THE RANGE OF ELDER CARE SERVICES IN LEWIS & CLARK COUNTY, MONTANA

By

Dana Hillyer

A professional project submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 1996

© COPYRIGHT

by

Dana Hillyer

1996

All Rights Reserved

P378
H5613

APPROVAL

of a professional project submitted by

Dana Hillyer

This professional project has been read by each member of the project committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

Marty Rhea, Ph.D., RNCS — Marty Rhea, PhD, RNCS (Signature) — 4-3-96 Date

Approved for the Department of Nursing

Kay Chafey, Ph.D., RN — Kathleen Chafey (Signature) — 4/1/96 Date

Approved for the College of Graduate Studies

Robert L. Brown, Ph.D. — R L Brown (Signature) — 4/6/96 Date

STATEMENT OF PERMISSION TO USE

In presenting this professional project in partial fulfillment of the requirements for a master's degree at Montana State University-Bozeman, I agree that the Library shall make it available to borrowers under the rules of the Library.

If I have indicated my intention to copyright this professional project by including a copyright notice page, copying is allowable only for scholarly purposes, consistent with "fair use" as prescribed in the U.S. Copyright Law. Requests for permission for extended quotation from or reproduction of this professional project in whole or in parts may be granted only by the copyright holder.

Signature Dana Sullyer

Date April 7, 1996

ACKNOWLEDGMENTS

I wish to acknowledge two people without whose assistance this professional project could not have been completed. I thank Marty Rhea, Ph.D., RNCS, for her support, encouragement, and guidance which helped me think critically about the issues I faced in undertaking this project. Her enthusiasm kept me inspired throughout the process. The second person I thank is Robert Caldwell, MD, my life partner. His patience and understanding provided me the emotional support I needed to stay focused. Moreover, without his computer expertise, this professional paper would not have been correctly formatted.

TABLE OF CONTENTS

Page

1. INTRODUCTION 1

Purpose of the Project 1
Background to the Project 1
Significance of the Project 2
Organization of Health Care Services 3
Demographics of an Aging Society 3
Impact of an Aging Population on Health Services 4
Elder Care Services 4
Nurses' Role in Coordinating Care 5
The Community Setting 6
Objectives of the Project 7
Summary 8

2. LITERATURE REVIEW 9

Evolution of Elder Care Services 9
Current Directions 10
Social Care Model 11
Health Care Model 11
Self-Determination 12
Continuum of Care 13
Structure of Elder Care Services 14
Community-Based Interorganizational Service System 14
Existing Models of Elder Care Services 15
Project OPEN's Model of Elder Care 16
Project OPEN's Research Findings 17
Description of Mt. Zion's Care Account 18
Nursing's Contribution to Elder Care Services 19
Overview of Two Nursing Outreach Models 19
Summary 20

3. PROJECT DESIGN 22

Data Collection 22
Assessment Procedure 23
Summary 24

4. PROJECT OUTCOME 25

Discussion 25
Evaluation by Service Restrictions 25
Client Eligibility and Financial Aspects 25
Geographic Boundaries and Rural Outreach 26
Evaluation by Service Category 26
Acute Inpatient, Extended Inpatient, and Ambulatory Care 26

Home Care, Outreach and Linkage, Health and Wellness..... 27
Housing..... 27
Comparison of Service Delivery Systems 27
Evaluation of Service Gaps and/or Overlaps 28
Project Limitations..... 29
Implications..... 31
Conclusion..... 34

5. REFERENCES CITED..... 35

6. APPENDICES..... 38

Appendix A Community-Based Services for Elders Residing in Lewis & Clark County, Montana 39
Appendix B Interview Questions 42
Appendix C Range of services in Lewis & Clark County according to service restrictions 43
Appendix D Grouping of services in Lewis & Clark County by category..... 53

LIST OF TABLES

Table Page

1. Current Elderly Populations.....7

2. Range of Services in Lewis & Clark County According to Service Restrictions.....Appendix C

3. Grouping of Services in Lewis & Clark County by Category.....Appendix D

ABSTRACT

The purpose of this project was to investigate and evaluate the full array of health care and social services provided for elders in Lewis & Clark County, Montana. The project was undertaken to determine the availability and accessibility of resources, services, and providers. Data were obtained through interviews and agency literature. Five particular types of data were sought: type of services offered, eligibility requirements, geographic boundaries, financial aspects, and rural outreach. Three assessment strategies were used to organize the data so that an accurate picture of the county's system of elder care services could emerge. One of these strategies included a comparison with a comprehensive model of elder care services identified in the literature review as a standard of delivering care. The results suggested that gaps exist in the county's system of care. One of the most important gaps identified was the absence of a specific geriatric focus in the delivery of medical and psychiatric/mental health services. The lack of specialized geriatric services increases the risk that certain health problems, specifically mental health problems, may go unrecognized and untreated. The focus, design, and organization of elder care services in Lewis & Clark County must change. One potential and innovative change that could serve to strengthen the county's system of care is the development of mental health nursing outreach.

CHAPTER 1

INTRODUCTION

Purpose of the Project

The purpose of this project was to investigate and evaluate the full array of health care and social services provided for elders in Lewis & Clark County, Montana. The aim of this assessment was to examine the availability and accessibility of resources, services, and providers. Describing the range of services is necessary to identify gaps and/or overlaps that may lead to a fragmentation or unnecessary duplication of services. Data gathered in this project will be analyzed to determine which services, including mental health services, are lacking or unequally distributed. The inclusion of mental health services reflects four current concerns in caring for elderly clients. First, depression and dementia are major mental health problems in the elderly (Buckwalter, Abraham, Smith, & Smullen, 1993). Second, these disorders frequently go unrecognized and untreated (Lebowitz & Niederehe, 1992). Third, the stigma associated with mental illnesses tends to negatively influence whether mental health services are utilized (Intermill & Rathbone-McCuan, 1991). And lastly, ageist attitudes among mental health professionals often prevent them from appropriately addressing elderly clients' concerns and needs (Burnside, 1988). Therefore, any assessment of elder care services must encompass the scope of health care services, including mental health care.

Background to the Project

The focus on elder care services evolves out of a deep concern for the quality of health care and social services provided to older adults. Myths of aging still persist in American society, despite an accumulating body of knowledge about the process of

growing older. Prominent beliefs, for example that physical and mental health problems are inevitable consequences of aging, continue to influence how the elderly receive health care services, especially mental health services. Many symptoms which elders or their care-givers bring to the attention of health care providers are mistakenly attributed to the aging process and appropriate treatment is not provided. Moreover, the reluctance of the elderly to ask for assistance and avail themselves of programs are additional factors which can negatively impact the delivery of services (Intermill & Rathbone-McCuan, 1991).

Two major assumptions underlie this project. First, physical and mental health are not separate phenomena, especially in the elderly. Ignoring mental health issues when a physical health problem is presented, or viceversa, leads to inadequate care. Health care and social services must use a holistic approach if individual client needs are to be met. Second, the stereotypical views of aging, the inadequacy of existing services to address the complex needs of older adults, and the elderly's fear or reluctance to utilize services create obstacles that hamper the delivery of quality of care. Overcoming these barriers is essential if the physical and mental health needs of the elderly are to be effectively addressed. Consequently, identifying and evaluating the existing range of services in a community assists in recognizing which obstacles are present and the degree to which they negatively impact service delivery.

Significance of the Project

Quality health care is dependent on the thoughtful organization of services and resources (Cary, 1992). The current increase in the population of elderly adults age 65 and older has significantly affected the health care delivery system in the United States (U.S.). The fact that people are living longer is clear. The question remains whether communities with an aging population are prepared to meet their health care and social service needs.

Nurses are in a position to take a leadership role in advocating for and delivering "well coordinated care options" so that the elderly can maintain or achieve an optimal level of functioning (Cary, 1992, p. 689).

