprivations in these areas compromise adequacy of adaptation. Studies by Palmore (1969) and Pfieffer (1970), which researched life situations as correlates of longevity, show this to be true.

When coping mechanisms are taxed beyond capacity, disease results (Verwoerdt 1973 and Weg 1976). Studies indicate that situations which threaten the security of the individual and evoke an adaptation behavior, also evoke major changes in body tissues, organs, and systems (Selye 1976). When these changes are sustained, they enhance the body's susceptibility to disease (Rahe et al. 1967). Research by Rahe et al. (1967) demonstrated that the greater the significance of a life change or life situations that cluster together, the greater becomes the risk of a breakdown of the body's resistance to general health change. The type of health change that may occur depends on the individual's particular constitutional or acquired weakness as well as his exposure to the etiological agents of the disease.

Since mind, body, and spirit are so closely integrated and influence one another, health depends on adequate psychological and social care as well as physical care. Persons working with the elderly should be alert to these areas of need and provide care which will promote and maintain health of the whole person (Chinn and Robins 1970).

Health Care Needs

Health Condition

Poor health is one of the pressing problems afflicting the elderly. The older the person, the more severe and longer lasting are his illnesses. The persevering nature of an illness, along with the older person's diminished recuperative powers, results in the need for more attention from the health team, longer hospital stays, and heavier expenditures for drugs and medical care than occurs among younger adults (Field 1972).

Chronic conditions can be found in the majority of older persons. The incidence rises steadily with increasing age, and the disability caused by these conditions is more severe than in younger persons. Yet, many aged persons are able to function. Chinn and Robins (1970) consider elderly persons well or healthy if they are able to function with reasonable independence, despite ailments or impairments. Jennings et al. (1972) agreed with this concept of health for the elderly when they defined high level wellness for the aged as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he is functioning" (p. 238).

The number of conditions afflicting an individual is a factor that influences the illness component of the aged. Older persons frequently have more than one illness and/or chronic condition at the same time. This superimposition of illness is attributed to lack of resistance to stress and diminished adaptability, and it greatly influences the rate of recuperation (Chinn and Robins 1970, Verwoerdt 1973, and Busse and Pfieffer 1977b).

Acute diseases occur less often in the elderly, according to the findings of a study done by the National Center for Health Statistics and as reported by Estes (1977). However, when an acute illness does occur, more days of restricted activity result. The data, obtained by household interviews on a probability sample, revealed a decreasing number of acute illnesses as age increased, beginning with persons under five years of age. The 45 to 64 age group had 144 acute illnesses and 928 days of restricted activity per 100 persons per year, in contrast to 109 illnesses and 1,092 days of restricted activity for those over 65. For the study, days of restricted activity was defined as a substantial reduction in activity normal for that day, and covered restrictions up to and including complete inactivity. The cause for the decreased incidence of acute illnesses is not known. A diminished level of

awareness of symptoms and diminished concern, leading to less acknowledgment of illness, are possibilities attributed by Estes.

Upper respiratory infection, influenza, and other respiratory ailments account for the majority of acute illnesses and for most of the days of disability for the aged. Injuries are the second most common cause of illness and disability, and digestive disturbances are third. These three categories alone account for four-fifths of the acute illness problems of the elderly. The conditions are simple enough in terms of diagnosis and treatment, but the superimposition of these illnesses on patients with underlying senility and chronic disease can result in drastic consequences (Estes 1977).

The older person's ability to adjust, adapt, repair, and restore are modified by age but they are not lost. Capacity to rally from insults to health depends not only on his capabilities, but also on the supports necessary and available to achieve optimal health and function (Brody 1973). Such supports include a broad spectrum of health and health related services which will provide for psychological, social, spiritual, and physical needs of the elderly. According to Brody, health care systems that are limited to a disease orientation will not meet the needs of the aging community.

Functional Ability

Older people are particularly prone to the onset of chronic illness and the possibility of functional impairment. Persons who are limited in functional capacity are usually candidates for long-term care. Because of the explicit criticism of depersonalization and potentially harmful psychological effects of nursing homes, more people with chronic illness and functional disability stay in their homes (Katz et al. 1972). Yet, few communities are prepared to meet the needs of these people. Day care centers, home health care, and homemaker services have been slow to develop and are available to only a small number of people.

The term functional impairment suggests dependence on others by an afflicted individual to cope with normal demands of daily living. Practical tasks, such as getting out of bed, bathing, dressing, preparing a meal, cleaning the home, or reaching essential services outside the home, are performed with extreme difficulty or only with the help of someone else (Bell 1973). Among the leading causes of disability in the United States are heart disease, with rheumatism and arthritis second, followed by impairments of the back and spine. For persons in nursing homes,

stroke, arthritis, and rheumatism are the most frequent disabling conditions (Katz et al 1972).

The incidence of functional impairment rises with increasing age. Studies indicate that most elderly persons with functional limitations are over 80 years old, women, single, and economically poor (Shanas et al. 1968, Managan et al. 1974, and Hain and Chen 1976). Eighty-one percent of persons over 65 has one or more chronic diseases, about 16 percent is unable to carry out their major activity, and 33 percent has no physical limitation on activity (Brody 1973). Hain and Chen's (1976) study of older people in high rise apartments showed 68 percent with minimal or no difficulty in performing activities, while the DuPage County study reported 89 percent in this category (Managan et al. 1974).

Loss or decrease of functional ability can lead to isolation, dependency, and loss of self-esteem. According to Carlson (1972), the loss of ability to do things for themselves from which they gain self-satisfaction is perhaps the greatest stress experienced by older persons. Independence is important for persons in any age group, but it takes on added dimensions for the elderly. In a society that values independence so highly, making decisions and doing things for oneself is a major source of self-esteem,

a personality trait most people seek to attain and maintain (Atchley 1972).

The facts that there is no cure for most chronic diseases and that aging has often been considered synonymous with illness and disability, have resulted in inadequate care for the aged. Hammerman (1974) complained that there is no prophylactic strategy built into the health care system. Acute ailments are treated, but the potentials of early detection and treatment are ignored, and therefore, the system "fail[s] to address the possibility of preventing premature aging and incapacitating disability" (Hammerman 1974 p. 254). He further stated that if indeed old age is physiological and not pathological, many of the presumed diseases of old age could possibly be avoided, minimized or arrested by timely diagnosis and treatment.

Katz et al. (1972) and Glick (1976) maintained that currently the achievement of primary prevention of chronic disease in the aged is not expected. A more realistic goal is secondary prevention which consists of slowing down the disease process after it has begun and prevention of complications. Since the threats of chronic disease are physical, psychological, and social, the services required to meet the needs of afflicted persons are interdisciplinary. Needs, such as housing, transportation, disturbed family relationships, and nutrition, may need to be met in

order to prevent an illness or the deterioration of an existing condition (Chinn and Robins 1970 and Eisdorfer 1976).

Ryder (1976) declared that patients have too long been described in terms of medical diagnosis and treatment. Attention is seldom given to the functional capacities of the person or the capabilities of the family and friends to assist him. The patient's social, economic, and psychological functional capacities need to be assessed as well as physical limitations. Lawton (1973) apparently held the same premise as Ryder but went a step further and described a variety of tests that can be used in assessing functional abilities. The tools encompass the areas of physical health, quality of self-maintenance, quality of role activity, intellectual status, social activity, emotional status, and attitudes toward the world and toward self.

Since there is an interdependence of physical state, adaptive behavior, and emotional state, a person can best be helped when the practitioner is aware of the patient's functional abilities. Centering on abilities, rather than disabilities, sets a positive tone for rehabilitation. Lawton and Brody (1969) discovered the great value of functional ability assessment when they developed two tools for this purpose and tested them in various institutional settings. The Physical Self-maintenance

Scale measured toileting, feeding, dressing, grooming, bathing, and physical ambulation. The second tool, Instrumental Activities of Daily Living, assessed ability for using the phone, shopping, food preparation, housekeeping, and laundering. The tool also assessed mode of transportation, responsibility for own medications, and ability to handle finances. The tools proved useful in providing early, brief, objective assessment and the information was found beneficial in planning individual care. Since the assessment was conducive to being repeated at intervals, it was useful for evaluating the patient's progress and the therapeutic plan, and for redirecting the plan when necessary.

The older person with disability needs restorative services to help him to be as independent as possible, even if the ultimate goal can be only self-care. Without support, the person tends to move increasingly into isolation, accelerating the loss of adaptability and capacity to function. Chinn and Robins (1970) described a chain reaction that occurs: dependency in one category leads to dependency in other categories. Fortunately, the chain reaction can, and often does, occur in the opposite direction when rehabilitation services are provided. Becoming independent in one sphere leads to independency in other areas.

Although aging involves a gradual increase in vulnerability to disease and a decrease of functional reserves, people can reach extreme old age in good health. While the aging process cannot be reversed, the specific diseases and their consequences can be dealt with in terms of prevention, treatment, and rehabilitation. A greater quality of life can be achieved by directing the individual toward the maximum physical and social effectiveness of which he is capable.

Social Isolation

One of the myths or stereotypes of aging is that most aged are lonely and isolated from their families and normal social relations. Studies have shown that this myth is not supported by research. In a cross-national survey by Shanas et al. (1968) it was found that about four-fifths of the aged in the United States live with someone else, three-fourths say they are not often alone, and 86 percent say they had seen one or more relatives during the previous week. Pfieffer (Busse and Pfieffer 1977b) in 1973 found that 28 percent of older persons living in the community lived alone. Nine percent did not have any meaningful contacts with relatives, friends, or visitors. The proportion of older people living in homes of relatives increases with advancing age and increasing

widowhood, according to Shanas (1977). Among those 75 and older, almost twice as many men and women live with relatives, as compared with those age 65 to 74.

In the literature, the term social isolation has various meanings. Bennett (1973) defined it as the absence of meaningful social roles, or rolelessness, and further described it as a socially induced sensory or stimulus deprivation. Butler and Lewis (1973) refer to individuals who have minimal or no contact with other human beings as social isolates. To Black (1973), social isolation meant a condition of deprivation of satisfaction-giving and other self-actualizing activity, combined with the sensory deprivation that is a necessary concomitant.

Many factors contribute to social isolation for the aged. As the process of aging increases, the universe of the older individual tends to become a smaller, more confined place. The number of familiar faces of friends, coworkers, relatives, and even spouse, decreases. Difficulty in communicating because of deafness, blindness and loss of ability to speak, adds to the shrinkage of their world. Physical disability makes it difficult to initiate social contacts. Geographic mobility of their children and widespread prejudice against the aged also contribute to possible isolation (Bennett 1973). Silverstone (1976) attributed physical disability of a spouse to isolation for,

when social patterns which were formerly shared by husband and wife are lost for one, they are often lost for both. Some individuals have had few personal relationships throughout life and continue this pattern into late life (Itzin 1970).

Busse and Pfieffer (1977b) contended that natural losses and solitary living arrangements are not enough to produce isolation. There is also a failure on the part of the individual to develop significant new relationships. At times a vigorous resistance to new relationships is encountered. Previous lack of social skills, lack of social opportunity, lack of transportation, as well as sensory losses and decreased physical mobility, are factors which contribute to the failure to make new friends.

Some people, according to Butler (1973), choose to remain alone, and this choice should be respected. It is important to be able to differentiate this group of people from those older people who truly want and need assistance in making changes in their lives. The emotional meaning of social isolation depends on whether it is a habitual life style or whether it has come about or been increased by emotional loss.

Isolation is not synonymous with loneliness. Loneliness can be a state of mind rather than actual social

alienation (Butler 1973). Such is the case when loneliness is not relieved despite the closeness of others or frequent contact with others. It is a well known fact that loneliness can be experienced in the presence of other people. Busse and Pfieffer (1977b p. 163) defined loneliness as the "awareness of an absence of meaningful integration with other persons or groups, a consciousness of being excluded from the system of opportunities and rewards in which other people participate." Persons who have recently lost a spouse are particularly vulnerable to feelings of loneliness.

Studies indicate that a person's life satisfaction is closely linked to the amount and quality of his social interaction. In the research mentioned previously in which Palmore (1968) studied relationships between activities and attitudes of 127 persons over 60 years of age, a fairly steady maintenance of activities and attitudes occurred. However, changes in activities that did occur were significantly and positively correlated with changes in total attitude. Those who reduced their activities as they aged tended to have a reduction in over-all satisfaction, and conversely, those who increased activities tended to enjoy an increase in satisfaction. Relative levels of activities and attitudes persisted as the subjects grew older.

The effects of social isolation vary with each individual according to his background and coping ability. Perry (1974) maintained that isolation leads to other problems such as poor nutrition, inadequate health care, confusion, depression, and these conditions in turn lead to further isolation. Bennett (1973) suggested that lack of social contacts may lead to serious and possible irreversible cognitive and other impairments, as well as poor social adjustment. An apparent disorientation can occur in an atmosphere of passivity, boredom, and day-to-day sameness (Simon 1976).

