

BRIDGING THE GAPS IN GERIATRIC CARE

As a position statement in the current values debate, the African adage, "It takes a village to raise a child," has fueled considerable controversy. However, practical experiences, like the forging of community ties to provide healthcare support to the elderly of Camden, NJ, suggest that the application of shared responsibility has value across the life span.

ASSESSING THE NEED

Camden is a culturally diverse city of 87,500, with a rapidly growing population segment aged 65 and older. The increase in size of that age category (which grew 48 percent between 1970 and 1990) and a clear deterioration in the social support network available to the elderly provided the impetus for Our Lady of Lourdes Medical Center to examine its healthcare services through an age-specific lens. The medical center—one of three hospitals in the Camden area—serves a large elderly population. It is a 375-bed facility offering primary and tertiary care and providing regional services in perinatology, cardiology, renal dialysis and transplant, and rehabilitation.

A 1992 study of health and human service needs in southwestern New Jersey (which includes the city of Camden) reported an abundance of traditional services for the elderly but an inadequate number of services for those who need care but prefer to live at home, either alone



Dr. Poh is the director of program and grant development, Our Lady of Lourdes Medical Center, Camden, NJ.

Volunteers Help Meet The Elderly's Nonmedical Needs

BY RUTH WEXBERG
POH, PhD

or with family members.¹ More than 21 percent of the elderly respondents to that survey acknowledged difficulty performing some activities of daily living.

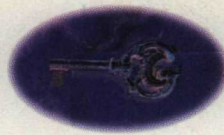
Concerned about these problems, the medical center reviewed the utilization of its services in 1991 and 1993. The data gathered revealed a clear need to develop programs to supplement traditional healthcare (see **Box**). One particularly important finding involved the role of social factors in prompting the elderly to visit the hospital emergency room (ER).

Summary Concerned about the paucity of services for elderly who need care but prefer to live at home, Our Lady of Lourdes Medical Center, Camden, NJ, embarked on an effort to obtain grant funds while seeking creative ways to meet the elderly's nonmedical needs.

One of the first programs developed was a Senior Companion Program. This federally funded program recruits low-income elderly citizens, trains them, and places them in the homes of seniors who need nonmedical services to remain in the community.

The program's success led to the establishment of Helping Hands in the Community, which recruits volunteers of all ages and incomes to serve as companions for seniors. An extension of this program, Helping Hands in Business, sought to help employers reduce the costs associated with lost productivity because of employees' responsibilities as care givers for elderly family members.

Finally, the Camden Senior Community Support Program uses aggressive case management in the emergency room and the hospital to determine whether the elderly need to be admitted to the hospital or can receive support from family or others to remain in the community.



ADDRESSING THE NEED

Recognizing the economic barriers to new program development, the Lourdes staff embarked on an effort to obtain grant funds while, simultaneously, seeking creative ways to use volunteers to meet the elderly's nonmedical needs. As a result of those efforts, four programs took shape. Their objectives were to:

- Prevent unnecessary and repeat hospitalizations
- Reduce hospital lengths of stay
- Maintain the elderly target population's independence in the community
- Reduce care giver stress while improving the quality of life for aging family members

Senior Companion Program One of the first programs developed at Lourdes was a Senior Companion Program. One of only two in the state, and the only one that is hospital based, this federally funded program² recruits low-income elderly citizens, trains them, and places them in the homes of seniors who need nonmedical services to remain in the community.

The project serves two distinct segments of the senior population. Ninety low-income volunteers, aged 60 or older, receive a modest stipend of \$2.45 an hour (which does not affect any of their other entitlements and is nontaxable), reimbursement for transportation, on-duty insurance, and an annual physical examination in exchange for providing 20 hours a week of essential nonmedical assistance to their peers. In addition, more than 300 frail or chronically impaired older citizens receive the day-to-day assistance they require to avoid institutionalization. To date, 245 senior companions have been trained and 952 seniors served.