Organization of Health Care Services

A complex assortment of public, private, and volunteer agencies makes up the broad range of health care and social services available in communities across the U.S. Ideally, each community's mix of services is integrated into a system of care so that clients can be provided services over time and through all levels of needed assistance (Evashwick & Branch, 1987). In reality, however, most communities' health care and social service systems form a maze, through which both clients and health care providers must negotiate (Burton, 1995). This maze, with its mélange of services and philosophical orientations, varying and often restrictive eligibility requirements, and complex reimbursement stipulations inevitably leads to fragmentation, duplication, and/or gaps in the delivery of services (Cary, 1992). Consequently, if there is to be an effective use of resources as well as development of innovative programs to address unmet needs, knowledge and understanding of the organization of services available in any one community is essential.

Demographics of an Aging Society

The availability and accessibility of health care and social services are key issues facing the U.S. health care system. The elderly population is dramatically expanding; the U.S. is an aging society. Currently, 12.6% of the population is 65 years or older. In the year 2000, 13% of the population will be elderly. By 2010, 14% of U.S. residents will be age 65 or over. In the year 2040, the U.S. Bureau of the Census projects that there will be more persons over age 65 than under age 20. Persons aged 85 and over; the "oldest old,"

are the fastest growing segment of the elderly population. They comprise 1% of the total population and 10% of all elder adults (U.S. Bureau of the Census, 1992).

Impact of an Aging Population on Health Services

The rapid population growth has far reaching implications in a society confronting limited health care dollars and budget deficits. Older adults tend to use a greater and more expensive share of health care resources, such as acute hospital care, extended care, and home health care (Evashwick & Branch, 1987). The yearly rate of hospitalizations for those over 65 is 400/1000. One percent of those age 65 to 74 live in nursing homes. The nursing home rate increases to 6-7% for persons age 75 to 84, expanding to 25% for those aged 85 or older. Older adults typically make at least six physician visits per year and receive the majority of home health care services. Although poor health is not necessarily synonymous with advancing age, persons 65 years and older, especially women, are more likely to have long-term, chronic conditions that impair functional and cognitive abilities, and require personal assistance and community resources (U.S. Bureau of the Census, 1992).

Elder Care Services

The goal of an integrated and comprehensive system of care for elders is to assist them in achieving, regaining, or maintaining a quality of life regardless of level of functioning or dependency. Central to this goal is the belief that elder care services must encourage and support elders in determining for themselves which options and care settings will best met their needs (Haber, 1986). The need for assistance with daily activities increases with age. While only 9% of persons 65 years and older require help with bathing, ambulation, and preparing meals, this rate jumps to 50% for those aged 85 and over (U.S. Bureau of the Census, 1995). The range of services needed by an aging

society encompasses both professional health care and social programs, as well as non-health and non-technical supportive resources (Torrens, 1987). Seven categories of services have been identified as essential for a comprehensive, integrated system of elder care services (Evashwick, 1987). These are acute inpatient hospitalization, extended inpatient hospitalization, ambulatory care, home care, outreach and linkage, health and wellness promotion, and housing. Yet, the success of a comprehensive care system, however, does not depend solely on the availability of programs. Even with services available in each category, clients may have difficulty accessing care due to lack of knowledge of available services, lack of transportation, or lack of coordination among providers. Optimal systems of elder care also emphasize multidisciplinary collaboration among providers, coordination of services, and ease of access to services (Weiss & Kreger, 1987).

Nurses' Role in Coordinating Care

Knowledge and coordination of community health care and social services are legitimate nursing functions. Successful care coordination depends upon sophisticated assessment and organizational skills, as well as an emphasis on client advocacy (Cloonan & Shuster, 1990). These responsibilities fall within the scope of nursing practice. Nurses use a holistic framework that helps them to assess persons in their environments. Human responses to illnesses, quality of life, and optimal levels of functioning are central issues on which nurses focus when providing patient care. An in-depth knowledge of a community's range of services and skill in negotiating services to be provided can mean the difference between community-based or institutional care, especially for elders with chronic illnesses (Burton, 1995). Moreover, a thorough understanding of what is available and what is lacking encourages nurses to take a leadership role in ensuring that elderly clients have access to services and care options (Griggs, 1987).

The Community Setting

The demographic characteristics of Montana, and Lewis & Clark County, are reflective of a burgeoning older population. In 1990, Montana's population was 799,065. Of these residents, 106,497 were 65 years or older. This is approximately 13.3% of the population, slightly above the nation's percentage of elder adults. Between 1980 and 1990, Montana experienced a 25.9% increase in its elderly population. By 2012, 14.9% of the state's inhabitants are projected to be 65 or older, with 2.6% projected to be 85 years or older. Approximately 30% of Montana's elderly live alone, the majority being women. Although only 1% of the state's elderly live in nursing homes, the nursing home population in Montana grew 41.7% between 1980 and 1990 (U.S. Bureau of the Census, 1992).

Lewis & Clark County is a predominantly urban county. Most residents live within a twenty mile radius of Helena, the county seat and the state's capital (Lewis & Clark, 1994). In 1990, the county population totaled 47,495 (U.S. Census of Population and Housing, 1990). The population density is approximately 13.7 persons per square mile. The number of persons 65 or over is 5504, comprising 11.6% of the population. This is one percentage point below the nation's percentage of elders.

The county includes two incorporated cities, Helena and East Helena, and five unincorporated towns, Augusta, Canyon Ferry, Craig, Lincoln, and Wolf Creek. Helena's principle employer is the state of Montana. ASARCO, American Smelting and Refining Company, is the major employer in East Helena. Of the remaining communities, Lincoln has a tourist based economy while Augusta is agriculturally based. The 1990 population of the county's urban center, including the 20 mile radius around Helena, was 41,698. Persons aged 65 or over numbered 4559, or approximately 11% of the population. Less than 6000 people live in the county's rural areas. Census data regarding the population of elderly in these areas, however, were not available. In contrast, the population of Helena

and East Helena was 25,884, with 3637 residents 65 or older. In these two communities, the elderly comprise 14.2% of the population (U.S. Census of Population and Housing, 1990). The higher percentage of elders is likely related to two trends (Conselyea, 1995). First, many retired government workers choose to remain in the area. Second, retirees moving in from other states, most notably Washington, have increased. Given the high percentage of elders in this area and the probability that this percentage will increase in the coming decade, an analysis and evaluation of the elder care services is essential if areas of need are to be identified and addressed. On Table 1 are illustrated the current standing of elderly populations in the U.S., Montana, and Lewis & Clark County.

Table 1. Current Elderly Populations.

Population	Nation	Montana	Lewis & Clark County	Helena & 20 mile radius	Helena & East Helena
Population 1990	248,709,873	799,065	47,495	41,698	25,884
Population of elders	31,241,831	106,497	5504	4559	3637
Percentage of elders	12.6%	13.3%	11.6%	11%	14.2%

Objectives of the Project

Four specific objective were developed for this project. They were:

1. To examine the full array of health care and social services for elders in Lewis & Clark County, Montana.

2. To determine if client eligibility, geographic boundaries, financial aspects, or rural outreach present barriers to receiving services.

3. To identify potential gaps and/or overlaps in the range of available services, including mental health services.

4. To evaluate the existing range of services in Lewis & Clark County using a model of comprehensive elder care services, identified in the review of the literature, as a standard of delivering care.

Summary

The changing needs of an increasingly older population and dwindling health care dollars challenge communities and providers to be responsive to older adults. Ideally, elders will "age in place," that is, remain in the setting of their choice, usually their homes, in communities that strive to meet their physical, psychological, social, and spiritual needs through a comprehensive and integrated system of services (Koff, 1992). Typically, however, outside forces - poverty, lack of health insurance, and few available or accessible services - create communities where elders age in place without resources and supports. The willingness of public officials to cut Medicare and Medicaid reflects a growing lack of commitment to serving the elderly and allowing them the opportunity to age in place with grace and dignity. As the year 2000 approaches, erosion of financial support for elder care services will limit the ability of communities to sustain the elderly in settings of their choice. The present uncertainty in health care financing has particular relevance for this project. Communities concerned with promoting quality of life, and providing comprehensive and integrated care for older adults, must explore innovative approaches to delivering and financing elder care services.