Partial isolation and desolation are attributed by Busse (1971) as a cause of stress in the older person. The human body and brain require external stimuli in order to remain efficient, and deprivation can result in temporary or permanent disability. Butler (1973) stated that isolation may lead to emotional and mental reactions in old age, but it, per se, is not the cause of these conditions.

Hypochondirasis can also result from social isolation and loneliness. Conti (1970) explained that the lonely elderly person expects to have some stiff joints or other aches and pains and when there is no diversion, these symptoms become the only frame of reference. According to Busse and Pfieffer (1977b), the sick role becomes a way of solving a psychological problem precipitated by loss of a

job, spouse, or friend. Psychic interest is withdrawn from one person or object and the person centers this interest on oneself, his own body, and its functioning.

Because isolation can precipitate physiological and psychological problems, persons interested in the elderly are concerned about isolated individuals and the factors which initiated the isolation. Programs to bring persons in contact with individuals their own age are available in many cities. These programs range from elaborate recreational centers with planned activities to congregate meals which serve the dual purpose of companionship and nutrition. Attempts are being made by various disciplines to provide for the social needs of older adults and thereby promote a higher quality of life.

Accessibility to Medical Care

The elderly person suffers from relatively few illnesses that are unique to his age group. However, one illness is often superimposed on an assortment of pre-existing chronic illnesses and on organ systems that have lost part of their reserve capacity. Thus, the elderly person presents a delicately balanced mechanism in which even a "minor" illness can lead to major consequences (Estes 1977).

Because of the delicately balanced mechanism of the aged, medical programs for them should emphasize prevention and health maintenance. However, our entire health care delivery system lacks adequate attention in these two spheres. Verwoerdt (1973) suggested setting up "well-aging" clinics that would place emphasis on health maintenance with a matter of fact attitude toward medical examinations. Many older people are reluctant to see a physician when symptoms are present because they are afraid--afraid that a serious illness will be diagnosed, that they will have to be hospitalized, undergo surgery, or pay for expensive medications. Regular visits to a "well-aging" clinic could reduce this fear.

A number of factors have made medical care inadequately accessible to the aged. These factors entail not only the health care system, but also physicians and situations of older people. There is a growing shortage of primary health care physicians. Two-thirds of the doctors are specialists and are less available as personal physicians than the generalists whom they have replaced (Estes 1977). There is also a maldistribution of physicians; the older areas of large cities and rural areas have failed to attract new physicians. There are very few physicians who specialize in the medical problems of the aged and, because

the older person may have several medical problems, it becomes necessary for him to see several specialists. This situation poses practical difficulties for the patient.

Another factor which diminishes accessibility to medical care is the situations which encompass the lives of older persons. Chronic diseases, to which the elderly are prone, require constant medical care if undue disability is to be prevented (Verwoerdt 1973). Low economic status, lack of transportation, denial of symptoms, and the erroneous opinion that illness and disability are part of the aging process, contribute to the elderly not seeking medical attention.

Although Medicare is available to the aged, it does not meet all their health needs. Public funds account for 68 percent of the aged person's health bill, according to Hammerman (1974). However, the funds are unevenly distributed. They meet 86.1 percent of the elderly's hospital bill, 71.3 percent of the physician's bill, 60 percent of nursing home expenditures, and only 23 percent of combined expenditures for dentist, drugs, eye glasses, hearing aids, home health, and other services. Consequently, the supports needed to promote health and prevent illness and disability are beyond economic feasibility for many older people.

What can be done to make health care more accessible? Nurse clinical specialists and geriatric practitioners could relieve part of the burden caused by shortage of primary health care physicians, for they are capable of performing health maintenance and preventive aspects of health care (Glick 1976). However, the services of nurses are made inaccessible to many of the aged because of Medicare restrictions and unavailability of third party payment. More home health programs and expansion of services of existing ones would bring medical and nursing care to a greater number of people. In other words, medical care is only a small part of what older people need. The services must meet the psychosocial as well as biological needs. Only a multidisciplinary approach can bring about the type of health care needed by older people (Chinn and Robins 1970).

Nutrition

Nutrition has an important influence on biological aging and therefore has been a focus of concern for those interested in the welfare of the aged. Food requirements for the elderly are not significantly different from younger people. Atchley (1972) and Butler (1973) contended that the daily food intake must simply be enough to supply

the needed vitamins and energy. Yet, older people seem to be vulnerable to poor nutrition.

Nutritional deficiencies can result from a number of factors, some of which are: poor dentition, reduced income, poor appetite, having to eat alone, and reduced functional ability. Older people have a tendency to prepare and to eat meals that take the least effort. This tendency may result in eating too much of the high carbohydrate foods or too little of any kind of food. This inadequacy of proper types and amounts of food can add up to nutritional deficiency and imbalance (Bozian 1976).

The psychological aspect of food and eating has important implications for nutrition of the elderly. For some people food symbolizes security, affection, strength, or pleasure. Food and eating are intimately related to social experiences. Some lonely people or people living alone may neglect their meals. For others, the lack of company may lead to greater emphasis on the satisfaction of eating, with overeating as a result (Verwoerdt 1973).

Malnutrition may present symptoms of senility. Howell and Loeb (1969) described a clinical syndrome called Protein-Calorie Malnutrition (PCM). In studies of nutritional needs of nerve cells, it has been determined that nerve cells can be "starved" to the point of not functioning or functioning very poorly. This suggests that poor

mental and emotional function found in senility may result from severe PCM. Types of symptoms that exist in subclinical forms of dietary deficiency are loss of appetite, fatigue, irritability, anxiety, loss of recent memory, insomnia, distractability, and mild delusional states. These symptoms can be induced by restricting the intake of special nutritional components. The symptoms also have been improved when older adults were put on well-balanced diets. Various amino acids and thiamin deficits have been identified as the cause of the senile-like symptoms.

Various programs have been initiated in an attempt to meet the nutritional needs of the elderly. Meals on wheels is one such method. The purpose of the program is to deliver hot meals to invalids at home. One hot meal is usually served each day; some programs also serve a cold meal. Modified diets are served as well as regular diets (Cairns and Caggiula 1974).

Another program provides meals for the elderly at centrally located areas. In 1972 Congress passed the Nutrition Program for the Elderly (Title VII of the Older American Act) to provide funds for this purpose. The aims of the program are to improve the nutrition of older people and, at the same time, to offset the isolation some of them experience. Meals are served five days a week and there are no eligibility requirements. The meals must contain

at least one-third of the Recommended Daily Allowances as established by the Food and Nutrition Board (Harper et al. 1976). Meals on wheels and congregate meals can do much to prevent or alleviate a viscious circle that leads to overeating or undereating.

Transportation

Most people in the United States consider the automobile indispensible for access, not only to work and school, but also to supplies, services, recreation, and socialization. For many people beyond the working years, this "necessity" becomes impossible for various reasons. One important factor is economic. Income is sharply reduced at retirement, and consequently, many older people cannot afford the purchase or upkeep of cars (Carp 1971). Even the cost of public transportation, where available, is often prohibitive.

Functional impairment is another factor that prevents use of the automobile. Losses in visual and auditory acuity, impairment of peripheral vision, slowed response-time, and reduced competence with complex tasks, especially under time-pressure, contribute to ending a career of driving, add to the difficulty of using the public transit system, and make walking an unsafe mode of travel for the older person (Carp 1971).

The characteristics of the public transportation system pose problems also (Cutler 1972). The vehicles are not built for people who have difficulty walking up steps. The walk to and from the place where the vehicle stops is, for some people, a difficult and insurmountable task.

The visual-motor changes and the increasing incidence of health problems which limit vehicular travel also inhibit travel by walking. Age-related changes, such as reduction in muscular strength, agility, and speed of movement, gait changes, the tendency to fall, and increasing bone fragility, compound the practice of walking and render it unsafe (Carp 1971). Furthermore, places to which people need or want to go are often not within walking distance.

Carp (1971) studied walking as a form of transportation for 709 older people. Persons who comprised the 44 percent who walked as a means of transportation several times a week or daily tended to be located in the center of the city, were Afro-American or Mexican-American, did not own a car, were poor, and were men. Places to which people most frequently walked were the grocery store (26 percent), homes of friends (25 percent), religious services (23 percent), shopping areas (18 percent), and the doctor's office (15 percent). Most of the walking trips took no more than 15 minutes each way. Fifty-three percent of the subjects

said walking met their needs very poorly, none said it met them well.

Atchley (1972) stated that people with transportation problems usually manage to get to the doctor and grocery store but do not get out to see their friends or relatives or to go to church or recreational facilities. Consequently, they are unable to do things that give meaning to life. They can maintain the body but not the spirit. A study by Cutler (1972) to determine the relationship between the availability of personal transportation and life satisfaction showed that 58 percent of those with transportation available to them were high in life satisfaction, while only 37 percent without transportation had high life satisfaction scores. These findings supported the hypothesis that mobility restrictions, as they constrict life-space and narrow the social world of the aged, are associated with low levels of life satisfaction.

Transportation was one of the topics considered at the White House Conference on Aging (1973). The committee spoke of transportation as a vital concern since the elderly must depend on travel for acquiring the basic needs of food, clothing, employment, and medical care. They also considered transportation as necessary for participation in spiritual, cultural, recreational, and other social events and specified that "to the extent that the elderly are

denied transportation services they are denied full participation in meaningful community life" (White House Conference on Aging 1973 p. 65).

The availability of transportation can increase the capacity for mobility among the aged and thereby expand the range of social interaction and activity, it can reduce isolation by promoting a sense of independence, and it can lead older persons to feel that they have some control over their environment (Cutler 1972). In short, available transportation enlarges the world of the older person and promotes a feeling of independence and well-being.

Alternatives for Health Care

The General Accounting Office, in a 1972 report to Congress, stated that "appropriateness of medical care depends on using the right facility for the right patient at the right time" (Richter and Gornerman 1974 p. 115). The report cited the types of health care facilities and indicated that each facility (the patient's home was listed as one) is important in the continuum of health care. How each facility is utilized determines the provision of appropriate health care that takes into consideration the person's level of illness and disability and his degree of independence. Three of the modes of health care delivery to the elderly will be discussed here: hospitalization, nursing home care, and home health services.

Hospitalization

For many years the hospital has been recognized as the primary facility for the care of the sick, including the elderly. This fact still remains true when the illness requires the highly specialized and centralized equipment of the modern hospital. However, when the illness is prolonged and the acute episode is over, continued hospitalization tends to no longer meet the needs of the individual, nor is it economically feasible.

In 1971, per capita health care for older persons was close to four times as high as for those under 65 years of age. The elderly comprise 10 percent of the population, yet incurred 27 percent of the health care costs (Brotman 1974). Reasons for the high expenditures for health care are partially given by Eisdorfer (1976). One out of every four older persons is hospitalized each year, a proportion twice that of their younger counterparts. The hospitalized elderly stay twice as long as younger persons. If other health services were available, the number of hospitalizations and hospital days could be reduced, thus lessening the cost of health care.

Hospitalization is readily available to the elderly because Medicare and other third party payments favor hospital care. If a medical condition requires care in a

hospital, Medicare hospital insurance pays for all covered services up to 60 days except for a preset deductible fee. In contrast, a person in a nursing home must have spent three days in a hospital prior to admission and must require skilled nursing or skilled rehabilitation services on a daily basis in order to receive Medicare benefits. To receive benefits for home health care the older person must be confined to the home and require intermittent skilled nursing or rehabilitative services (U.S. Department of HEW 1977). Because of these restrictions, hospitalization becomes the choice method of receiving health care for many older persons who might otherwise benefit from home health services.

Since early discharge from the hospital is a trend, many patients need at least part-time health care after leaving the hospital. Discharge planning is a great necessity if there is to be continuity of care. Continuity of care is dependent on the health professional's awareness of patients' needs and on their planning for ways to meet those needs (Ambrose 1973). Although a multidisciplinary approach is important and necessary to make the patient's transition from hospital to home, or from hospital to a skilled nursing facility, as easy as possible, Dawson and Stern (1973) believed that the hospital nurse has the

primary responsibility for identifying post hospital needs and for making referrals to community agencies.

Nursing Home Care

After a lengthy study of long-term care, the Senate Subcommittee (1975) declared that long-term care for older people stands as the most troublesome component of the entire health care system. America has failed to produce satisfactory institutional care--or alternatives--for its chronically ill older people. The White House Conference on Aging (1973) also recognized the inadequacy of the health care system to meet the needs of older people, and noted that facilities for providing long-term services were in short supply and many were of substandard quality.

The number of nursing homes and extended care facilities has risen since proprietary institutions have been allowed. However, the overall quality of care has not improved sufficiently to make nursing home care a desireable option for the elderly. Many fear and dread institutional care and, consequently, cling to remaining in their homes. Shanas et al. (1968) reported two housebound aged in the homes for every one aged person in institutions.

The dread of institutionalization is attributed to many factors. The low quality of care in many nursing homes and the fact that institutions, for the most part,

are poorly equipped, staffed and organized, tend to cause opposition to their use by both the older person and the family (Goldfarb 1977). Many of the elderly dread the prospect of institutional care because they view it as the end of the little independence they have (Tobin and Lieberman 1976). Those who have children interpret the move to an institution as rejection by their families. In a social survey by Shanas (1962), all older people, without exception, viewed institutionalization as a prelude to death.