Helping Hands in the Community (HHIC) The success of the Senior Companion Program and the unmet demand for companions led, in 1989, to the establishment of Helping Hands.³ This program recruits volunteers of all ages and incomes and allows them to determine how many hours a month they can contribute. They receive no stipend, but for every hour of service they provide, they receive an hour of service credit. This credit may be used for their own needs (if the volunteer is elderly or disabled) or assigned to a friend, the community, or the volunteer credit bank.

Once volunteers have begun working in the program, their interest in the service credit component becomes minimal. Their continuation as volunteers in the program stems, rather, from their enjoyment in helping others, the bonds formed with clients, and the recognition and support they receive from program staff.

Helping Hands services are personalized. Volunteers provide transportation to and from

The program recruits low-income elderly citizens, trains them, and places them in the homes of seniors.

healthcare providers, obtain medicines from the pharmacy, act as advocates for the elderly, and ensure a safe environment for recovery. Program staff serve as an information resource for the elderly, helping them access other useful community services.

Helping Hands currently has 738 participants, including 152 volunteers, generating more than 4,500 hours of service a year.

Helping Hands in Business (HHIB) This experimental program,⁴ an extension of Helping Hands in the Community, grew out of an understanding that business productivity is directly affected by the aging of the population, compounded by the growing numbers of women in the work force (since women are the primary source of care for their elderly family members). The costs of caregiving responsibilities are reflected in employees' lateness, absenteeism, time spent on the job arranging for eldercare, reduced training or promotion opportunities, and withdrawal from the work force while at the height of productivity.

HHIB sought to reduce the costs associated with lost productivity by pooling public and private resources to deliver cost-effective support, through their worksites, to employees who care for

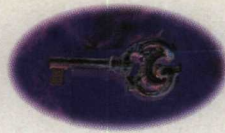
NEEDS ASSESSMENT

A 1991 needs assessment, conducted by the department of social services staff at Our Lady of Lourdes Medical Center, yielded the following data:

- Of the 13,500 people coming to the emergency room for care:
 - 20 percent were elderly.
 - 75 percent of those elderly were admitted as hospital inpatients.
- Of the three ethnic groups identified during the assessment:
 - 30 percent were Hispanic.
 - 30 percent were African American.
 - 40 percent were white.
- Fifty-nine percent of the Hispanics surveyed had visited an emergency room at least once in the year prior to the study, compared with 25 percent for the other two racial groups.
 - Forty-nine percent of the seniors had social problems that were at least partially responsible for their emergency room visits. The most frequently cited reasons were:
 - Lack of assistance in meeting personal needs
 - Lack of knowledge about how to access community services
 - Language barriers that impeded the ability to seek service

A 1993 assessment examined the average length of stay and number of emergency room admissions for patients over 60, compared with an under-60 patient population.

- The older patient group had a 32 percent longer average length of stay (12.88 versus 8.75 days)
- The older patient group had a 20 percent higher frequency of emergency room admissions (13.67 versus 10.87 days).



elderly relatives. This was to be accomplished by establishing functioning service credit programs in corporation and business collectives and by adding other components (e.g., care management, health education) as needed. The project:

- Offered cost inducements to the private sector to provide eldercare
- Formulated comprehensive packages of services that could be marketed by a hospital to local businesses and industries in varying combinations
- Developed a pricing structure for corporations to provide service credit eldercare through their cafeteria of benefits or existing employee assistance programs
- Developed marketing mechanisms to raise employers' consciousness of the problems faced by their care-giving employees and to promote program use

Although staff learned a lot through this project and produced useful prototype material, the program did not develop as expected, largely because of its initiation during a period of corporate downsizing and curtailment of employee benefits.

Camden Senior Community Support Program (CSCSP) Focusing on seniors who come to the ER for service, the CSCSP uses aggressive case management in the ER and the hospital. First, bicultural and bilingual case managers make psychosocial assessments of the elderly to determine whether they need to be admitted or can be supported in the community. The case managers make similar assessments of at-risk seniors already admitted to the medical center.

The case managers make appropriate referrals to existing community-based programs and follow up on care plans. Trained community volunteers are recruited to accompany the patient home from the ER or to visit within 24 hours after discharge to check home safety and supports. When other family or community supports are lacking, the elderly patient may be referred to Lourdes Senior Companion or Helping Hands program for continuing assistance. To date, CSCSP has served 9,971 seniors.