CHAPTER 2

LITERATURE REVIEW

Much of the literature concerning elder care services in the U.S. is descriptive. Most authors either review current models of care or advocate for a specific approach to delivering services. The focus for this literature review was to establish a basic understanding of elder care services by exploring themes present in these descriptive works. To this end, specific topic areas were chosen and explored relating to this project's purpose. These topic areas were evolution of services, current directions in service delivery, structure of elder care services, existing models of elder care, and nursing's contribution and involvement in services.

Evolution of Elder Care Services

The organization and delivery of elder care services in the U.S. evolved out of the Older Americans Act (OAA) and subsequent policy changes that have occurred since the 1970s. The passage of the OAA mandated a set of community-based services be developed to improve the lives of older adults (O'Shaughnessy & Price, 1987). Area Agencies on Aging (AAA) were directed to plan, coordinate, and pool resources to establish programs aimed at servicing the needs of the well elderly (Alter, 1988). These programs addressed needs related to income, emotional and physical well being, housing, employment, social services, and civic, cultural, and recreational opportunities (O'Shaughnessy & Price, 1987). A major policy shift occurred with the 1978 Amendments to the OAA. These amendments directed AAAs to develop linkages with health planning agencies (Benjamin, Lindeman, Budetti, & Newacheck, 1984). This shift resulted in designing elder care services that targeted the medically frail elderly population (Alter, 1988). The substantial

cuts in Medicare and Medicaid funding which occurred during the Reagan Administration further changed the direction of elder care services. In the face of spending cuts, hospitals were forced to discharge early and states were obliged to restrict nursing home admission criteria (Alter, 1988). Consequently, in-home medical care services greatly expanded. A third major shift transpired in 1981 when Congress granted authority to the Department of Health and Human Services to waive certain Medicaid requirements (O'Shaughnessy & Price, 1987). This change led to what is currently referred to as the Medicaid Waiver Program which allows states greater latitude in providing services for vulnerable populations. As a result, states have been able to augment their elder care services by integrating long-term health care with existing well elderly programs (Benjamin et al., 1984).

Current Directions

Four directions in elder care services were identified in this review. The first direction is illustrated by Cantor's (1991) Social Care Model. This model bases services on the belief that assistance needed by older adults is primarily of a social nature, rather than of a health or medical nature. The health care model utilized by most hospitals providing elder care is representative of the second direction. Services in this model are a combination of both health care and social programs. Haber's (1986) conceptual framework, based on self-determination at different levels of environmental restrictiveness, is characteristic of the third direction. This conceptual framework is used to categorize differing degrees of self-determination promoted by in-home and community-based long-term care services funded by the Administration on Aging. Lastly, the fourth direction is exemplified by Evashwick's (1987) continuum of care model. This model incorporates

both the health and social care models into an integrated system of care defined by seven of categories services.

Social Care Model

Cantor (1991) proposed a social care model for providing elder care services. She defined this model as a holistic approach encompassing both formal and informal support systems that addressed three areas of need. These were "opportunities for socialization, self-affirmation, and self-actualization; assistance with everyday tasks of daily living; and help with personal care needs arising out of severe disability" (p. 337). A series of concentric circles were used to represent the relationships between elderly clients and the support systems with which they interacted. Underlying these concentric circles were articulated linkages connecting varying levels of support with the elderly client. Cantor argued this social model of care best met older adults' needs for independence and self-mastery of their environments.

Health Care Model

Anderson (1993) reported an increase of geriatric services available in community hospitals. Elder care services offered through these hospitals appeared to have been based on a health care model. In other words, services obtained in this model tend to focus on preventative and ambulatory care needs of elderly clients. The American Hospital Association's 1991 annual survey (as cited in Anderson, 1993) noted that 62% of U. S. community hospitals offered at least one of the following eight geriatric services: adult day care, Alzheimer's diagnostic and assessment services, emergency response system, geriatric acute care, geriatric clinics, respite care, and senior membership program. Many hospitals have developed their elder care services to fill gaps present in existing community-based services. As noted by Anderson, hospitals in Salt Lake, UT, Chicago,

IL, and Prairie du Chien, WI, have developed some system of geriatric services that provide a greater number of health care options beyond those of home health or nursing home services. Anderson observed that this trend was expected to continue as communities evaluated their existing services and moved toward integrated systems of care.

Self-Determination

Haber (1986) developed a conceptual framework based on self-determination and restrictiveness of environment to evaluate 30 Administration on Aging (AOA) research and demonstration projects. A self-determining, least restrictive environment was defined as one that "provided the most home like atmosphere, allowed maximum personal choice for care recipients and care-givers, and encouraged optimal family involvement without overwhelming family resources" (p. 39). After reviewing the AOA projects, Haber concluded these projects represented a continuum of self-determination and restrictiveness of environment. Services considered to be self-sustaining by family members and required minimal professional involvement were identified as the most self-determining services in the least restrictive environments. These included respite care and mutual help groups. Services directed by formal agencies, involved professional resource personnel, and had alternative facilities for care-giving activities were classified as intermediate. These included adult day care, expanded home care, and educational and training programs. Finally, services for institutionalized clients that focused on minimizing the isolation from the larger community and maximizing supportive services were designated as the least self-determining services in the most restrictive environments. These included programs that either linked institutionalized residents to the community or provided transitional services to residents discharging from institutions. Haber believed this framework could inform policy makers, program developers, and practitioners on the scope of elder care services which encourage self-determination.

Continuum of Care

Evashwick (1987) used the concept of a continuum of care to construct an ideal service system for elderly and other vulnerable populations. She defined a continuum of care as follows:

> an integrated client-oriented system of care composed of both services and integrating mechanisms that guides and tracks clients over time through a comprehensive array of health, mental health, and social services spanning all levels of intensity of care (p. 23).

Seven basic categories of services were identified as essential in an ideal continuum of care. These categories were acute inpatient, extended inpatient, ambulatory care, home care, outreach and linkage, wellness and health promotion, and housing. Services of acute inpatient included acute medical, surgical, psychiatric, and rehabilitation, as well as comprehensive geriatric assessment and consultation. Extended inpatient services included skilled and intermediate nursing care, psychiatric intermediate care, swing beds, nursing home follow-up, and respite care. Ambulatory care services were medical, psychiatric, nursing, and rehabilitation services provided by community health professionals. Geriatric assessment clinics, day hospitals, adult day care, mental health clinics, satellite clinics, and counseling, alcohol, and substance abuse treatment were also defined as ambulatory care programs. Home care included all services rendered in the home, such as home health reimbursed by Medicare and Medicaid and home health reimbursed by private pay, hospice, high technology home therapy, durable medical equipment, home visitors, home delivered meals, homemaker services, and personal care. Outreach and linkage involved those services that focused on health education and screening / information / referral / telephone contact, transportation, emergency response system, and support groups. Health and wellness services included educational programs, wellness clinics, recreational and social groups, senior volunteers, congregate meals, and meal discounts. Housing

consisted of continuing care retirement communities, senior housing, congregate care facilities, and adult family homes.

Structure of Elder Care Services

The structure of elder care services in most communities has grown out of the initial mandates of the Older Americans Act (OAA) that called for development of a comprehensive and coordinated service system for older adults (O'Shaughnessy & Price, 1987). One specific concept identified in the literature relating to structure was community-based interorganizational services system. This concept provided a framework on which to examine two existing elderly service delivery systems.

Community-Based Interorganizational Service System

Alter (1988) used the concept of a community-based interorganizational service system to compare two elderly service delivery systems: one in an Iowa county and one in an Illinois county. A community-based interorganizational service system was defined as the subset of all human service organizations found within a community whose purposes were to serve or treat a specific client population. Elder care services in these two counties were compared on six variables used in previous interorganizational research. These variables were size, centrality, differentiation, integration, vertical control, and scale of service.