The older person's view of the nursing home as a last residence is fairly realistic, considering the ages of persons who reside in them. Tobin and Lieberman (1976) stated that the elderly in long-term facilities average 82 years of age. In many institutions 20 percent or more of the residents are 90 years old or over. Slightly less than 5 percent of all people 65 years old and over reside in institutions. Sixteen percent of those in the age group of 85 and older are in institutions, in contrast to two percent of the 65 to 75 age group.

The chance for institutionalization sometime before death was found to be one in four in a 20 year longitudinal study by Palmore (1976). Factors that increased the possibility of the need for institutional care were living

alone, being separated or never married, having none or few children, and being female.

A lack of alternatives to institutional care, such as home health services, causes institutionalization to be imposed on many people. Traeger (1975 p. 96) stated

> It should not be necessary for the individual who can receive needed treatment in his own home or in ambulatory care facilities and who can remain in his own home environment with supplemental life support services to enter an institution simply because societal concern has not been extended to develop resources that meet his needs.

Tobin et al. (1972) demonstrated through research that many persons are in nursing homes who do not require the type of services offered. Ten persons were selected from a list of those waiting to enter a nursing home (five were admitted by the time the study was done). A panel of thirty-eight judges was given the ten case studies to read and was asked if dispositions for the subjects would have been different if ancillary services had been available, and if so, what services would be necessary. Fifty percent or more of the judges recommended admission for only two of the subjects. A variety of recommendations for supportive services was made for the other subjects.

Studies cited by Kristen and Morris (1972) also demonstrated unnecessary residence in nursing homes. A study in Massachusetts revealed that only 37 percent of the residents required full time, skilled nursing care.

Fourteen percent needed no institutional care, 25 percent required minimal supervised living, and 23 percent needed only limited and periodic nursing care. In Buffalo, New York, a similar study found that 27 percent was not in need of institutional care.

Advanced age with debility or multiple impairments, such as sight, hearing, mentation, and self-care ability, together with a need for care, are reasons for entering a nursing home. There is usually an absence of available resources--money or family-- sufficient to provide a "one bed nursing home", as Goldfarb (1977) called it, in their own homes. Tobin and Lieberman (1976) suggested that older people enter long-term care facilities to assure survival by retarding further deterioration, maintaining residual capacities, and restoring lost function. Such goals are congruent with the care that should be expected in an organized health care facility. Yet, many older persons in long-term care institutions can be found with a condition that Tobin and Lieberman called "institition personality syndrome". Persons with this syndrome are usually disoriented and disorganized, withdrawn, apathetic, depressed and hopeless. In view of such condition, the nursing home can be considered to cause more incapacity than it cures.

Bell (1973) stated that elderly who are institutionalized suffer from depersonalization, deepening isolation and separation from normal society, loss of privacy, deprivation of intimate relationships, and the threat of higher mortality rates, as compared with older persons living in the community. Goldfarb (1977) indicated that entrance into facilities of poor quality tends to downgrade the person's image of himself. His disability may then become greater and there may be a development or exaggeration of psychological and emotional disorders. According to Tobin and Lieberman (1976), even the best of long-term care institutional environments induce harmful institutional effects since the newcomer cannot escape the identifications that include being sick and in need of care, being closer to death, and possessing a limited and uncontrolled future.

In their study of 100 aged persons who applied to one of the best long-term care facilities, Tobin and Lieberman (1976) discovered that the greatest psychological decrements occurred in anticipation of the dreaded institutionalization. Once the decision was made to enter the nursing home, changes began to occur. The foreseen losses, the separation, and the feelings of abandonment resulted in an extreme reaction. The person increasingly became

cognitively restricted, apathetic, unhappy, hopeless, depressed, anxious, and less dominant in relationships with others. The person in the anticipatory phase already looked like an institutionalized person. Once the applicant entered the nursing home he usually went through a period of acute disequilibrium lasting one or two months and then an initial adjustment was made. Changes in the psychological status during the first two months were minimal. The person usually became preoccupied with his body and perceived himself as having less capcaity for self-care as he identified with the old, sick, and frail residents. By the end of the first year after admission to the nursing home, some residents showed no adverse effects, while others had either markedly deteriorated or died. Of the 85 subjects who entered the institution, 44 suffered these extreme outcomes.

To cause serious negative effects, the move to an institution must have the meaning of loss for the older person. Even the transfer from one institution to another, effecting the loss of friends, familiar persons, and a familiar environment, can have adverse effects on the well-being and physical survival of the aged. Two studies by Blenkner (1967) indicated that the mortality rate of older persons, whose care was coordinated by social workers, rose

in proportion to the number of elderly admitted to institutions. Approximately half of the deaths occurred within the first three months of institutionalization and the remainder were distributed rather evenly over the other three quarters.

Since the institutional process is associated with damaging psychological consequences, and for some, with hastened mortality, Tobin and Lieberman (1976) strongly advocated that all possible efforts be made to prevent unnecessary or premature institutionalization. The decision for placement in even a high quality nursing home should follow only after serious efforts have been made to determine whether continued independent living might be possible if ancillary services were utilized. "Economic costs can only be one consideration in planning for people. Human costs are certainly of more importance" (Tobin and Lieberman 1976 p. 224).

Goldfarb (1977) agreed that older persons should be helped to stay in their own homes or in homes of family members. However, he cautioned that staying in the home should occur only as long as the needs of the older person can be met without "senseless destruction" of family and social patterns. Attempts to keep the physically or mentally ill old at home are often overenthusiastic and exceed

what is physically, emotionally, or financially practical for the family and the community.

Literature is replete with suggestions that alternatives to institutional care can be developed and made available to all people. Only when alternatives are available can older people and families have viable options to meet protective and health care needs.

Home Health Care

There is a growing awareness among the people of America that institutional care is only one way to provide for the well-being of older chronically ill persons. With supportive care, many people could remain in their familiar home environment when illness or physical impairment occur, and have their needs met satisfactorily. Thus, home health care is becoming an important method of delivering health care.

The White House Conference on Aging (1973) emphasized the principle of health care as a basic right of every individual. To assure this right, it is necessary that a comprehensive health care system be available to all people. Hospitals or other institutions do not meet the needs of people who require minimal assistance with their health problems and they fail to provide the continuum of care that is needed after discharge. Home health care can

bridge the gaps in the health care system and provide the option of health care in the home.

Cost of hospitalization is another reason for providing home health services. Richter and Gonnerman (1974) stated that in 1972 the General Accounting Office reported to Congress that

> the cost of building, equipping, and maintaining our modern hospitals has become so great that it is no longer economical to use an acute hospital for convalescent care, treatment of chronic illness, or custodial care" (p. 113).

Medicare standards, with the utilization review committee, do not allow payments in a hospital or skilled nursing facility when the type of care needed could be provided elsewhere. Medicare payments end at the time further inpatient care is no longer "reasonable and necessary" (U.S. Department of HEW 1977 p.8). Consequently, many patients return to their homes before they are ready to care for themselves adequately.

Home health care is defined by the National League of Nursing (1974 p. 1) as

> an array of health care services provided to individuals and families in their places of residence or in ambulatory settings for purposes of preventing disease and promoting, maintaining or restoring health, or minimizing the effects of illness and disability.

An organized home health agency plans, coordinates, and implements services that are appropriate to the needs of

the individual and his family. A broad spectrum of services is provided, either by staff members of by members of various health professions through contractural agreement. Basic essential services that can be offered consist of nursing, homemaker-home health aide, occupational and physical therapy, speech pathology services, social work, nutrition, and medical supplies and equipment. Many other services may be offered and arranged for by the agency.

Three levels of care are provided by the home health service. The first level, intensive services, is utilized by those individuals who can benefit from professional diagnostic, therapeutic, and supportive services under professional supervision and coordination on an intermittant basis. Without this type of service the individual would need to be hospitalized. Intermediate services are the second level of care. These services are designed for those who need convalescent care after an acute illness or have a temporary disability related to chronic illness. Individuals with long-term care needs receive the third level, basic services, which are a combination of health supervision and maintenance designed to maintain such persons in their homes, thus preventing or postponing the need for institutionalization (U.S. Department of HEW 1976c).

In 1973 the American Hospital Association (1973) issued a policy statement which indicated that the home plays a significant role in promoting health and facilitating the healing process. The statement urged that home health care services be developed, fully supported, and utilized because such services

1. contribute to health and well-being of the patient and his family
2. restore the patient to health and/or maximum function
3. prevent costly and inappropriate admissions to institutions
4. reduce readmissions to institutions
5. make possible earlier discharge from the hospital, extended or intermediate care facility, or nursing home (p. 2).

Older people generally prefer to stay in their own homes rather than enter an institution, even when disabled (Markson et al. 1973, Bell 1973, Hammerman 1974, and Lawton 1974). Bell (1973), in his study of the elderly in Florida, found that 85 percent of the older people surveyed wanted to live out their remaining years at home. Tobin and Lieberman (1976) stated that older people fear the present health care system with its emphasis on institutionalization and therefore do without direct health services in an attempt to cling to independent living. Often this lack of services results in accelerated deterioration. The desire for older people to maintain independent living in the community can only be realized when supportive services

are available that realistically strengthen the person's resolution to remain at home.

Total services offered by a home health agency include professional and paraprofessional skills. Therapeutic and rehabilitation services are provided by nurses, occupational and physical therapists, speech pathologists, and social workers. In consultation with a physician, they bring quality care to the ill at home, teach self-care, stress prevention of illness, and help the family to cope with the demands involved in having a patient at home.

The home health aide, with her paraprofessional skills, is an important member of the home health team. Through her services of personal care, the aide can be a valuable adjunct to the expertise of professionals. Home health aides are defined by Coyle (1976) as paraprofessional persons who are especially trained and supervised by professionals to give multiple social and health care services to persons in their homes. Assignments are made according to the patient's needs as determined by the agency staff, and are based on "doing for the clients those things which they are unable to do for themselves." Periodic assessment of the patient's needs and evaluation for continuing service are performed by a professional person.

Home health aide services include both personal care services and supportive services. The scope of personal care services includes assisting with bathing, shampooing hair, assisting with ambulation, helping with simple prescribed exercise, taking vital signs, and assisting with medications. The aide also gives emotional and psychological support as needed, and regularly reports the client's conditions to the supervisor. The supportive services administered by the aide encompass basic homemaking duties (Terlizzi 1976). Occasionally the services of the home health aide are all that an older person needs in order to be able to stay in his own home.

Few studies on home health aide services have been published. One such study by Nielson et al. (1972) was done with 100 older persons who were discharged from a geriatric rehabilitation hospital. Homemaker-home health aid services were provided to one group in order to determine if the program would prevent or delay hospitalization. In the service group 6 persons died and 4 elderly were institutionalized for a total of 8 days, while 4 in the control group expired and 14 patients spent 53 days in an institution.

A total home health care program for the homebound in New York City was surveyed by Brickner et al. (1976). Clients in the first 24 months of the program's operation numbered 222 with a variety of disabilities. Through the

skills of a multi-disciplined team, 23 persons improved to the extent that they were no longer homebound. It was estimated that 85 of these persons were able to remain at home rather than be institutionalized because of the home maintenance program. The investigators maintained that care in the home was about one-third as expensive as nursing home care.

Although home health care plays an important role in the delivery of health care and has proven to be less costly than other types of care, Medicare and other insurances are slow to permit payment for such services. Medicare requires that a patient be confined to his home, be under the care of a physician, and be in need of skilled and intermittent nursing care, physical therapy, or speech therapy before becoming eligible for home health benefits. The homebound requirement impedes the delivery of health care since there are many who are not homebound who need and could benefit from home health services. The Forward Plan for Health - Fy 1978-82 (U.S. Department of HEW 1976d) recommended that the homebound requirement be removed and replaced with prior physician certification and continuing professional review.

For home health aide services, Medicare permits reimbursement only if skilled nursing, physical therapy, or speech therapy is also needed by the patient. Only

personal care services are reimbursable, not housekeeping duties (U.S. Department of HEW 1977). This restriction has been criticized because food preparation, laundry, and cleaning are reimbursable expenses in the institutional setting. Because of the restrictions, home health programs account for less than one percent of Medicare expenditures (Moore and Somers 1976). Blue Cross and some commercial health insurance agencies are gradually including homemaker services in covered benefits but are following the Medicare model. Older people receiving public assistance are allowed homemaker services. This dichotomy in regulations results in the middle income group being generally without an adequate funding source for services which could prevent or delay institutionalization.

A continuum of health care, from the most simple to the highly sophisticated, should be available for all people to use according to their needs (American Public Health Association 1974). With the increase in the population of the elderly, the higher costs and shorter terms of hospitalization and other institutional care, the desire of many to remain in their homes, and a more informed public about disease and self-care, the need for home health services will continue to increase and should be available to all people (Hammerman 1974).