EVALUATING PERFORMANCE

Although comprehensive, rigorously designed evaluations of the programs must await additional funding, the following data have been compiled.

Senior Companion Program The Senior Companion Program is evaluated annually. The 1995 evaluation⁵ was performed by three members of the Senior Services Advisory Council, who used prepared questionnaires to conduct 15- to 20-minute telephone interviews with a sample of site supervisors, volunteers, and program clients.

All supervisors interviewed were unanimous in their belief that the program is a "lifesaver for target residents" at their site, permitting them to

serve inner-city clients, serve people not eligible for other programs, help clients do things they otherwise could not do, and provide expert advice regarding residents with Alzheimer's disease. Eight of the 11 supervisors stated that they knew that regular companion visits had been effective in keeping clients out of hospitals or nursing homes. Nineteen out of 24 clients interviewed stated emphatically that they would not have been able to remain in their homes without the assistance of their companions. Of the 13 clients who were hospitalized after they started receiving help from the Senior Companion Program, about 50 percent said their stay had been shortened because of the in-home assistance received.

Sixty-six percent of the companions thought their activities were responsible for keeping their clients out of hospitals and nursing homes. At a cost of \$3,666 for 20 hours a week, one companion can provide care to an average of three clients. The cost saving over longer lengths of hospital stay or admission to a nursing home are clear.

Companions also expressed gratitude for the opportunity to help others while deriving substantial emotional, spiritual, and concrete health and financial benefits for themselves in the process. This program certainly establishes a win-win environment for all involved.

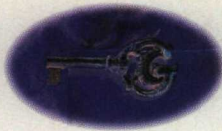
Helping Hands in the Community HHIC was evaluated after its first full year of operation in 1991⁶ and again in 1992⁷ (with funds from the Pew Charitable Trusts). In 1991 the evaluators looked at data from 295 participants and interviewed 34 of them; in 1992 evaluators assessed data from 90 volunteers and 60 interviews.

Helping Hands participants were primarily white and female. The population served was older in the second year than in the first (with the over-80 group growing from 18 percent to 55 percent) and was far more likely to live alone (47 percent in 1991, versus 83 percent in 1992).

Both the 1991 and 1992 evaluations revealed that the services most frequently used were transportation and grocery shopping. Also important was "friendly visiting." Satisfaction ratings from all participants were high in both years. Almost 58 percent of the 1991 sample said that without Helping Hands' intervention, they probably would not have been able to get the assistance they needed. Interviewers who took part in the 1992 evaluation estimated that 30 percent of the respondents were at risk for nursing home placement and that 40 percent would have needed either an adult day care center or a paid home health aide had they not received Helping Hands services.

The 1992 estimated per capita cost for each HHIC recipient was \$320 a year, compared with estimated annual nursing home costs of more than

Bicultural and
bilingual case
managers make
psychosocial
assessments of
the elderly to
determine
whether they
need to be
admitted to the
ER or can be
supported in
the
community.



\$30,000 a year or paid in-home care of \$12,000 a year; thus the program is clearly cost-effective. Of equal or greater importance is the reported improvement in the program participants' quality of life. A 1995 satisfaction survey⁸ confirmed that most of the recipients were highly satisfied with the program. Although the majority of them had had long histories of hospitalizations since age 60, 20 percent reported no additional hospitalizations since enrolling in the program.

Helping Hands in Business Because this program was new and experimental, it was not evaluated. Had it fulfilled expectations, cost savings to employers could have been substantial. Twenty percent to 30 percent of employees are believed to have some responsibility for elder care giving. In a firm of 1,000 employees, where no support program exists, that estimated percentage translates to \$400,000 a year in lost productivity costs.⁹ With the rate scale developed, the HHIB program would have cost employers one-fourth of that amount.