Alter (1988) described the service delivery system in Iowa as a first generation delivery system. This meant a large, loosely coordinated, nondifferentiated, but comprehensive system with low vertical control and centrality and a smaller scale of services. Conversely, the services in Illinois were determined to be a second generation delivery system. This meant a smaller, highly differentiated, stable bureaucratic system with high centrality and vertical control and a larger scale of service. As a result of

comparing the two systems, Alter found a paradox of service delivery existed. On the one hand, the characteristics of a first generation, decentralized system allowed for innovation, flexibility, and the involvement of community volunteers. On the other hand, this same system was poorly organized, unable to provide a large volume of service, and lacked a high level of accountability among participating organizations. In contrast, the second generation, highly centralized system provided a larger volume of services, was more tightly organized, used resources wisely and maintained a high standard of accountability, but lacked flexibility and local autonomy and excluded volunteers and community support. Alter concluded that while centralization and increasing vertical control of community-based delivery systems could improve services, the negative effects of losing flexibility, innovation, community involvement, and autonomy appeared to adversely impact second generation systems. She urged community planners to consider these negative effects carefully when seeking to restructure and integrate existing services.

Existing Models of Elder Care Services

Since the mid 1970s, several communities, often in conjunction with local hospitals, have developed various models of elder care services that continue to operate today (Weiss, 1987). While these models differ in organization of services, scope of services, and types of elderly clients served, these programs do share the underlying principle of care coordination. Weiss (1987) defined care coordination as "an integrating mechanism within a continuum of services" that consisted of six fundamental components: "functional assessment, risk appraisal, care planning, and team conferencing, service referral and procurement, monitoring and tracking, and reassessment" (p. 274-275). The goal of a care coordinated system is to organize medical, health, and social services so that individual needs are effectively met and their independent functioning is maintained or

restored. Although several models of elder care services exist, describing each of them is beyond the scope of this project. Therefore, one model, Project OPEN (Organizations Providing for Elderly Needs) at the Mt. Zion Hospital and Medical Center in San Francisco, CA, and the model which succeeded it, the Mt. Zion Care Account, was chosen to be highlighted for this review.

Project OPEN's Model of Elder Care

Project OPEN initiated at Mt. Zion was a five year research and demonstration program funded by the Health Care Financing Administration from 1978 to 1983 (Weiss & Monach, 1985). The project was designed to provide services for chronically ill, elderly clients on Medicare who had difficulty maintaining their independence in the community. Project OPEN used a comprehensive case management design to improve these clients' access to and utilization of community-based services. Weiss & Monach (1985) reported that the project's two main objectives were "to implement a comprehensive delivery system of long-term health and social services" and "to evaluate the impact of a hospital-based brokerage model of service delivery on the elderly population's service utilization patterns, health and social service care costs, and functional well-being" (p. 14).

Participants in the project were elderly clients who were at risk of becoming dependent on others or of becoming institutionalized. Referrals were received from Mt. Zion, participating community agencies, families, and the clients themselves. Once clients consented to services, the initial intake process began. A comprehensive functional assessment and evaluation was administered by a project coordinator who was either a nurse or a social worker. After the assessment was complete, a multidisciplinary case conference was held in order to develop a 6 month care plan. This care plan identified client problems, highlighted needs, defined treatment goals, and specified which services and providers were to be involved. Project OPEN advantages included service

coordination and extended Medicare benefits. Service coordination involved linking clients to appropriate formal and informal services by contacting providers and arranging for services. Extended Medicare benefits were a group of waivered services that had not previously been covered by Medicare. Included among these services were adult day health care, social day care, homemaker/chore care, home delivered meals, respite care, transportation, and mental health care.

Project OPEN's Research Findings

Weiss and Monach (1985) reported on the results found when Project OPEN measured the effects of its hospital-based brokerage model on the functional ability and utilization patterns of its demonstration group participants. The data obtained from this group were compared with similar data obtained from a randomized control group of clients utilizing the existing delivery system. Functional assessments were administered, care planning was provided, service utilization patterns were screened, and costs of services were monitored for every participant at six month intervals for 18 months.

Weiss and Monach (1985) noted the demonstration group received a significantly greater and more appropriate level of services than the control group. Moreover, the demonstration group maintained functional status, had greater access to health services, and experienced lower rates of acute inpatient services. In comparison, the functional status of the control group deteriorated, they had less access to health services, and had higher rates of acute inpatient hospital activity. The most significant finding, however, was the cost savings for the demonstration group. Cost analysis indicated a 15% cost savings. These savings were attributed to the decrease in acute hospital services during the first six months, the decrease in the number of physician visits, the prevention of premature or inappropriate institutionalization, and the availability of a comprehensive package of elder care services. Weiss and Monach concluded that Project OPEN's success supported the

development of more hospital-based brokerage models to improve access and utilization of community-based services.

Description of Mt. Zion's Care Account

Mt. Zion's Care Account Program, which developed out of Project Open at Mt. Zion Hospital, is a preferred provider organization of 17 geriatric services that make up the continuum of care within the San Francisco Institute of Aging (Weiss, 1987). These services are offered through the Mt. Zion Hospital and Medical Center which began programs for the elderly as early as the 1940s (Weiss & Kreger, 1987). In addition to the geriatric services, Mt. Zion offers traditional inpatient, outpatient, and skilled nursing services, as well as contractual arrangements with other outside agencies to provide a comprehensive benefit package for elders covered by Medicare (Weiss, 1987). Although Mt. Zion's Care Account Program entails a wide range of elder care services, its success is based on the philosophy by which its services are designed and coordinated (Weiss & Kreger, 1987). This philosophy directly mirrors Evashwick's (1987) definition of a continuum of care (refer to p. 14 of this manuscript). Four essential factors underlie the delivery of services. First, Mt. Zion's Care Account Programs have been designed to maintain each elderly client's maximum functional independence. Second, the range of services available has been developed to adapt to the changing needs of elderly clients, so that "as needs change so do services" (Weiss & Kreger, 1987, p. 35). Third, because all services are within one organization, client transition among services occurs with ease and without loss of continuity of care. Finally, the care account system focuses on coordination and integration of services. Care management and interdisciplinary conferences facilitate coordination among formal services of the care account program, as well as the informal services provided by family and friends. Re-assessment and re-

evaluation of clients on a regular basis to identify changes in mental and physical functioning are important aspects of care coordination.

Nursing's Contribution to Elder Care Services

With respect to the delivery of elder care services, the majority of the nursing literature has focused on the areas of care coordination and client advocacy (Burton, 1995; Cary, 1992; Cloonan & Shuster, 1990; Griggs, 1987). While nurses' roles in these areas have been essential to ensuring that elder care services remain accessible, appropriate, and available, their roles as designers of specific models of care are equally essential. Yet, nursing models of care are more frequently found in the oncology (Shegda & McCorkle, 1990) than the gerontology literature. Two models of psychiatric nursing outreach for rural elders, however, were located and reviewed. The decision to include these outreach models in the literature review relates to the overall principles underlying the delivery of outreach services. These are conducting comprehensive assessments, utilizing multidisciplinary treatment approaches, and coordinating and integrating formal and informal community resources. These principles are similar to the previously described standards guiding Mt. Zion's Care Account Program. Although these outreach models concentrate on providing psychiatric/mental health services, a key component basic to these models is the emphasis on meeting clients overall health care needs. In other words, physical health problems and/or social service needs are not ignored, but addressed through activation of existing community resources and services (Abraham & Neese, 1993). Consequently, as nursing models of care, they go beyond being discipline specific and can serve as future models for designing elder care services.