Nursing Implications

Perhaps no other age group needs such a variety of interdisciplinary services as does older adults. The many losses which they experience, vulnerability to malnutrition, severity of acute illness, and the predominence of chronic disease and its residual, call for team planning, consultation, and care in order to restore and maintain health of the older person and promote his independence (Chinn and Robins 1970). The nurses' role in planning and providing health care to meet the needs of older people will be discussed.

Assessment

Before nursing care can be planned adequately for an individual, an assessment must be done to ascertain the person's strengths, weaknesses, and needs. Gathering data for the older person is wider in scope than for younger adults. The psychosocial and physiological changes which accompany aging are often present, and there may be additional problems resulting from a life with physical and emotional stresses (Wolanin 1976a).

A review of literature on assessment revealed a variety of areas that are emphasized by the authors. All elicit basic information about psychosocial and physical function abilities. The nursing history that obtains

information about the patient's usual life style and manner of functioning prior to seeking health care was seen by Hefferin and Hunter (1975) as a means of preserving the dignity and identity of the individual. The history also can be utilized to facilitate participation of family and patient in nursing care.

Assessment, according to Lantz (1976), should identify the individual's perceptions and expectations related to health and illness. It should also furnish clues to the patient's ability to meet his personal needs and to cope with the problems he faces. Wolanin (1976a) divided assessment into three areas: assessment of the person as a physiological and social being, assessment of the physical and social environment in which he lives, and assessment of his interaction with the environment. These areas of evaluation are applicable in any health care setting. For the patient in the home, Remnet (1976) advocated that proximity of children or other family members, friends, and neighbors be assessed for frequency of contact and services exchanged.

Assessment of family dynamics was viewed by Gress (1973) to be especially important for the patient in a nursing home so that nursing personnel can help the patient to retain his personal identity and his identity as a

family member. The anxiety level of the family and the impact of institutionalization on them should also be assessed so the nurse could help the family to discuss their difficulties. Physical assessment of the older adult should determine the patient's capacity for performing activities of daily living. The patient's normal pacing activities should also be observed to facilitate planning that would avoid rushing him beyond his capacity (Wolanin 1976a).

An indepth history of the patient's dietary habits was recommended by Luke (1976). This history would include likes and dislikes, ethnic preferences, knowledge of nutrition, appetite status, ability to chew, manner of purchasing food, and with whom the person eats.

The process of assessment does not end with the initial assessment. It should continue throughout the time the individual is being cared for, regardless of the setting. Continued assessment is necessary for evaluation of the progress the patient is making and for changing the plan of care as different needs occur.

Planning Nursing Care

Wolanin (1976a p. 399) recommended that nurses plan nursing care for the elderly with the following principle

in mind:

> The elderly person does not come asking to find a new life-style, or even a greatly altered one, but that those who are in the helping professions recognize and honor his way of life while assisting in making alterations which are required by lack of the person's resources.

The author assigned to nursing the responsibility of determining how far the older person wants someone to take over some of his tasks, and to what extent the patient is able to maintain control. Bengston and Manuel (1976) stated that it is very important for an individual to have the feeling that he has the personal power to influence his environment and is able to have an effect on the immediate societal world.

Wolanin (1976a) cautioned that planning with the elderly does not involve only a short period of time in the now, but has implications far into the future. The planning must be predictive in nature and involve input from the patient for clarification. Cooperation of the patient in meeting goals is best obtained when the goals are shared in the planning stage and in evaluation of progress.

Planning patient care demands seeing the patient as a unique individual and in the totality of his being. Knowledge of the aging process should serve as a guide while planning, implementing, and evaluating care in order that the multiplicity of problems can be given proper

priorities as the patient moves through the various stages of recovery. Wolanin (1976b p. 432) stated, "At no time is the older person one who can wait until later for some attention to be paid to problems of secondary or tertiary significance." While the patient is in the acute phase or an illness, nursing must not allow decrements in functional ability to occur. Quality of life needs to be considered as well as recovery from a disease entity.

A major goal in health care of the elderly is to discover and maximize the patient's potential (Jennings et al. 1972 and Hutchins et al. 1972). Focusing on capabilities rather than disabilities will enable the nurse to help the patient achieve and maintain his highest degree of independence.

In planning home care, the nurse needs to be aware of the patient's values, life-style, and habits. The plan of care should minimize the need for changing life-long habits and patterns (Remnet 1976). The scope of services for the person at home may be wider than the patient in the nursing home or hospital. Housing, nutrition, housekeeping, and transportation are but a few of the environmental concerns that might require planning and intervention. All nurses, but especially home health nurses, need to be familiar with community resources that can be utilized in meeting the older person's health related needs.

Discharge planning is an integral part of a patient's plan of care. Possible problems at discharge time should be identified soon after the patient is admitted so a plan of action might be initiated as soon as possible. Delayed discharge planning often results in costly prolonged hospital stays (Kulys 1970).

Patient teaching, which has as its ultimate goal the self-dependence of the patient, is an important part of the discharge plan (Ambrose 1973). Teaching the older person may require a slow pace and much repetition, Involving the family in the teaching sessions can serve a dual purpose: a source of motivation for the family and patient, and a means of helping the family to adapt hospital procedures to the home situation (Wahlstrom 1967). The family should be involved as much as possible in discharge planning, especially if referral to an intermediate care facility, nursing home, or home health care is required.

Implementation of Nursing Care

Implementation of patient care should be aimed at helping the patient to achieve the goals set for and/or with him. The implementation should be accomplished by a variety of team members, including the patient. During this phase, the nurse continues to collect data about the patient as a person, his condition, his problems,

his reaction and feelings. The plan is evaluated and adjusted as necessary.

In implementing patient care, changes should be kept at a minimum if possible. What health professionals may regard as change for the better may be seen by the older adult as another change which requires psychic energy to integrate. There is never a time when continuity of personnel and coordinated nursing is so obviously beneficial as when treating the elderly (Hall and Weaver 1974).

Health Condition and Physical Function

Since acute illnesses in the elderly are usually severe and prolonged and are frequently superimposed on chronic conditions, nursing interventions must consider both acute and chronic illnesses. Nursing actions should be aimed at preventing deterioration of the chronic condition, assisting the patient to maintain functional ability, and preventing immobilization disabilities associated with bedrest, as well as treating the acute condition. An elderly individual who has been active at home will need encouragement to remain as active as his condition and treatment will allow (Rosenow and Long 1972).

When it is not possible to restore function, the older adult must learn to live with disability. Nursing actions should emphasize the person's abilities and assets

and minimize the handicapping aspects of the disability. Emotional and psychological support will need to be given until the disability is accepted by the individual and throughout the learning phase of rehabilitation (Rosenow and Long 1972).

Social Isolation

Social isolation poses a threat to older adults. A thorough social history is needed to identify possible isolated individuals. For the person who is isolated, it is necessary to discover the cause of isolation and/or loneliness before a possible solution can be offered. Some persons find satisfaction in solitude, and this quality needs to be respected and reinforced by the nurse (Black 1973). Others may need a renewed interest in themselves and their environment before they can attempt involvement in a group (Conti 1970).

For persons who desire increased interaction with others, the nurse should be able to recommend community resources for group participation by the elderly. Participation in groups, even very small groups, can reinforce in a positive manner the ego strength and personal identity of older persons (Carter 1976). This type of peer support offers friends, caring attention, interested listeners, hope for the future, acceptance, support, and recognition.

Accessibility of Medical Care

Utilization of medical care is more of a problem to some older people than its accessibility. Older persons tend to attribute minor ailments to the aging process and therefore do not seek medical attention until symptoms are pronounced (Estes 1976). Older persons should be taught that old age does not cause disability and that pain, weakness, and other symptoms are usually caused by a disease process. If medical attention is sought when symptoms appear, increased illness and disability can often be prevented. Emphasis should be placed on the importance of going to the doctor for routine check-ups as well as for follow-up care. Participation in screening programs aimed at detection and prevention of chronic illness should be encouraged (Chinn and Robins 1970).

Service needs - Nutrition and Transportation

Nutrition is a primary factor in how well older people evade disease, respond to therapy, and enjoy life (Luke 1976). A thorough history of dietary habits should enable the nurse to help the patient improve his nutritional status. Consultation with a dietitian should be utilized for patients with malnutrition and obesity problems, as well as with special dietary prescriptions. Verwoerdt (1973) advised that the whole person must be considered when

recommending special diets and teaching adherence to them. Both physical and psychological aspects need to be assessed for their relative importance and their effect on each other. A special diet may improve a physical problem but create a psychological one, such as depression, that might cripple the person more than the disease would.

For the person with a poor appetite and lack of motivation to cook because he lives alone, or for the person who overeats to compensate for loneliness, the nurse could recommend congregate meals. The program of meals on wheels, which provides at least one nutritious meal a day for homebound persons, is available in many cities. Homemakers are another option for supplying meals. A homemaker will plan and prepare meals as well as shop for groceries (Coyle 1976).

Transportation has an influence on health in an indirect way. If transportation is unavailable or difficult to obtain, food and other necessities cannot be procured, medical attention becomes unattainable, and interactions with others outside the home are minimized (Carp 1971). Older persons should be made aware of transportation that is available to them at no cost or reduced rates. In communities where transportation programs have not been initiated, the nurse, realizing the health implications, could be influential in stimulating the planning of such a program.

Evaluation

Evaluation is the phase in the nursing process by which the nurse finds out if nursing interventions proposed to meet the individual's needs, actually did meet them. Evaluation takes place concurrently with the provision of nursing care and adjustments in the nursing care plan are made as needed. The patient and the entire health team should participate in the evaluation process (Hall and Weaver 1974).

Summary

The physiological and psychosocial aspects of the aging process and their ramifications were discussed in the first part of this chapter. It was emphasized that the aging process itself does not cause illness but makes the person more vulnerable to conditions that require health care interventions. Five health and health related areas were developed according to their influence on the aged, the needs they precipitate, and nursing interventions that can be utilized to meet those needs. The five areas included health condition, functional ability, accessibility to medical care, social isolation, and service needs such as nutrition and transportation. Three of the most common health delivery systems, hospitals, nursing homes, and home

health services, were discussed in relation to their availability and manner of meeting the health needs of older adults.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

This study was a quantitative-descriptive study of the population description type (Fellin 1969) designed to elicit a description of health care needs of older persons which could be met by a home health care delivery system. A personal interview using a questionnaire was conducted in the homes of eighty subjects to obtain the data.

Setting

The data for this study were gathered from persons 65 years of age and older in their homes in a city of 20,085 population (1976 figures) in a midwestern state. The city is a county seat and is characterized by rapid growth in recent years which can be attributed, at least in part, to the increase in the number of industrial plants. The city population increased by approximately 4,000 in a six year span. The residents are described as predominantly white, middle class, and affluent, with relatively few families living below poverty level.

In 1970 there were 1,576 persons over 65 years of age in the city (U.S. Bureau of Census 1970); more recent figures are not available. The growth rate of this segment of population differs from the national growth. Between 1960 and 1970 the number of citizens in this city decreased by 3.3 percent while the older population increased 27.3 percent. Of the elderly in the city, 39.5 percent were 75 years of age and older. It is this age group that has the highest percentage of health condition problems, physical disability, and social isolation (Managan et al. 1974 and Shanas et al. 1968).

The city contains a 200 bed general hospital and a nursing home with 150 beds. Personal medical care is provided by 22 private physicians and the hospital emergency room; no clinics are available. There are no geriatric physicians or nurse specialists practicing in the area, and there is an insufficient number of primary care physicians in the city (one per 2,500 persons in the city, not counting people from surrounding communities). One nurse in the county public health department is designated to administer nursing care in the homes throughout the county. In 1976 this nurse served 27 patients in their homes.

Programs to meet the psychosocial, nutritional, housing, and transportation needs of the elderly are

functioning in the city. The weak link in the provisions for the older people appears to be in the home health care and homemaker areas.

Population

The population for this study consisted of persons over 65 years of age. The most recent available list of this population is one obtained three years ago from the county clerk's office. Since the list included persons over 60 years of age, adjustments of age were made for the sample selection. Five percent of those over 65 years of age, a total of eighty persons, were randomly selected from the list for the sample. This number was anticipated to be adequate to obtain a precise estimate of health care needs. It was pre-established that eighty persons would be interviewed. Persons unable to be contacted or who refused to participate were eliminated and additional subjects were randomly selected from the available list.

The Tool

The tool used for this study was a questionnaire (Appendix A) developed by Managan et al. (1974) which was used by the authors for a similar study. The questionnaire was developed to determine the extent to which health problems existed in the study population. The items for the

instrument were selected to identify persons with problems in five areas which have implications for nursing intervention in the home. The five areas of health problems included in the tool are: 1) health condition, 2) physical functioning, 3) accessibility of medical care, 4) social isolation and 5) service needs (transportation and meals). Demographic questions sought information about age, sex, occupation, place of birth, educational level, and age and relationship of other persons in the household. A total of twenty questions was asked.