Camden Senior Community Support Program Funds provided by the New Jersey State Department of Health paid for a comprehensive evaluation of this program. Program evaluators—faculty from Rutgers University's School of Social Work—collected data from 625 patients seen in 1993 and 1994¹⁰ and from 640 patients in 1995.¹¹ Forty-three percent of those assessed were receiving only Social Security and/or SSI, and 16 percent were on public assistance. The most common reason for providing CSCSP service was the need for home care (54 percent), followed by need for discharge planning (51 percent, lack of community support (15 percent), language barriers (7 percent), and lack of transportation (7 percent).

About 25 percent of the sample received in-home assessments after discharge. More than twice as many patients referred for home care had prolonged stays than those who did not need this service. The average length of stay for those served had dropped to 8.98 at a time when the stay for the over-60 hospital population as a whole was 10.82.


In the 1993-94 study, patients served by the CSCSP spent an average of 1.84 fewer days in the hospital than the total over-60 population during the same time period. The CSCSP services thus effected a cost savings of \$1,150 per patient, or, for the six-month period covered by the study, an estimated savings of \$556,600—almost three times the cost of the entire program for a year. During the appraisal period, 11 patients were sent home from the ER under the program's supervision. At this rate, hospitalization (at an average cost of \$625 a day) would have cost the hospital \$123,000 a year.

The 1995 study showed an average length of stay over a three-month period for the CSCSP

sample over 60 years of age to be 11.2 days, compared with 10.9 for the hospital population aged 60 and over. The increase was attributed to higher acuity (perhaps as a result of changing hospitalization patterns), and researchers thought that the participants' stay "may have been more protracted without CSCSP intervention."¹²

VOLUNTEERS MAY BE KEY

Use of volunteers to provide nonmedical supports may signify the critical difference in maintaining a high quality of life for the elderly. Efforts to develop new and creative ways of involving volunteers with those in need should be the focus of future experimentation. □

 For more information, contact Ruth Wexberg Poh at 609-757-3969.

Elderly
patients served
by the
Camden Senior
Community
Support
Program spent
an average of
1.84 fewer
days in the
hospital.

NOTES

1. Health Visions, "Supporting the Elderly in Our Communities: An Assessment of Health and Human Service Needs in Southwestern New Jersey," Pennsauken, NJ, 1992.
2. Lourdes Senior Companion Program is funded by the Corporation for National Services and a Camden County Block Grant.
3. Helping Hands in the Community has been funded by the New Jersey Department of Human Services, the Pew Charitable Trusts, the Subaru Foundation of America, the Camden County Office of Aging, Camden County Board of Chosen Freeholders, and Camden County Human Services. Currently the program is supported by the Camden County Office on Aging and the New Jersey State Department of Health.
4. Helping Hands in Business was funded by seed money from the Federal Administration on Aging, supplemented by a Robert Wood Johnson Foundation grant.
5. Lourdes Senior Services Advisory Council Senior Companion Program Evaluation, Our Lady of Lourdes Medical Center, Camden, NJ, December 1995.
6. Victoria Windus, "Our Lady of Lourdes Medical Center Helping Hands Program, Program Evaluation," Temple University, Philadelphia, 1991.
7. Deborah Shapiro, "An Evaluation of the Helping Hands Program of Our Lady of Lourdes Medical Center," Rutgers University, Camden, NJ, 1994.
8. "1995 Evaluation of Helping Hands Program," Our Lady of Lourdes Medical Center, Camden, NJ, December 1995.
9. Seymour Wolfbein and Joseph Kohut, "The Women Are Coming," in *Special Report, The Business and Aging Partnership of Philadelphia Corporation for Aging, "Aging: The Feminization of the Workforce and the Case for Eldercare,"* American Management Association, August 1992.
10. Deborah Shapiro and Raymond Sanchez Mayers, "Evaluation of Camden Senior Community Support Program: Second Year," Rutgers University, Camden, NJ, 1994.
11. Deborah Shapiro and Raymond Sanchez Mayers, "Evaluation of Camden Senior Community Support Program: Third Year," Rutgers University, Camden, NJ, 1996.
12. Deborah Shapiro and Raymond Sanchez Mayers, 1996.