Overview of Two Nursing Outreach Models

The Elderly Outreach Project in Iowa and the Rural Elder Outreach Program in

Virginia were two outreach models identified in the literature. They were designed to serve the mental health needs of the rural elderly in their respective communities. Both programs rely on a system of referrals from a variety of community resources. However, Iowa's Elderly Outreach Project is noted for using a community gatekeeper referral program, a system of community lay persons trained to recognize symptoms of emotional distress in the elderly. Staffing patterns for the two models are similar. Both have a multidisciplinary focus, though Virginia's Elder Outreach Program utilized only nurses as outreach providers. The outreach mental health services provided by these programs include comprehensive assessment, case management, counseling, and care-giver support. In both Iowa and Virginia, the outreach teams utilize existing community resources, assist in coordinating an array of services, and provide additional educational and supportive programs for their communities. The three most common mental health problems encountered by the outreach teams are depression, dementia, and coping with chronic illness. The majority of the clients served have been women. The annual direct cost per patient per year has been $622.00 in Iowa and $1015.00 in Virginia (Buckwalter et al., 1993; Abraham & Neese, 1993).

Summary

Based on this review of the literature the following conclusions were drawn. First, political and social forces continue to shape the organization and delivery of elder care services. Second, regardless of the model described, successful delivery of elder care services appears to be contingent on coordination and integration of services, linkages among support systems, and maintaining independence and enhancing self-mastery of environments. Third, integration of elder care services must not sacrifice community

involvement and local autonomy. Finally, psychiatric/mental health nursing models of elder outreach can enhance existing elder care services.

CHAPTER 3

PROJECT DESIGN

Data Collection

The full array of health care and social services in Lewis & Clark County was identified through the current U.S. West Telephone Directory (1995/1996), the Tri-County Guide to Community Resources (Summit Project, n.d.), and a resource list provided by the Alzheimer's Association (Wallace, 1994). All possible elder care resources were then organized according to the categories used in the guides and the directory. These sections were aging services, senior services, elderly and handicapped services, housing, nursing homes, respite care, inpatient and outpatient medical services, and inpatient and outpatient psychiatric services (Appendix A). Arranging services in this way allowed for ease of gathering agency information and enabled an initial picture of the range of elder care services to emerge. The identified resources included those agencies whose services were specifically designed for older adults, such as those programs administered by the Rocky Mountain Development Council (RMDC), as well as those agencies whose services were aimed at all adult clients, such as home health services and out-patient medical services. Agency information was obtained either through brief telephone interviews or requests for mailings of agency literature. Five particular types of data were sought: types of services offered, eligibility requirements, geographic boundaries, financial aspects, and rural outreach. These types of data represent potential barriers to receiving available services and relate directly to the project's third objective identified in Chapter 1.

In-depth interviews, either by phone or face to face, were conducted in some cases with key agency personnel. The decision to conduct interviews grew out of a desire to develop an understanding of elder care services based on perspectives of those involved in

providing care. Individuals interviewed included the program directors of St. Peter's Behavioral Health Division, Heritage House, Alzheimer's Association, Senior Center, Senior Companions, Foster Grandparents, and Blind Senior Companions. These individuals were chosen either as a result of their direct involvement in elder care services, i.e., aging services programs, or their interest in the needs of elders which surfaced when agencies were first contacted for information. A set of interview questions was developed to guide these interviews; however, questions were asked only if it seemed necessary to direct the interview towards a specific area of information (Appendix B). In general, these interviews were informal with open-ended questions asked to stimulate discussion and obtain data.

Assessment Procedure

Three approaches were used to assess the spectrum of elder care services in Lewis & Clark County. First, the information collected through interviews and agency literature was organized into a table summarizing each agency's services, eligibility requirements, geographic boundaries, financial aspects, and rural outreach (Appendix C). Second, the different agencies and programs were grouped and arranged into a table according to Evashwick's (1987) seven categories of service that define an ideal continuum of care: Acute inpatient, extended inpatient, ambulatory care, home care, outreach and linkage, health and wellness promotion, and housing (Appendix D). Evashwick's continuum of care model was chosen as an assessment strategy because it provided a comprehensive framework for organizing the range of services in Lewis & Clark County. Using Evashwick's model was essential since the initial grouping used during data collection did not accurately reflect the true scope of services available. Third, the county's services were compared to the Mt. Zion Care Account. Mt. Zion was chosen for two reasons.

First, the research findings suggested that as a comprehensive model of elder care services, the Mt. Zion program demonstrated cost savings and increased elderly clients' access to health and social services. Second, the four essential factors which underlie Mt. Zion's philosophy of care are critical variables in the success of its programs and exemplify Evashwick's ideal continuum of care. Therefore, Mt. Zion represents a standard by which to measure other elder care delivery systems.

Summary

The project's four objectives served as a basis for the development of the assessment strategies. These strategies helped to sort the data into a coherent whole so that an accurate description of the county's system of elder care services could emerge. This in turn, allowed for the range of services to be evaluated.

CHAPTER 4

PROJECT OUTCOME

Discussion

Services for elders in Lewis & Clark County were evaluated from four different perspectives which developed out of the project objectives and assessment strategies. From the first perspective, restrictions of client eligibility, geographic boundaries, financial aspects, and rural outreach were examined to determine the availability and accessibility of services. Evaluation of the county's services according to Evashwick's (1987) seven categories provided the second perspective. Comparison with Mt. Zion's Care Account Program comprised the third evaluative perspective. And lastly, an evaluation of whether services were lacking and/or duplicated was undertaken.

Evaluation by Service Restrictions

The range of services in Lewis & Clark county can be described on the basis of client eligibility, geographic boundaries, financial aspects, and rural outreach (Appendix C). Services in the county were found to be affected by at least one of these service restrictions.

Client Eligibility and Financial Aspects. Program requirements, either client eligibility or financial considerations, restrict which clients can receive services. The Senior Companion and Foster Grandparent programs confine volunteers to those who meet low income criteria set by the federal government. The three licensed adult foster care homes have strict client eligibility guidelines and, at this writing, accept only private pay residents. The only adult day care program for cognitively impaired older adults, located in Helena, also has specific client criteria which exclude individuals who are incontinent

and/or have impaired mobility. Home health services reimbursed through Medicare and Medicaid are time limited. Southwest Telepsychiatry services are circumscribed by narrow financial reimbursement rules.

Geographic Boundaries and Rural Outreach. Most services are located in the county's urban center and must be accessed at the site where services are offered. Transportation resources are accessible primarily in Helena and East Helena. Elders living in the county's rural areas may find themselves potentially isolated from needed services or programs. Rural outreach is limited. Home health services are the only medical care services available in the county's rural communities. Other additional services available outside the urban center include the senior centers and their accompanying nutrition programs in Augusta and Lincoln.

Evaluation by Service Category

Each of the seven basic service categories described by Evashwick (1987) are represented by one or more agencies or programs in the county (Appendix D). These categories are acute inpatient, extended inpatient, ambulatory care, home care, outreach and linkage, health and wellness, and housing. Although many types of county services - medical, rehabilitative, psychiatric/mental health, chemical dependency, and social services - are present within these seven categories, only programs serving social needs have a specific geriatric focus.

Acute Inpatient, Extended Inpatient, and Ambulatory Care. Acute inpatient and ambulatory care services lack specialized geriatric assessment and consultation clinics. Only one physician specializes in elder care. Extended inpatient services have limited respite care and do not have definitive nursing home follow-up programs.

Psychiatric/mental health services within all three of these categories do not specialize in the needs of older adults, nor do they reach out to isolated or home bound elders.

Home Care, Outreach and Linkage, Health and Wellness. The most extensive services which focus on elderly clients are available in the categories of home care, outreach and linkage, and health and wellness. Services found in these categories have excelled in addressing issues and needs which are of particular concern to the elderly, such as discounted meals, opportunities for volunteer, social, and recreational activities, health screening clinics, and political activism. Nevertheless, these services emphasize physical, rather than mental health concerns.