In the tool the questions pertaining to physical functioning were patterned after the Index of the Cross National Study reported by Shanas et al. (1968 p. 26). The scoring procedure for each parameter was adapted from a questionnaire used by the Administration on Aging and reported in Social Indicators for the Aged (Institute on Interdisciplinary Studies 1971 p. 51-90). Each indicator score represents a composite of several questionnaire items. The score ranges between zero and one. A score of zero represents no problems, while a score of one represents the most severe problems.

Method of Collecting Data

Approval to conduct the study was sought from the Human Rights Research Committee of Texas Woman's University

prior to beginning the survey. To obtain the data for this study, personal interviews were conducted in the homes of eighty persons 65 years of age or over. The researcher and one volunteer administered the interviews. The volunteer, a Licensed Practical Nurse, received specific instructions from the researcher about the process. A tool composed of structured questions and one open-ended question was utilized by the interviewers. Demographic data were included at the beginning of the questionnaire.

The randomly selected subjects were contacted by telephone to explain the study and determine if they were willing to participate. Appointments for the interviews were made. Households from which there was no response to the initial phone call were called two subsequent times. For persons without listed phone numbers, three attempts were made to contact them in their homes. Records were kept of the number of households contacted, those unable to be contacted, and those who refused to participate in the survey.

Each person to be interviewed was informed verbally of the purpose of the interview and the manner of participation. Those subjects whose hearing impairment prevented an adequate verbal explanation were provided with an explanation in writing (Appendix B). Permission to interview the person was obtained in writing from each individual. Those

who voiced fear or reluctance were allowed to read the questions to dispel fears about the type of questions being asked. Assurance of confidentiality was given to the subjects. As each question was asked the response was recorded on the questionnaire.

Treatment of Data

Each possible answer on the questionnaire was assigned a numerical value when the questions were formulated. The numerical values of the several responses for each health parameter were totaled and then subjected to a formula to obtain a score. Scores ranged from zero, indicating no problem, to one, indicating a severe problem. The scores were then tabulated for percentage and frequency distribution. Tables were used to display the data.

Summary

This investigation was a survey designed to obtain information about health care needs of older people. A sample of eighty subjects was randomly selected to be interviewed in the homes of the subjects. Data were collected by use of a questionnaire used previously by other researchers. Percentage and frequency distribution were used in analysis of the data.

CHAPTER IV

ANALYSIS OF DATA

Introduction

A quantitative-descriptive research study was conducted to determine health care needs of older persons living in the community. Eighty randomly selected subjects 65 years of age and older were interviewed to determine their health status in five areas: 1) health condition, 2) physical function, 3) accessibility of medical care, 4) social isolation, 5) service needs (transportation and nutrition). Data collected from the sample will be presented and interpreted in this chapter.

Description of the Sample

The sample in this study consisted of eighty persons 65 years of age or older who lived in the community. To obtain the specified number of persons, 122 people were randomly selected; 42 did not participate in the study. Of the 42, 12 refused to participate; one would not sign the consent form but otherwise would have participated. Two of the selected persons were known to be in a nursing home, and three persons had expired. Table 1 summarizes the disposition of the 42 selected persons who did not participate

in the study. In the table, the number listed as "not home" included individuals listed in the telphone book but could not be contacted with three attempts by phone or by knocking at their door. Persons listed under the heading "does not live there" are those whose home appeared to be empty or the interviewers were informed that the person no longer resided at that address.

TABLE 1

DISPOSITION OF UNAVAILABLE SUBJECTS

Unavailable Subjects	Number	Percent
Not home	11	26.2
Does not live there	14	33.3
Refused	12	28.6
Nursing home	2	4.8
Expired	3	7.1
Total	42	100.00

The age distribution of the 80 subjects interviewed ranged from 65 years to 89, with a mean age of 73.02. Thirty-three (41.25 percent) of the subjects were 75 years of age and older, the age group which usually has the most health problems. According to the 1970 census (U.S. Bureau of Census. Kansas. 1970), this age group comprises 39.46

percent of the older population in the city where the study was conducted. The age and sex distribution of the sample is summarized in table 2.

TABLE 2

DISTRIBUTION OF SUBJECTS BY AGE RANGE AND SEX

Age Range	Females		Males		Total	
	N	%	N	%	Number	Percent
65-69	19	23.75	7	8.75	26	32.50
70-74	12	15.00	9	11.25	21	26.25
75-79	13	16.25	6	7.50	19	23.75
80-84	8	10.00	5	5.00	12	15.00
85-89	2	2.50	0	0	2	2.50
Total	54	65.50	26	32.50	80	100.00

Fifty-four (67.5 percent) individuals in the study group were females and 26 (32.5 percent) were males, constituting a ratio of approximately 2:1. In the city where the data were obtained, women comprised 60.72 percent of the elderly population, and men 39.28 percent. The mean age for both sexes in the study was close: 73.35 for women and 72.69 for men.

Twenty-five percent of the sample population lived alone, and of the 20 persons, only two were men. Those who

lived with spouses comprised 68.75 percent of the sample; the remaining 6.25 percent lived with an adult child or a non-relative. Of the 20 persons living alone, only four were under 75 years of age. A summary of household composition is contained in table 3.

TABLE 3

HOUSEHOLD COMPOSITION BY AGE RANGE AND SEX

Household Composition	65-74		75-84		85-90	Total	
	F	M	F	M	F	Number	Percent
Lives alone	4	0	12	2	2	20	25.00
Lives with others							
Spouse	25	15	7	8	0	55	68.75
Adult child	0	1	1	0		2	2.50
Non-relative	2	0	0	0	1	3	3.75
Total	31	16	20	10	3	80	100.00

Two persons in the sample of 80 were foreign born; one was born in Russia and the other in Ireland. Of those born in America, 15 were born in another state. Only one subject was black. This small number was expected since the total city population contains only 354 (2.2 percent) blacks (U.S. Bureau of Census. Kansas. 1970).

The educational level of the sample ranged from less than seventh grade (7.5 percent) to college graduation (8.75

percent). The majority of individuals finished grade school or received at least a partial high school education. Six of the subjects received less than seven years of schooling while 18 individuals attended college. Table 4 summarizes the educational status.

TABLE 4

SUBJECTS' EDUCATIONAL STATUS BY NUMBER AND PERCENT

Educational Status	Number	Percent
Grades 1-6	6	7.50
Grades 7, 8, 9	28	35.00
Grades 10, 11	7	8.75
High School Graduate	19	23.75
Partial College	11	13.75
Professional Training	2	2.50
Total	80	100.00

Presentation and Discussion of Findings

The five health parameters included in this study are presented with score distribution and percentage in table 5. The score range between zero and one represents a composite of several questions for each parameter. Zero indicates no health problem in a particular parameter and the score of one represents a severe problem. A scale in increments of .25 is used in table 5; the lowest increment,

TABLE 5

DISTRIBUTION OF HEALTH PROBLEMS BY PARAMETER SCORES

Scores	Health Condition		Physical Function		Accessibility to Medical Care		Social Isolation		Service Needs	
	N	%	N	%	N	%	N	%	N	%
0	60	75.00	36	45.00	76	95.00	13	16.25	73	91.25
.01-.25	4	5.00	30	37.50	1	1.25	25	31.25	5	6.25
.26-.50	7	8.75	11	13.75	1	1.25	20	25.00	2	2.50
.51-.75	8	10.00	3	3.75	1	1.25	19	23.75	0	0
.76-1.00	1	1.25	0	0	1	1.25	3	3.75	0	0
Total	80	100.00	80	100.00	80	100.00	80	100.00	80	100.00

.01 to .25, indicates a problem of low magnitude while the highest increment, .76 to 1.00 represents a problem of high magnitude. In many of the following tables the parameters will be reported in increments of .50.

As shown in table 5, the least number of problems was reported in the area of accessibility to medical care, with only four persons having a score above zero. The area of social isolation revealed the most problems in number (67 persons with scores above zero) as well as in magnitude, with 22 persons, or 27.5 percent of the sample, with scores ranging above .51. Each parameter is presented in detail.

Health Condition

Questions about health conditions centered on the subject's ability to ambulate, number of sick days during the past month, and where the person was cared for while sick. Three-fourths of the respondents reported no health condition problem, with the greatest percentage (30 percent) occurring in the 65 to 69 age group. Those with problems in the score range of .01 to .50 numbered 11 persons (13.75 percent) and 9 individuals (11.25 percent) had scores of .51 or above. Conditions to score minimally above .51 required one of three patterns during the previous month: 1) the person is usually up and around but had been ill for 2 to 3 weeks and spent time at the hospital, 2) the person

is usually up and around but was ill at home for more than 3 weeks, 3) the person usually stays in bed or in a chair, had been ill for 2 to 3 weeks at home or 1 to 2 weeks at the hospital. Of the 20 persons with health condition problems, 8 were sick for longer than 3 weeks, 4 were ill for 8 to 21 days, and 8 for less than 7 days. Five of the 20 subjects were hospitalized; 15 spent the sick days at home. Of the 9 subjects with scores above .51, seven persons were in the 75 to 84 age range. Since the incidence of illness, especially chronic conditions, increases with age, this finding was expected. The two subjects over 85 years of age reported no health condition problem. Table 6 portrays the health condition problems by age range and score levels.

TABLE 6

HEALTH CONDITION SCORES BY AGE RANGE

Age Range	No problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
65-69	24	30.00	2	2.50	0	0	26	32.50
70-74	12	16.25	6	7.50	2	2.50	21	26.25
75-79	14	17.50	2	2.50	3	3.75	19	23.75
80-84	7	8.50	1	1.25	4	5.00	12	15.00
85-89	2	2.50	0	0	0	0	2	2.50
Total	60	75.00	11	13.75	9	11.25	80	100.00

In comparing men and women with health condition status, 20 of 26 men had no problem in this area, while 40 of 54 women had no problem (table 7). In the score range of .51 or above were eight women and one man. Six of the women and the man were over 75 years of age. Two women were in the age range of 70 to 74. Older aged persons generally have more illnesses or are more incapacitated than the younger aged (Shanas et al. 1968). Also, women tend to have more illnesses than men (Palmore and Maddox 1977).

TABLE 7

HEALTH CONDITION SCORES BY SEX

Sex	No problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
Females	40	50.00	6	7.50	8	10.00	54	67.50
Males	20	25.00	5	6.25	1	1.25	26	32.50
Total	60	75.00	11	13.25	9	11.25	80	100.00

Physical Function

The interview questions on physical functioning focused on the older person's ability to perform tasks which make him independent of others for personal care. These tasks included getting about the house, going up and

down stairs, getting out of the house, ability to wash and bathe self, to dress and put on shoes, and to feed self. The largest problem area among the six tasks was going up and down stairs, with more than half (52.5 percent) of the subjects having some difficulty or inability to do so (table 8). Five persons were unable to go out of doors and 13 had difficulty going out.

TABLE 8

PHYSICAL FUNCTION DIFFICULTY BY NUMBER AND PERCENT

Physical Function	No Difficulty		Some Difficulty		Cannot Do		Total	
	N	%	N	%	N	%	N	%
About the house	65	81.25	15	18.75	0	0	80	100
Up and down stairs	38	47.50	31	38.75	11	13.75	80	100
Out of house	62	77.50	13	16.25	5	6.25	80	100
Washing and bathing	60	75.00	20	25.00	0	0	80	100
Dressing	69	86.25	11	13.75	0	0	80	100
Feeding self	80	100.00	0	0	0	0	80	100

Of the personal care items, 25 percent of the subjects had difficulty with bathing and 11 persons (13.75 percent) had difficulty dressing. All of the subjects were able to feed themselves.

The composite scores for the physical function parameter according to age are displayed in table 9. Almost half of the subjects (45 percent) had no problems with any of the physical function tasks. The largest number of persons had scores in the .01 to .50 range. Only three individuals scored .51 or over, although four others had scores of .50. In order to score above .50, an individual must have the equivalent of some difficulty with five of the tasks and inability to perform one. Of the three persons with scores above .51 one lived alone, one lived with a spouse, and one lived with a retarded son. Their ages ranged from 70 to 82. Of the four respondents with scores of exactly .50, three whose ages were between 77 and 80 lived alone. The seven subjects with scores of

TABLE 9

PHYSICAL FUNCTION SCORES BY AGE RANGE

Age Range	No Problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
65-69	20	25.00	6	7.50	0	0	26	32.50
70-74	7	8.75	13	16.25	1	1.25	21	26.25
75-79	6	7.50	12	15.00	1	1.25	19	23.75
80-84	3	3.75	8	10.00	1	1.25	12	15.00
85-89	0	0	2	2.50	0	0	2	2.50
Total	36	45.00	41	51.25	3	3.75	80	100.00

.50 or above were women. Five were homebound. None of the male subjects scored .51 or above (table 10). These findings support the statement of Shanas et al (1968) that women are more likely to report difficulties getting about and are more likely to be homebound than men.