Housing. Although different types of housing alternatives are beginning to surface, such as licensed adult foster care homes, housing options for elderly residents in the county remain limited. Only two housing facilities are strictly for independent seniors, and of these, only one provides subsidized rent and a meal plan. Three other apartment facilities are available, but are not restricted to elderly adults. Younger persons with disabilities and handicaps are also eligible. Rents are subsidized in these facilities, but only one of the three complexes also provides a meal plan.

Comparison of Service Delivery Systems

In comparison to the range of services offered by the Mt. Zion Care Account, the spectrum of services available to elders in Lewis & Clark County appears, on initial observation, to be similar. With the exception of certain adult day health respite care programs, specialized geriatric assessment, acute care, and rehabilitation services, Lewis & Clark County elders have access to programs and providers that seem to meet their health, wellness, psychosocial, and educational needs. In contrast, however, the available services lack the focus, design, and organization of the Mt. Zion Care Account Program.

An underlying philosophy that accentuates client independence and changing needs, promotes easy transition among various programs, and stresses coordination and integration of services is not evident in the delivery of elder care services in Lewis & Clark County.

Specific services for elders in Lewis & Clark County were developed by separate agencies and institutions, such as the Area IV Agency on Aging, the Rocky Mountain Development Council (RMDC), and St. Peter's Hospital. Moreover, the county and state administer different programs aimed at meeting the needs of elderly citizens. Lewis & Clark County directs subsidized housing, the Medicaid waiver program, and a nursing convalescent center, while the state oversees Adult Protective Services. Access to services and management of client needs lack Mt. Zion's centralized, continuity of care approach. As a result of the multiple points of entry, the system of care for Lewis & Clark County elders is often fragmented, creating a situation in which services are pieced together, rather than coordinated (personal communication, K. Hosner, November 21, 1995). The dearth of specialized geriatric services in the county, especially those that focus on assessment of medical, psychosoical, and mental health needs, further contributes to fragmentation of services and ineffective management of client care (Weiss, 1987). This absence of coordination and integration of elder care services in the county stands out as a major deficit in the overall system of available services.

Evaluation of Service Gaps and/or Overlaps

Lewis & Clark County does offer a range of elder care services that meet varied life needs, but falls short of providing a coordinated and integrated system of care. With respect to duplication of services, significant overlaps between agencies or programs are not readily apparent. Although two home health care agencies provide services, the extent to which they overlap and the effect this might have on client care is unclear from data

collected. Further investigation would be necessary to determine the degree of duplication and possible fragmentation produced when two home care agencies serve the same communities. With regard to gaps in the present array of elder care services, needed services are both missing and scarce. Specialists in geriatric care, as well as programs which offer a multidisciplinary approach to elderly clients' complex biopsychosocial needs are lacking. Adult day care, respite for care-givers, transportation, and housing options are limited in scope and insufficient to meet the needs of a diverse group of elders with differing levels of dependency (personal communication, C. Stivik, November 21, 1995). Home health services are confined to medical and personal care. Psychiatric home health care for elders at risk is as yet unavailable. Eligibility criteria, financial stipulations, and population boundaries also create barriers to existing services by excluding certain types of elderly clients. Elders with dementia whose behaviors are problematic, such as wandering, confusion, disorientation, and incontinence, are not eligible for licensed adult foster care. These elders who cannot be cared for by family have the nursing home as their only option for care, an option that ultimately is more costly. Financial stipulations also exclude many persons from receiving services. Programs such as Senior Companions, Foster Grandparents, and Licensed Adult Foster Care confine services to those who meet income guidelines. Elderly persons in the middle income range may not qualify because they neither have fixed incomes nor the ability to pay out of pocket for services. Older adults living in the county's rural communities must have or arrange transportation to Helena in order to access the majority of health and social services.

Project Limitations

While a clear picture of the range of elder care services in Lewis & Clark County emerged from the data, certain aspects of the project's design limit the interpretation of the

findings. A major limitation involved comparing a hospital-based model of elder care located in a large metropolitan area to an assorted collection of services, agencies, and providers found in a non-metropolitan county of a predominantly rural state. Differences in population sizes and boundaries, economic bases, tax revenues, financial resources, and operating budgets hindered an equal comparison between systems of care and potentially biased the inferences drawn from the comparison. The absence of a coordinated and integrated system of care in Lewis & Clark County could be related more to the lack of resources than to the lack of a coherent, comprehensive model of care. The scope of the project did not allow a more thorough assessment of the role county resources assumed in the development and organization of elder care services. Consequently, any conclusions based on the Mt. Zion comparison must be regarded as tentative.

The methods for collecting agency information was a second limiting factor. The strategies used for gathering the data did not consider or attempt to measure the degree to which agencies and programs coordinated services. Although subjective data from interviews with certain agency personnel suggested a lack of coordination among providers, objective confirmation based on the data cannot be determined. Therefore, judgments made about the lack of a coordinated and integrated system of elder care services in the county remain provisional.

Examining the range of elder care services in Lewis & Clark County raises important questions regarding continuity of care and access to services which could not be answered within the scope of the project. Bachrach (1986) stated that continuity of care was dependent on whether "true access to needed services" existed (p. 171). She identified four dimensions of continuity of care which would be relevant to future investigations focusing on elder care services in the county. The first dimension was longitudinal access, or the availability of services over a long period of time. The second one was

psychological access, or the manner in which services are felt to be helpful and accommodating by the client. Financial access or clients' abilities to pay for services was the third dimension. Finally, the fourth dimension was geographical access which entailed either the distance clients had to travel for services or whether services were brought to the clients unable to travel. One possible way to determine whether an accessible, coordinated, and integrated continuum of elder care exists in Lewis & Clark county would be to follow a group of clients through the spectrum of available services.

Implications

Despite the project's limitations, the findings do suggest that gaps exist in the system of care available to elders in Lewis & Clark County. One of the most important gaps identified is the absence of a specific geriatric focus in the delivery of medical and psychiatric/mental health services. The lack of specialized geriatric services increases the risk that certain health problems, specifically mental health problems, may go unrecognized and untreated. Although growing older is not necessarily associated with a greater risk for mental illnesses, epidemiological studies have estimated between 15% to 25% of older persons have significant mental health problems (Rathbone-McCuan, 1992). Factors that can be associated with aging, such as poverty, isolation, and chronic physical health problems, can place the elderly at risk for disability as a result of a mental illness, especially depression or dementia (Lebowitz & Niederehe, 1992).

The significance of depression in the elderly can not be overstated. Dysfunction, premature institutionalization and death are often the consequences of an untreated depression. Lesser (1994) cited depression as the most frequent cause of psychiatric hospitalization in patients age 60 and older. Depression in the elderly is complicated by the complex biological, psychological, and social changes occurring with aging (Burnside,

1988; Lebowitz & Niederehe, 1992). Sensory impairments, problems with mobility, withdrawal in response to loss, and social isolation as a result of role transition may confound a diagnosis of depression. In addition, detecting depression in the elderly is problematic, as it may be masked. Clinicians may misread presenting symptoms, such as irritability, and dismiss the person as "just getting old" (Burnside, 1988). Older adults may hide their symptoms, especially a depressed mood, because of fear of stigma and rejection or out of the belief that they are somehow weak (LaGodna, 1988). Depression may look like dementia, thus creating a need for an in-depth assessment, as cognitive impairment caused by depression can be treated (Burnside, 1988). Finally, depression may be secondary to physical illness, pharmacologic effects of medications, or a precipitating event, such as an abrupt, profound loss. All of these factors combined underscore the need for psychiatric/mental health services that specialize in the needs of an aging population.

Given the high percentage of elders in the county's urban center and the fact that depression and dementia are major mental problems confronting older adults, the county's elder care services must focus on the mental health needs of this population. Yet, simply adding specialized psychiatric/mental health services may not improve the availability and utilization of services or eliminate barriers. Fear of the stigma associated with obtaining psychiatric services and fear of receiving insensitive treatment from professionals they do not know keep many elderly from utilizing available resources. Furthermore, geriatric mental health researchers and clinicians have found that effective mental health services for elders are dependent on coordination among care providers, integration of services, multidisciplinary treatment teams, and increased Medicare and Medicaid benefits for services that reduce the need for expensive long-term treatment (George, 1992; Burns & Taube, 1990; Harper, 1992). Innovative approaches are needed to address and fill the gaps

present in Lewis & Clark County. One such approach that is both innovative and can overcome the above barriers is mental health nursing outreach.