TABLE 10

PHYSICAL FUNCTION SCORES BY SEX

Sex	No Problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
Female	24	30.00	27	33.75	3	3.75	54	67.50
Male	12	15.00	14	17.50	0	0	26	32.50
Total	36	45.00	41	51.25	3	3.75	80	100.00

Comparison of mobility scores of this study group with those reported by Shanas et al. (1968 p. 23) and by Managan et al. (1974 p. 427) revealed a higher rate of difficulty with mobility for this sample than in the other two studies. In the study sample, 76.25 percent of the subjects can go out of doors without difficulty, while in studies by Managan and Shanas, 87.5 percent and 89 percent respectively could do so. More persons are homebound in this study also. Table 11 compares the three studies in the area of mobility.

TABLE 11

COMPARISON OF AMBULATORY AND HOMEBOUND STATUS OF THE STUDY SAMPLE WITH TWO OTHER STUDIES

Ambulatory and Homebound Status	Study Sample N	Study Sample %	Managan Study %	Shanas Study %
Can go outdoors without difficulty	61	76.25	87.5	89.0
Can go outdoors with difficulty	14	17.50	9.1	6.0
Ambulatory (Subtotal)	75	93.75	96.6	95.0
Homebound	5	6.25	3.4	5.0
Total	80	100.00	100.00	100.00

Social Isolation

Social isolation was studied from responses regarding how often during the past week the subject spoke to someone on the telephone or visited in person with others, and how often in a period of a month meetings or activities of clubs or informal groups were attended. Of the five parameters studied, this one had the highest number of scores above .51, indicating that some individuals have very little contact with persons outside the home. Thirteen women and nine men, or 27.5 percent of the respondents,

were included in the high score group (table 12). Only 13 individuals (16.25 percent), 10 women and 3 men, reported no problem with social isolation as defined for this study. Since the sample contained a ratio of two women to every man, the study results indicate that men are more isolated than women. More than one-third of the men in the sample and about one-fourth of the women had scores of .51 or above.

TABLE 12

SOCIAL ISOLATION SCORES BY SEX

Sex	No Problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
Female	10	12.50	31	38.75	13	16.25	54	67.50
Male	3	3.75	14	17.50	9	11.25	26	32.50
Total	13	16.25	45	56.25	22	27.50	80	100.00

When age and social isolation are considered, the greatest percentage of scores for all ages occurred in the .01-.50 range (56.25 percent). Of the 13 individuals who reported no isolation problems, eight persons were 65 to 69 years of age. In the .01-.50 score range, as age increased, the number and percent of problems decreased. However, in the higher score range, as the age increased, so did the

isolation responses through the first three age groups. Proportionately, the age group between 80 and 84 had the least number of persons in the high range scores than any age group, with the exception of those between 65 and 69 years of age. Table 13 summarizes social isolation according to the age variable.

TABLE 13

SOCIAL ISOLATION SCORES BY AGE

Age Range	No Problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
65-69	8	10.00	15	18.75	3	3.75	26	32.50
70-74	2	2.50	12	15.00	7	8.75	21	26.25
75-79	2	2.50	9	11.25	8	10.00	19	23.75
80-84	1	1.25	8	10.00	3	3.75	12	15.00
85-89	0	0	1	1.25	1	1.25	2	2.50
Total	13	16.25	45	56.25	22	27.50	80	100.00

According to the respondents' answers, educational status demonstrated a relationship to the degree of isolation of the subjects. In the high range of isolation scores, the percentage of isolated persons decreased as education increased. Table 14 summarizes the extent of isolation according to educational status.

TABLE 14

SOCIAL ISOLATION SCORES BY EDUCATIONAL STATUS

Educational Status	No Problem		.01-.50		.51-1.00		Total	
	N	%	N	%	N	%	N	%
Grades 1-6	0	0	2	2.50	4	5.00	6	7.50
Grades 7, 8, 9	3	3.75	16	20.00	9	11.25	28	35.00
Grades 10, 11	2	2.50	3	3.75	2	2.50	7	8.75
High School Graduate	3	3.75	12	15.00	4	5.00	19	23.75
Partial College	2	2.50	8	10.00	1	1.25	11	13.75
College Graduate	2	2.50	3	3.75	2	2.50	7	8.75
Professional Training	1	1.25	1	1.25	0	0	2	2.50
Total	13	16.25	45	56.25	22	27.50	80	100.00

A comparison of questions pretaining to isolation revealed that women used the telephone everyday almost twice as much as men, and men visited in person with others every day slightly more often than women. More women than men responded that they attended meetings or group activities four or more times a month. However, fewer men than women responded that they never attended such activities. The number of homebound women may have accounted for this difference.

Comparison of Three Parameters

The parameters of health condition, physical function and social isolation were examined while controlling for age, sex, and scores above .51 in one parameter. Tables 15 and 16 summarize the comparison of social isolation with health condition and physical function scores.

TABLE 15

DISTRIBUTION BY HEALTH CONDITION AND SEX FOR SUBJECTS WITH SOCIAL ISOLATION SCORES OF .51 AND ABOVE

Sex	Social Isolation	Health Condition		
		0	.01-.50	.51-1.00
Female				
65-69	2	3	0	0
70-74	4	3	0	1
75-79	4	3	0	1
80-84	2	0	0	2
85-89	1	1	0	0
Subtotal	13	9	0	4
Male				
65-69	1	1	0	0
70-74	3	3	0	0
75-79	4	4	0	0
80-84	1	1	0	0
Subtotal	9	9	0	0
Grandtotal	22	18	0	4

Of the 22 respondents who scored above .51 on social isolation, 18 persons or 81.8 percent had no health condition problem and 34.6 percent (8 persons) scored zero in the physical function parameter. Four of the 13 women scored above .51 in health condition and 3 in physical function. Three of these women were homebound. None of the nine men

TABLE 16

DISTRIBUTION BY PHYSICAL FUNCTION AND SEX FOR SUBJECTS WITH SOCIAL ISOLATION SCORES OF .51 AND ABOVE

Sex	Social Isolation	Physical Function		
		0	.01-.50	.51-1.00
Female				
65-69	2	2	0	0
70-74	4	1	1	1
75-79	4	0	3	1
80-84	2	0	1	1
85-89	1	0	1	0
Subtotal	13	4	6	3
Male				
65-69	1	0	1	0
70-74	3	1	2	0
75-79	4	3	1	0
80-84	1	0	1	0
Subtotal	9	4	5	0
Grandtotal	22	8	11	3

scored above .51 in either health condition or physical function. This finding indicates that, for the majority of older people, social isolation, as determined by this study, is not related to health problems. It was noted that the respondent with the highest social isolation score (.999) lived alone but had no health condition problem and had some difficulty going up and down stairs but no other ambulation difficulty.

In the health condition parameter, respondents with scores above .51 numbered 6 women between the ages of 70 a and 82. Two of these scored in the high range in physical function and 4 in social isolation. The 3 respondents with physical function scores above .51 also scored above .51 on the social isolation and health condition parameters. All were women over 70 years of age who were homebound.

Accessibility of Medical Care

Inability to see a doctor when needed for an illness during the past month, reason for not being able to see a physician, and having a family doctor were factors which sought to determine problems with medical care accessibility. Four persons (5.0 percent) responded with a problem. One subject, a 66 year old male, needed to see a doctor but was unable to get an appointment soon, and one person had no family physician. Two respondents, 79 and 80

year old women classified as homebound, were unable to leave the house to go to the physician's office.

Service Needs

Service needs focused on a hot meal daily and availability of transportation. Four women between the ages of 75 and 84 missed a hot meal once or a few times a week. Three of these were homebound and the other had severe emphysema. None of the other respondents (95 percent) missed a hot meal because of inability to prepare or obtain it.

The question concerning transportation sought information about the frequency, during a month, of which the subject stayed home because a ride was unavailable. Two subjects, one man and one woman, reported lack of transportation once or twice a month. Both were in their seventh decade. One woman responded with "many times" although she had access to, and utilized, transportation furnished for older persons by the city.

Summary

In this chapter, the demographic characteristics of the respondents were reviewed and problems in five health parameters were examined. The age range of the eighty subjects was from 65 to 89 years, with a mean age of 73.02. The ratio of women and men was approximately 2:1. While 18

of the 54 women lived alone, two of the 26 men reported living alone.

Of the five health parameters studied, accessibility to medical care presented the least number of problems with only four persons having scores above zero, two of whom scored above .51, indicating that the individuals needed to see a doctor but were unable to do so in the month prior to the interview. The area of social isolation revealed the most problems in number as well as intensity. Proportionately, more men than women scored above .51, which means they had little or no contact with people outside the home. This finding is inconsistent with findings in the literature that women were more isolated than men. When social isolation was compared with physical function and health condition, it was noted that isolation was not influenced by these two health factors.

Health condition responses showed that three-fourths of the subjects had no problems, and the number of those with scores of .51 or over increased as age increased. A health condition score above .51 implied an illness within the previous month lasting three weeks or more and treated at home, or an illness of one to three weeks treated at a hospital. In the area of physical function, the most difficult task was going up and down stairs, and the least problematic task was feeding self, with all the subjects

able to do so. A larger percentage of persons were homebound in this study than in two other studies (Shanas et al. 1968 and Managan et al. 1974).

Service needs were reported by seven persons, none of whom scored above .51. Four respondents demonstrated minor nutritional needs, and three reported transportation needs.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

A descriptive study was devised and implemented to determine health care needs of older persons. This chapter presents an overview of the study, draws conclusions about the results, discusses implications of the study, and makes recommendations regarding further research.

Summary

The study was conducted on elderly individuals living in the community to determine health care needs which have implications for home health care. To determine the need, an interview questionnaire consisting of 20 questions concerning five health parameters was utilized. The health parameters studied were health condition, physical function, accessibility of medical care, social isolation, and service needs which included nutrition and transportation. Frequency distribution and percentage were used in analysis of the data.

The sample for this quantitative-descriptive study was a group of eighty persons over 65 years of age who were randomly selected from a list of the older population in a

city of 20,085 citizens. Interviews were conducted in the homes of the subjects. The ages of the sample group ranged from 65 to 89 years. The majority was females, which is representative of the national aged population.

The scoring procedure of the interview questions involved assigned numbers for each possible answer. A composite of several questionnaire items yielded a score for each health parameter ranging between zero and one. A score of one represents the most severe problems, while a score of zero represents no problem.

The parameter which demonstrated the least number of problems for the sample group was accessibility of medical care. Two individuals reported inability to leave the house to see a doctor, one reported not being able to get an appointment within a reasonable time, and one had no family physician.

Next in the order of least reported problems was in the area of service needs, which included hot meals each day and availability of transportation. Four respondents reported missing a hot meal once or several times a week because they were unable to prepare it themselves. Unavailable transportation once or twice a month was reported by two subjects, and one individual reported staying home many times a month because of lack of transportation.

Health condition, physical function and social isolation parameters indicated varying levels of need. Of the three, social isolation scored highest in the number of persons with problems, as well as the highest number of persons with scores of .51 or above. Considering the percentage of men in contrast with the percentage of women who had high social isolation scores, men in this sample were more isolated than women. This finding is inconsistent with the national survey done by Shanas et al. (1968) which showed women to be more frequently isolated. Reasons for lack of interaction were not sought in this study.

The health condition parameter had a high number of scores (75 percent) indicating no problem. Nine of the 20 persons with health condition problems scored .51 or above, implying that within the previous month an illness of 2 to 3 weeks occurred which was treated at a hospital, an illness of more than three weeks was cared for at home, or for the person who usually spends the day in bed or in the chair, an illness of 2 to 3 weeks was treated at home or 1 to 2 weeks were spent in a hospital. Five of the 20 subjects were hospitalized during their illness, the other 15 remained at home.

Physical functioning scores showed that slightly less than half of the respondents had no problem in this

area, and only three had scores of .51 or above. To score .51 or above, the person must have had the equivalent of some difficulty with five of the physical functioning tasks and inability to perform one. The majority had minimal problems, with difficulty going up and down stairs rating the highest number of responses. Tasks which some respondents were unable to perform were going out of the house and walking up and down stairs.

When three parameters, social isolation, health condition, and physical function were compared, it was noted that 9 of the 13 subjects with scores above .51 in social isolation had no health condition problem and 4 of the 13 scored above .51 in physical functioning. Since only four persons attributed social isolation to health condition or physical function problems, the study indicated that lack of social interaction does not result from poor health condition or poor functional ability.

Conclusions

The study resulted in the following conclusions:

1. Health condition problems increased as age increased. This finding is consistent with those of other studies which reported that older aged persons generally have more illnesses or are more incapacitated than the younger aged.

2. Subjects tended to stay at home during illness rather than be hospitalized

3. Age was not a specific contributing factor in social isolation, nor did isolation appear to result from health problems or physical functioning impairment

4. More men were isolated than women, which is contrary to findings of other studies

5. Education appeared to have an influence on social isolation. As education increased, social isolation decreased.

6. Women had more physical function and health condition problems than men. This finding verifies previous study findings that women report more illnesses than men.

7. Homebound subjects were women over 70 years of age

8. Nutrition, transportation, and medical care accessibility are minimal problems among the study participants

Implications

The findings of this study indicate the need for health education, health maintenance, and health monitoring programs for the elderly. Screening programs and health education could be helpful in aiding individuals to remain

healthy or to seek health care as early as possible. Evaluation of physical functioning abilities could result in planning with the individual for ways to facilitate ease of activities of daily living and to promote safety in the home.