The choice of mental health nursing outreach to meet the needs of elders in Lewis & Clark County is based on the goals of nursing outreach. These are restoration and/or maintenance of clients' independence and self-care abilities and prevention of premature hospitalization or institutionalization. These goals are very similar to the four factors underlying Mt. Zion's philosophy of care. A typical program of mental health nursing outreach provides services in the clients' homes. These services include comprehensive assessment, health promotion/illness prevention, case management, counseling, and care-giver support. Such a program of outreach services allows for greater options for families caring for elderly members who may be at risk for institutionalization. Furthermore, nursing outreach emphasizes a multidisciplinary, holistic approach to meeting health needs, both physical and psychological, as well as the coordination of services and care-givers, both formal and informal. In addition, mental health nursing outreach works to strengthen existing community resources, rather than simply adding new ones. Finally, this system of care may alleviate the fears associated with mental health treatment. Nurses have long been accepted in community settings and are less likely to be associated with a "stigma of craziness or welfare" (Buckwalter et al., 1993). Because the central focus of all nursing practice is on the nurse-client relationship, nurses who reach out to elders at risk work to develop trust, allay fears, promote health, and support adaptive behaviors.

Conclusion

Despite the limitations in this project, the four objectives identified in the introduction were met. First, the full array of health care and social services were identified and examined either through agency literature and/or interviews. Second, the service

restrictions of client eligibility, geographic boundaries, financial aspects, and rural outreach were described and identified as potential barriers elders may encounter when accessing services. Third, as had been suspected prior to undertaking the project and on the basis of the literature review, the absence of a specific geriatric focus in the delivery of medical and psychiatric/mental health services was determined to negatively impact services in Lewis & Clark County. Lastly, the range of services was evaluated against the Mt. Zion Care Account Program. Although differences between Mt. Zion and Lewis & Clark County prevented an equal comparison, valuable insights were still gained. These insights relate to realizing the importance of creating a model of elder care services that emphasizes clients' independence and changing needs, promotes transitions among services, and coordinates and integrates services. These are the factors that appear to be responsible for Mt. Zion's success and are critical to delivering quality of care.

Elder care services in Lewis & Clark County do not necessarily have to add services in order to meet the needs of its aging population. Rather, the focus, design, and organization of the services must change. Although the health care system in general is facing an uncertain future, communities and providers must not allow that uncertainty to prevent the emergence and establishment of alternatives to the present system. An innovative approach, such as mental health nursing outreach, can serve to strengthen existing services and community resources, while overcoming the barriers which characterize the current system.

REFERENCES CITED

Abraham, I.L. & Neese, J.B. (1993). Outreach to the elderly and their families: Focus on the rural south. Aging, 365, 26-31.

Alter, C.F. (1988). The changing structure of elderly service delivery systems. The Gerontologist, 28, 91-98.

Anderson, H.J. (January 5, 1993). Geriatric services grow. Hospitals, 67(1), 31-33.

Bachrach. L.L. (1986). The challenge of service planning for chronic mental patients. Community Mental Health Journal, 22, 170-174.

Benjamin, A.E., Lindeman, D.A., Budetti, P.P., & Newacheck, P.W. (1984). Shifting commitments of long-term care: The role of coordination. The Gerontologist, 24, 598-603.

Buckwalter, K.C., Abraham, I.L. Smith, M. & Smullen, D.E. (1993). Nursing outreach to rural elderly who are mentally ill. Hospital and Community Psychiatry, 44 821-823.

Burns, B.J. & Taube, C.A. (1990). Mental health services in general medical care and in nursing homes. In B.S. Fogel, A. Furino, & G.L. Gottlieb (Eds.), Mental health policy for older Americans: Protecting minds at risk (pp. 63-84). Washington, DC: American Psychiatric Press.

Burnside, I. (1988). Nursing and the aged: A self-care approach. New York: McGraw-Hill.

Burton, D. (1995). Agency maze. In I. Lubkin (Ed.), Chronic illness: Impact and interventions (3rd ed., pp. 459-480). Boston: Jones and Bartlett.

Cantor, M.H. (1991). Family and community: Changing roles in an aging society. The Gerontologist, 31, 337-346.

Cary, A.H. (1992). Promoting continuity of care: Advocacy, discharge planning, and case management. In M. Stanhope & J. Lancaster (Eds.), Community health nursing: Process and practice for promoting health (pp. 681-703). St. Louis: Mosby.

Cloonan, P.A. & Shuster, G.F. (1990). Care coordination: A resource-intensive component of home health nursing practice. Public Health Nursing, 7, 204-208.

Conselyea, J.D. (1995, November-December). Everyone needs a home. Active Montanan, pp. 3-4.

Evashwick, C.J. & Branch, L.G. (1987). Clients of the continuum of care. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 45-56). Rockville, MD: Aspen.

Evashwick, C.J. (1987). Definition of the continuum of care. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 271-291). Rockville, MD: Aspen.

George, L.K. (1992). Community and home care for mentally ill older adults. In J.E. Birren, R.B. Sloane, & G.D. Cohen (Eds.), Handbook of mental health and aging (pp. 793-813). San Diego: Academic Press.

Griggs, M.J. (1987). The role of the nurse in the continuum of care. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 349-364). Rockville, MD: Aspen.

Haber, D. (1986). In-home and community-based long-term care services: A review of recent AOA projects involving self-determination. The Journal of Applied Gerontology, 5, 37-50.

Harper, M.S. (1992). Home- and community- based mental health services for the elderly. In K.C. Buckwalter (Ed.), Geriatric mental health (pp. 122-129) Thorofare, NJ: Slack.

Intermill, N.L. & Rathbone-McCuan, E. (1991). Mental health services for elders in rural America. Kansas City: National Resource Center for Rural Elderly.

Koff, T.H. (1992). Aging in place: Rural issues. Generations, 16, 53-55.

LaGodna, G.F. (1988). Aging women and depression: Unresolved conceptual, etiologic, and epidemiologic issues. Issues in Mental Health Nursing, 9, 285-298.

Lebowitz, B.D. & Niederehe, G. (1992). Concepts and issues in mental health and aging. In J.E. Birren, R.B. Sloane, & G.D. Cohen (Eds.), Handbook of mental health and aging (pp. 3-26). San Diego: Academic Press.

Lesser, I. (1994, March). Neuroimaging findings in late-life depression. Psychiatric Times, pp. 26, 28.

Lewis & Clark County Budget Narrative (1994). Lewis & Clark County, MT: Author.

O'Shaughnessy, C. & Price, R. (1987). Financing and delivery of long-term care services for the elderly. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 271-291). Rockville, MD: Aspen.

Rathbone-McCuan, E. (1992). Rural mental health service for the elderly: A discussion of short-range futures. In C.N. Bull & S.D. Bane (Eds.), The future of aging in rural America: Proceedings of a national symposium 1991 (pp. 85-100). Kansas City: National Resource Center for Rural Elderly.

Shegda, L.M. & McCorkle, R. (1990). Continuing care in the community. Journal of Pain and Symptom Management, 5, 279-286.

Summit Project: Tri-County Partnership for Substance Abuse Prevention. (n.d.) A Tri-county guide to community resources. Helena, MT: Author.

Torrens, P. (1987). The continuum of care: The patient and family's view. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 295- 309). Rockville, MD: Aspen.

U.S. Bureau of the Census (1992). Sixty-five plus in America. Current population reports, special studies P23-178. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census Statistical Brief (1995). Sixty-five plus in America. Washington, DC: U.S. Government Printing Office.