The number of persons who prefer to stay in their homes despite functional disability and illness indicates a need for home health services. A multidisciplinary approach to health care in the homes could be of value in improving health and quality of life.

Since isolation can result in loneliness, depression, and psychosomatic illness, evaluation of activities provided for the elderly should be undertaken to determine their suitability and desireability for the people of the city. Methods for making the activities known to people should also be assessed. It was beyond the scope of this study to determine the cause or effects of isolation. It may be that these rural people are used to providing their own source of entertainment and that they enjoy quiet leisure in their homes.

Although this study did not include patients in hospitals, implications for nursing service can be deduced. The large number of older people with minimal or severe functional disability in their homes points to the need

for a thorough admission assessment of psychosocial and functional ability. Nursing care should be planned to foster independence and maintain or increase functional ability. Such assessment and nursing care could stimulate early discharge planning involving the health team which would insure continuity of care after discharge. Need for follow-up health care in the home should be carefully assessed and appropriate referrals made. Nurses need to be aware of resources available for assisting the elderly and disabled.

Since the number of older aged adults is increasing and also the number of older persons with health problems, geriatrics should be an integral part of the nursing curriculum. Special emphasis should be placed on the well-aged and on primary and secondary prevention. Clinical practice should include, when possible, the well-aged as well as those with illness.

Continuing education incorporating normal physiology of the aging and psychosocial problems of the aged should be made available for nurses. Personnel working among the aged in long-term facilities should have well planned orientation programs on care of the aged, as well as continuing education to improve their understanding of the aging process and the uniqueness of individuals undergoing the process.

Recommendations

As a result of this study it is recommended that

1. The study be replicated in other communities

2. The study be replicated with a stratified random sample according to age

3. The tool be revised in subsequent studies to include more questions of greater depth for the parameters of health condition, physical function, and social isolation, and the areas of accessibility to medical care and service needs be omitted

4. A survey be done to determine the older person's awareness of available programs which could foster social interaction

5. Studies be done to determine physical and psychosocial needs of persons who are homebound

LIST OF REFERENCES

Articles

Aldrich C. and Mendkoff, E. 1963. Relocation of the aged and disabled: a mortality study. Journal of American Geriatric Society. 11:185-94.

Ambrose, Sister Anne. 1973. Discharge plans--the weakest link. Hospital Progress. 54(3):58-60.

American Public Health Association. 1974. Home health services: a national need. A position paper. American Journal of Public Health. 64(2):179-83.

Bell, W. G. 1973. Community care for the elderly: an alternative to institutionalization. Gerontologist. 13(3):349-54.

Bennett, Ruth. 1973. Social isolation and isolation-reducing programs. Bulletin of New York Academy of Medicine. 49:1143-63.

Black, Sister Kathleen. 1973. Social isolation and the nursing process. Nursing Clinics of North America. 8(4):575-85.

Blenkner, Margaret. 1967. Environmental change and the aging individual. Gerontologist. 7(1):101-105.

Bozian, Marguerite W. 1976. Nutrition for the aged or aged nutrition? Nursing Clinics of North America. 11(1):169-78.

Brickner, Philip W.; Janeski, J.; Rich, G.; Duque, S. T.; Starita, L.; LaRocco, R.; Flannery, T.; and Werlin, S. 1976. Home maintenance for home bound aged. Gerontologist. 16(1):25-29.

Brody, Stanley J. 1973. Comprehensive health care for the elderly: an analysis. Gerontologist. 13(4):412-17.

Brotman, Herman. 1974. The fastest growing minority: the aging. American Journal of Public Health. 64(3): 249-52.

Busse, Ewald. 1971. Biological and sociological changes affecting adaptation in mid and late life. Annals of Internal Medicine. 75(July):115-20.

Butler, Robert N. 1974. Successful aging. Mental Health. 58(3):7-12.

Cairns, Stella and Caggiula, Arlene W. 1974. Evaluation of the attitudes of recipients of home-delivered meals. Journal of American Dietetic Association. 65(11):560-62.

Carlson, Sylvia. 1972. Communication and social interaction in the aged. Nursing Clinics of North America. 7(2):269-78.

Carp, Frances. 1971. Walking as a means of transportation for retired people. Gerontologist. 2(2):104-111.

Carter, Carolyn McCraw. 1976. Community mental health programs and the elderly. Nursing Clinics of North America. 11(1):125-33.

Conte, Mary Louise. 1970. Loneliness of old age. Nursing Outlook. 18(8):28-30.

Coyle, Edna Hurlock. 1976. Homemaker-home health aide services. Journal of Gerontological Nursing. 2(2):37-40.

Cutler, Stephen J. 1972. The availability of personal transportation, residential location and life satisfaction among the aged. Journal of Gerontology. 27(3):383-89.

Dawson, Norma and Stern, Martha. 1973. Perception of priorities for home nursing care. Nursing Research. 22(2):145-48.

Eisdorfer, Carl. 1976. Issues in planning for the aged. Gerontologist. 16 (1 pt 1):12-16.

Glick, Seymore M. 1976. Preventive medicine in geriatrics. Medical Clinics of North America. 60(6):1325-32.

Hain, Sister Mary Jeanne and Chen, Shu-Pi C. 1976. Health needs of the elderly. Nursing Research. 25(5):433-39.

Hammerman, Jerome. 1974. Health services: their success and failure in reaching older adults. American Journal of Public Health. 64(3):253-56.

Harper, J. M.; Jansen, G. R.; Shigetomi, C. T.; and Frey, A. L. 1976. Menu planning in nutritional programs for the elderly. Journal of American Dietetic Association. 68(6):529-34.

Hefferin, Elizabeth A., and Hunter, Ruth E. 1975. Nursing observation and care planning for hospitalized aging. Gerontologist. 15(1):57-60.

Howell, Sandra C. and Loeb, Martin B. 1969. Nutritional needs of older people. In Nutrition and aging: A monograph for practitioners. Published in Gerontologist. 9(3 pt 2):17-29.

Jennings, Muriel; Nordstrom, Margene; and Shumake, Norine. 1972. Physiological functioning in the elderly. Nursing Clinics of North America. 7(2):237-52.

Kristen, Helen and Morris, Robert. 1972. Alternatives to institutional care for elderly and disabled. Gerontologist. 12(2):139-145.

Kulys, Regina. 1970. Discharge planning. Hospitals. 44(9):39-43.

Lantz, J. 1976. Assessment: a beginning to individualized care. Journal of Gerontological Nursing. 2(6): 34-40.

Lawton, M. Powell. 1974. Social Ecology and the health of older people. American Journal of Public Health. 64(3):257-59.

Lawton, M. Powell and Brody, Elaine. 1969. Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist. 9(2): 179-86.

Luke, Barbara. 1976. Good geriatric nutrition is a lifelong nursing matter. RN. 39(7):24-26.

Managan, Dorothy; Wood, J.; Heinichen, C.; Hoffman, M.; Hess, G.; and Gillings, D. 1974. Older adults: a community survey of health needs. Nursing Research. 23(5):426-32.

Markus, Elliot; Blenkner, M.; Bloom, M.; and Downs, T. 1972. Some factors and their association with post-relocation mortality among institutionalized aged persons. Journal of Gerontology. 27(3):376-82.

Moore, Florence M. and Somers, Anne R. 1976. Homemaker services--essential option for the elderly. Public Health Reports. 91(4):354-59.

Muhlenkamp, Ann F.; Gress, Lucille D.; and Flood, Mary A. 1975. Perception of life change events by the elderly. Nursing Research. 24(2):109-112.

Nielsen, Margaret; Blenkner, M.; Bloom, M.; Downs, T.; and Beggs, H. 1972. Older persons after hospitalization: a controlled study of home aide service. American Journal of Public Health. 62(8):1094-1101.

Palmore, Erdman B. 1968. The effects of aging on activities and attitudes. Gerontologist. 8(2):259-70.

_____. 1969. Predicting longevity. Gerontologist. 9(2):247-58.

_____. 1976. Total chance of institutionalization among the aged. Gerontologist. 16(6):504-07.

Perry, P. Wingfield. 1974. The night of ageism. Mental Health. 58(3):13-20.

Pfieffer, Eric. 1970. Survival in old age: physical, psychological and social correlates of longevity. Journal of American Geriatric Society. 18(3):273-79.

Rahe, Richard H.; McKean, J. D.; and Ransom, A. J. 1967. A longitudinal study of life changes and illness patterns. Journal of Psychosomatic Research. 10:355-66.

Richter, Lorraine and Gonnerman, Alice. 1974. Home health services and hospitals. Hospitals. 48(10):113-116.

Ryder, Claire F. 1976. Basic data requirements for home health care. Medical Care. 14 (5 supp):46-52.

Senate Subcommittee on long-term care issues: report on nursing homes. 1975. Journal of Gerontological Nursing. 1(1):37.

Shanas, Ethel. 1974. Health status of older people. American Journal of Public Health. 64(3):261-63.

Terlizzi, Lois Plundert. 1976. Homemaker-home health aides. Occupational Outlook Quarterly. 20(4):61-65.

Tobin, Sheldon S.; Hammerman, Jerome; and Rector, Vicki. 1972. Preferred disposition of institutionalized aged. Gerontologist. 12(2 pt 1):129-33.

Traeger, Brahna. 1975. Home care: providing the right to stay home. Hospitals. 49(20):93+.

Wahlstrom, E. Dorothy. 1967. Initiating referrals. American Journal of Nursing. 67(2):332-35.

Weinberg, Jack. 1970. Environment, its language and the aged. Journal of American Geriatric Society. 18(9):681-86.

Books

American Medical Association. 1972. Socioeconomic issues of health. Chicago: American Medical Association.

Agate, John. 1970. The practice of geriatrics. 2nd ed. Springfield, Illinois: Charles C. Thomas.

Atchley, Robert C. 1972. The social forces in later life: an introduction to social gerontology. Belmont, Ca.: Wadsworth Publishing Ce.

Bengston, Vern L. and Manuel, Ron C. 1976. The sociology of aging. In Aging: prospects and issues. Revised edition. Edited by Richard H. Davis. Los Angelus: University of California Press.

Birren, James E. and Shaie, K. Warner. 1977. Handbook of Psychology of Aging. New York: Nostrand Reinhold Co.

Busse, Ewald W. 1977. Theories in aging. In Behavior and adaptation in late life. 2nd ed. Edited by Ewald Busse and Eric Pfieffer. Boston: Little, Brown and Co.

Busse, Ewald and Pfieffer, Eric, ed. 1977a. Introduction. In Behavior and adaptation in late life. 2nd ed. Boston: Little, Brown and Co.

_____. 1977b. Functional psychiatric disorders in old age. In Behavior and adaptation in late life. 2nd ed. Boston: Little, Brown and Co.

Butler, Robert N. and Lewis, Myrna. 1973. Aging and mental health. St. Louis: C. V. Mosby Co.

Chinn, Austin B. and Robins, Edith G. 1970. Health aspects of aging. In The daily needs and interests of older people. Edited by Adeline M Hoffman. Springfield, Il.: Charles C. Thomas.

Cumming, Elaine and Henri, William. 1961. Growing old: the process of disengagement. New York: Basic Books.

Estes, E. Harvey, Jr. 1976. Health experience in the elderly. In Behavior and adaptation to late life. 2nd ed. Edited by Ewals Busse and Eric Pfieffer. Boston: Little, Brown and Co.

Fellin, Phillip; Tripody, T.; and Mayer, H. 1969. Exemplars of social research. Itasca, Il.: Peacock Publishers.

Field, Minna. 1972. The aged, the family and the community. New York: Columbia University Press.

Goldfarb, Alvin I. 1977. Institutional care of the aged. In Behavior and adaptation in late life. 2nd ed. Edited by Ewald W. Busse and Eric Pfieffer. Little, Brown and Co.

Goldman, Ralph. 1971. Decline in organ function with aging. In Clinical Geriatrics. Edited by Isadore Rossman. Philadelphia: J.B. Lippincott Co.

Gress, Lucille D. 1973. The family with an elderly member. In Family health care. Edited by Barbara Hymovich and Martha U. Barnard. New York: McGraw-Hill Book Co.

Hall, Joanne E. and Weaver, Barbara R. 1974. Nursing of families in a crisis. Philadelphia: Lippincott.

Hutchins, Bertha E.; O'Brien, Doratha; and Coleman, Carol. 1972. The health care setting and the rehabilitative management of the elderly. In Caring for and caring about elderly people: a guide to the rehabilitative approach. Edited by Janet M. Long. Rochester, N. Y.: Rochester Regional Medical Program.

Institute on Interdisciplinary Studies. 1971. Social indicators for the aged. Minneapolis: Institute on Interdisciplinary Studies.

Itzin, Frank. 1970. Social relations. In The daily needs and interests of older people. Edited by Adeline M. Hoffman. Springfield, Il.: Charles C. Thomas.

Katz, Sidney; Ford, A.; Downs, T. D.; Adams, J.; and Rusby, D. I. 1972. Effects of continued care: a study of chronic illness in the home. Washington, D.C.: Department of Health, Education and Welfare.

Kimmel, Douglas C. 1974. Adulthood and aging. New York: John Wiley and Sons.

Lawton, M. Powell. 1973. The functional assessment of elderly people. In Readings in Gerontology. Edited by Virginia Brantl and Sister Marie Raymond Brown. St. Louis: C.V. Mosby.

Maddox, George. 1968. Persistant lifestyle among the elderly: a longitudinal study of patterns of social activity in relation to life satisfaction. In Middle age and aging. Edited by Bernice L. Neugarten. Chicago: University of Chicago Press.

_____. 1973. Growing old: getting beyond the stereotypes. In Foundations of Practical Gerontology. 2nd ed./revised. Edited by Rosamonde R. Boyd and Charles G. Oakes. Columbia, S. C.: University of South Carolina Press.

Neugarten, Bernice L: Havighurst, R. J.; and Tobin, S. S. 1968. Personality and patterns of aging. In Middle age and aging. Edited by Bernice L. Neugarten. Chicago: University of Chicago Press.

Palmore, Erdman and Maddox, George. 1977. Sociological aspects of aging. In Behavior and adaptation in late life. 2nd ed. Edited by Ewald Busse and Eric Pfieffer. Boston: Little, Brown and Co.

Public Law No. 94-63 S.66. Act of July 29, 1975. Amendment to the Public Health Service Act. U.S. Government Printing Office.

Remnet, Valerie L. 1976. The home assessment: a therapeutic tool to assess the needs of the elderly. In Nursing and the aged. Edited by Irene M. Burnside. New York: McGraw-Hill Book Co.

Rockstein, Morris. 1976. Biology of aging in humans - an overview. In The physiology and pathology of human aging. Edited by Ralph Goldman and Morris Rockstein. New York: Academic Press.

Rogers, Martha. 1970. Theoretical Basis of Nursing. Philadelphia: F. A. Davis Co.

Rosenow, Ann and Long, Janet M. 1972. Introduction. In Caring for and caring about elderly people: a guide to the rehabilitative approach. Edited by Janet M. Long. Rochester, N. Y.: Rochester Reginal Medical Program.

Selye, Hans. 1976. The stress of life. Revised ed. N. Y.: McGraw-Hill Book Co.

Shanas, Ethel. 1962. The health of older people: a social survey. Cambridge: Harvard University Press.

_____. 1977. Living arrangements and housing of old people. In Behavior and adaptation in late life. 2nd ed. Edited by Ewald Busse and Eric Pfieffer. Boston: Little, Brown and Co.

Shanas, Ethel; Townsend, P.; Wedderburn, D.; Friis, H.; Milhoj, P.; and Stehouwer, J. 1968. Old people in three industrial societies. New York: Atherton Press.

Silverstone, Barbara and Hyman, Helen Kandel. 1976. You and your aging parents. New York: Pantheon Books.

Tobin, Sheldon S. and Lieberman, Morton A. 1976. Last home for the aged. San Francisco: Jossey-Bass Publishers.

U.S. Bureau of the Census. 1970. Census of Population: 1970. Vol. 1. Characteristics of the Population. Part 18, Kansas. Washington D.C.: U.S. Government Printing Office.

U.S. Department of Commerce. Bureau of the Census. 1976. Statistical abstracts of the United States.

U.S. Department of Health, Education and Welfare. 1976a. Health: United States 1975. Rockville, Md.: U.S. Department of Health, Education and Welfare.

_____. 1976b. Health in the United States. 1975: a chartbook.

_____. 1976c. Health resource statistics 1975.

_____. 1976d. Public health service. Forward plan for health: FY 1978-82.

_____. 1977. Your Medicare Handbook.

Verwoerdt, Adriaam. 1973. Biological characteristics of the elderly. In Foundations of Practical Gerontology. 2nd ed./revised. Edited by Rosamonde R. Boyd and Charles Oakes. Columbus, S. C.: University of South Carolina Press.

Weg, Ruth. 1976. The changing physiology in aging. In Aging: prospects and issues. 3rd ed./revised. Los Angelus: University of Southern California Press.

White House Conference on Aging. 1973. Toward a national policy on aging: preceedings of the 1971 White House Conference on aging. Vol. II. Washington, D. C.: U.S. Government Printing Office.

Wolanin, Mary Opal. 1976a. Nursing assessment. In Nursing and the aged. Edited by Irene Mortenson Burnside. New York: McGraw-Hill Book Co.

_____. 1976b. Nursing evaluation and goals. In Nursing and the aged. Edited by Irene Mortenson Burnside. New York: McGraw-Hill Book Co.

Youmans, E. Grant. 1973. Some views on human aging. In Foundations of Practical Gerontology. 2nd ed./ revised. Edited by Rosamonde R. Boyde and Charles Oakes. Columbus, S. C.: University of South Carolina Press.

Pamphlets

American Hospital Association. 1973. Health services in the home: definition and position statement. Chicago: American Hospital Association.

National League of Nursing. 1974. Proposed model for the delivery of home health services. New York: National League of Nursing.

APPENDIX A

HEALTH QUESTIONNAIRE

Date _____ Questionnaire No. _____

Please record the answer to each question by marking an X in the box before the answer given.
EACH QUESTION MUST HAVE AN ANSWER.

First, I'd like some information about yourself.

1. How old were you on your last birthday? _____

(Observe for SEX and RACE)

2. Sex ☐ Male ☐ Female

3. Race ☐ White ☐ Non-white

4. Where were you born? (Just country if foreign born)

☐ U.S.A.
City _____
State _____

☐ Foreign born, specify _____

5. Does anyone live in this house with you?

☐ No ☐ Yes

(If "YES" ask:)

5a. May I please have their age and relationship to you?

	Age	Relationship
Spouse Adult child Sibling Spouse of child Grandchild Other related person Non-related	____	_____
	____	_____
	____	_____
	____	_____

Questionnaire No. _____

6. What is the highest grade level you completed in school?

- 7 ☐ Less than seven years of school
- 6 ☐ 7th, 8th, or 9th grade
- 5 ☐ 10th or 11th grade
- 4 ☐ High school graduate
- 3 ☐ Partial college training
- 2 ☐ College or university graduation
- 1 ☐ Graduate professional training
- 0 ☐ No answer, why _____

7. What is/was your last major occupation?

SPECIFY: _____

Now I would like to ask you a few questions about your health.

8. Are you usually up and around most days?

- 0 (2) ☐ No, completely bedridden
- 1 (2) ☐ No, usually stay in bed
- 2 (1) ☐ Yes, in chair
- 3 (0) ☐ Yes
- 9 ☐ No answer, why _____

☐ H-1

Questionnaire No. _____

9. During the last month, about how many days were you sick to the point of having to give up some of your regular activities like visiting, going shopping, or cooking for yourself?

0 ☐ No days

1 ☐ 1-7 days (1 week or less)

2 ☐ 8-14 days (1-2 weeks)

3 ☐ 15-21 days (2-3 weeks)

4 ☐ 22 days or more (3-4 weeks)

9 ☐ No answer, why _____

☐ H-2

(Include all bedridden and/or homebound in # 4 above)

(If sick ask:)

10. When you were sick, for the most part, were you at home but up and around, at home in bed, at the home of a friend or relative, or in a hospital or nursing home?

0 (1) ☐ At home but up and around

1 (1) ☐ At home in bed

2 (1) ☐ At the home of a friend or relative

3 (2) ☐ At a hospital or nursing home

8 (0) ☐ Does not apply -- no sick days

9 ☐ No answer, why _____

☐ H-3

H score _____

11. Now I am going to read a list of activities that many people have difficulty with as they grow older. After I read each one, please tell me if you have no difficulty with it, have some difficulty, or whether you cannot do it at all.

11. (Check appropriate box)

Questionnaire No. ____

	No Diff.	Some Diff.	Cannot Do It	
Getting about the house	0 ☐	1 ☐	2 ☐	☐ PF-1
Going up and down stairs	0 ☐	1 ☐	2 ☐	☐ PF-2
Washing and bathing	0 ☐	1 ☐	2 ☐	☐ PF-3
Dressing and putting on shoes	0 ☐	1 ☐	2 ☐	☐ PF-4
Getting out of the house	0 ☐	1 ☐	2 ☐	☐ PF-5
Feeding yourself	0 ☐	1 ☐	2 ☐	☐ PF-6

PF score ____

12. About how many times did you talk to someone - friends, relatives, or others on the telephone last week?

0 ☐ Everyday
1 ☐ Several times
2 ☐ Once
3 ☐ Not at all
9 ☐ No answer, why ____

☐ SI-1

13. How many times during the last week did you visit in person with friends, neighbors, or a relative who does not live here?

0 ☐ Everyday
1 ☐ Several times
2 ☐ Once
3 ☐ Not at all
9 ☐ No answer, why ____

☐ SI-2

14. In a period of a month, about how often do you go to meetings or activities of clubs or informal groups that you belong to?

0 ☐ 4 or more times
1 ☐ 2-3 times
2 ☐ Once
3 ☐ Never
9 ☐ No answer, why ____

☐ SI-3

SI score ____

Questionnaire No. _____

15. During the last month have you wanted to see a doctor because of some ailment or illness but you were unable to see him?

0 (0) ☐ No 1 (2) ☐ Yes

9 ☐ No answer, why _____

☐ MC-1

(If YES ask:)

16. Why were you unable to see a doctor?

0 ☐ Unable to get an appointment within a reasonable time.

1 ☐ No transportation

2 ☐ No one to help me

3 ☐ Too sick to leave the house

4 ☐ Other reason. Specify_____

8 ☐ Does not apply

9 ☐ No answer, why _____

☐ MC-2

17. Do you have a family doctor?

0 (1) ☐ No 1 (0) ☐ Yes

9 ☐ No answer, why _____

☐ MC-3

MC score _____

18. How often during the past month have you skipped a <u>hot</u> meal because you were unable to fix the meal yourself and you did not have someone to fix it for you?

0 ☐ Never

1 ☐ Once a week

2 ☐ A few times a week

3 ☐ 5 or more times a week

9 ☐ No answer, why__ _____

☐ N-1

N score _____

Questionnaire No. ____

19. How many times during the past month have you been unable to go somewhere because you didn't have a ride?

0 ☐ Never

1 ☐ Once or twice

2 ☐ 3 or 4 times

3 ☐ Quite a few times

9 ☐ No answer, why _____

☐ T-1

T score _____

20. Is there anything else that you feel is a problem or need in your way of life today?

_____

_____

_____

SN score _____

Thank you for your time and help. This will be very helpful to our study and to other older people.

APPENDIX B

EXPLANATION TO THE SUBJECT ABOUT THE RESEARCH
(by the researcher)

My name is Sister Dominic Haug. I am a registered nurse and I am currently working on a masters degree at Texas Woman's University in Dallas, Texas. A research project must be done as part of the requirement for a masters degree.

My research project involves interviewing persons 65 years of age and older to determine health needs and needs that are related to health. In order to get the information I need I would like to ask you twenty questions.

Your name will not appear on the questionnaire, nor will it be used in anyway in the study. The only risk might be personal embarrassment or invasion of your privacy.

You may end your participation in the study at any time.

The results of this study may be helpful in providing information about the health care needs of older people.

Do you have any questions?

Before I ask you any questions it is necessary for you to sign a form giving me permission to ask you questions.

(The form is given and signatures are obtained.)

EXPLANATION TO THE SUBJECT ABOUT THE RESEARCH
(by the volunteer interviewer)

My name is _____. I am helping Sister Dominic Haug to get information for a research paper. Sister Dominic is a registered nurse who is working on a masters degree at Texas Woman's University in Dallas, Texas. A research project must be done as part of the requirement for a masters degree.

Sister Dominic's research project involves interviewing persons 65 years of age and older to determine health needs and needs that are related to health. In order to get the information she needs I would like to ask you twenty questions.

Your name will not appear on the questionnaire, nor will it be used in any way in the study. The only risk might be personal embarrassment or invasion of your privacy.

You may end your participation in the study at any time.

The results of this study may be helpful in providing information about the health care needs of older people.

Do you have any questions?

Before I ask you any questions it is necessary for you to sign a form giving me permission to ask you questions.

(The form is given and signatures are obtained.)

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

I, the undersigned, hereby authorize Sister Dominic Haug, a graduate student at Texas Woman's University in Dallas, Texas, or a person delegated by her, to interview me regarding my health and health related topics for a paper she is writing at school.

The purpose and my part in the interview has been explained to me by _____.

I understand that my method of participation will be to answer the questions I am asked. I can end this participation at any time.

I understand that my name will not appear on the questionnaire, nor will my name be used in the study.

I understand that this study may be helpful in providing information about the health care needs of older people.

An offer to answer all of my questions regarding the study has been made.

_____ _____

Subject's signature Date

_____

Interviewer's signature

* *

IF THE SUBJECT IS UNABLE TO SIGN, COMPLETE THE FOLLOWING:

The subject is unable to sign because:

_____ _____

Significant other Date

_____

Relationship