U.S. Census of Population and Housing (1990). U. S. Department of Commerce, Economic, and Statistic Administration, Bureau of the Census: Summary Tape File #3. Washington, DC

U.S. West Direct. (March 1995/1996). The white & yellow pages. Englewood, CO: Author.

Wallace, D. (1994). Adult children caring for their parents. Unpublished Resource Guide.

Weiss, L.J. & Kreger, M.C. (1987). Examples of the continuum of care. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 43-43). Rockville, MD: Aspen.

Weiss, L.J. & Monach, J.O. (1985). San Francisco's Project OPEN: A long-term care health system development and demonstration program for the elderly. PRIDE Institute, Journal of Long-Term Care, 4,(1), 13-23.

Weiss, L.J. (1987). Care coordination: An integrated mechanism. In C.J. Evashwick & L.J. Weiss (Eds.), Managing the continuum of care (pp. 271-291). Rockville, MD: Aspen.

APPENDICES

APPENDIX A

Community-Based Services for Elders Residing in Lewis & Clark County, Montana

Aging Services

Rocky Mountain Development Council Area IV Agency on Aging:

- Senior Nutrition Program - Daily Dinner Club/Home Delivered Meals
- Retired Senior Volunteer Program
- Senior Citizen Centers
- Senior Companion Program
- Youth and Older Workers Employment Program

Housing

- Helena Housing Authority
- Eagles Manor
- Serendipity Apts.
- Sunset Capitol Apts.

Senior Services

- Lewis & Clark County Health Department: Medicaid Waiver Program for Elderly and Handicapped
- Montana Senior Citizens Association
- Elder Serve, Inc.
- Sixty-plus Senior Program (St. Peter's Hospital)
- Alzheimer's Association SW Montana

Nursing Homes

- Big Sky Care Center
- Helena Nursing Home
- Cooney Convalescent Home
- Williamson House
- Our House
- Shelby House

Adult Day Respite Care

- Heritage House

Inpatient Medical Services

- St. Peter's Community Hospital

Outpatient Medical Services

Home Health Care:

- HomeLink of St. Peter's Community Hospital
- West Mont Home Health Services

Hospice:

- HomeLink of St. Peter's

Primary Care:

- Geriatrics (Elder Care) - Lee Harrison, MD

Inpatient Psychiatric Services

- Support Center of St. Peter's Community Hospital

Outpatient Psychiatric Services

- Mental Health Services, Inc.

- Support Center of St. Peter's Hospital - Partial Hospitalization Program
- Psychiatric Associates of St. Peter's Community Hospital

Grief Counseling:

- Hospice of St. Peter's HomeLink

Chemical Dependency Treatment:

- Boyd Andrew Chemical Dependency Care Center

APPENDIX B

Interview Questions

Types of Services, Comprehensiveness of Services, and Agency Philosophy:

1. What is/are the type/types of service(s) provided by your agency? Are there specific client needs that your agency addresses?

2. How does your agency provide these services: information/referral, direct care, education/research?

3. Are there services that your agency would like to provide but does not provide?

4. What services are needed that your agency does not provide and are not met by other community agencies/services?

5. What do you perceive are the strengths of the services your agency provides?

6. What are the limitations?

7. What types of financial support does your agency receive?

Eligibility Requirements:

1. What clients are eligible for your services?

2. What screening criteria do you use?

3. What are the direct costs to the client for your services? (Medicare? Medicaid? Private Pay? 3rd Party?)

Geographic Location and Accessibility:

1. What geographic location does your agency serve?

2. Does your agency make home visits in order to provide services?

3. Does your agency provide outreach to clients living in remote areas of the county?

APPENDIX C

Range of services in Lewis & Clark County according to service restrictions

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
St. Peter's Community Hospital	Inpatient medical services; acute care	Services provided to children and adults regardless of ability to pay	Helena; Lewis & Clark County; and surrounding counties- Broadwater, Jefferson	Private Insurance, Medicaid, Medicare, Private pay	Residents must access services in Helena
West Mont	Home health care, Personal assistance program, Home medical equipment, Habilitation services, Child care services	Home health & IV services must be ordered by a physician: Habilitation services provided to disabled	Statewide; Lewis & Clark County	Private Insurance, Private Pay, Medicare, Medicaid: Habilitation services funded in part by MT Dept. of Social & Rehabilitation Services	Does serve communities of Augusta, Lincoln, and Wolf Creek.
HomeLink of St. Peter's Hospital	Home health care, Home O2, Home infusion, & Private duty	Services must be ordered by a physician	Lewis & Clark, Jefferson Counties	Private Insurance, Private pay, Medicare, Medicaid; Private duty nursing services through private pay	Services to communities in Lewis & Clark County
Hospice of St. Peter's Hospital	Hospice care, Grief support services	Services usually ordered by a physician, Hospice is available to all persons who need and desire it regardless of ability to pay	Helena and communities outside of Lewis & Clark County	Private Insurance, Medicare-Part A, Medicaid, Private pay, donors	No

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Lewis & Clark Medicaid Waiver Program for Elderly & Handicapped	Provides a network of home and community based support services for person who are in need of such services so that they may remain in an independent living situation	65 years and older or physically handicapped; must meet nursing home eligibility and Medicaid eligibility	Lewis & Clark County	Medicaid and Private pay	Serves residents of the county
Lee Harrison, MD	Primary Care Elder Care	none	Helena area	Private Insurance, Private Pay, Medicare, Medicaid	Clients must access services in Helena
St. Peter's Community Support Center	Acute care inpatient psychiatric treatment, crisis stabilization: programming no specific geriatric focus	Adults 18 years and older	Helena, Lewis & Clark County, only In-patient Psychiatric Hospital in Mental Health Region IV (12 counties in SW Montana	Private Insurance, Private Pay, Medicare, Medicaid	No
St. Peter's Community Hospital Partial Hospitalization Program	Psychiatric day treatment program - has a dual diagnosis focus: no specific geriatric focus	Adults 18 years of age and older Referral from a physician or community agency	Primarily residents of Helena	Private Insurance, Private pay, Medicare, Medicaid	No
Mental Health Services, Inc. Helena Outpatient Clinic	Short-term individual counseling; short & long-term group counseling for adults, children & families	None	Primarily Helena - Client must come in for services	Private Insurance, No Medicaid, Sliding scale for low income	No

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Mental Health Services, Inc: Helena Community Support Services	Outpatient mental health, Psychiatric Day Treatment, Support and Crisis line, community living support, outpatient psychiatric services, crisis stabilization services, no specific geriatric focus	Adults & children with severe and persistent mental illness	Lewis & Clark, Jefferson, Broadwater Counties	Private Insurance, Medicaid, State contracts	Community outreach and counseling by 24-hour Crisis Response Therapists via phone - little travel outside the immediate Helena area
Psychiatric Associates of St. Peter's Community Hospital	Outpatient psychiatric services and counseling, no specific geriatric focus, APRN and psychiatrist provide consultation to area nursing homes	None	Primarily Helena, residents must come in for services	Private pay, Private Insurance, Medicare, Medicaid	APRN may do home visits in the Helena area, outreach to local nursing homes
S. W. Telepsychiatry	Outpatient psychiatric services consultation via satellite network	None, depends on whether telesite is available	Mental Health Region IV	Medicare and Blue Cross / Blue Shield **do not reimburse.** Medicaid and other health insurance will reimburse for a visit via satellite network, but will not reimburse for cost of equipment or transmission	Yes, to those areas with sites

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Boyd Andrew Chemical Dependency Care Center	Outpatient Chemical Dependency Treatment, After care, Family counseling, Transitional Living Facilities Intervention, DUI Court School, Minors in possession, Assessment, Education, no specific geriatric focus	Anyone affected by drug or alcohol abuse	Lewis & Clark, Jefferson, Broadwater Counties	Private Insurance, sliding fee based on income and ability to pay	Rural offices outside of Lewis & Clark County
Heritage House	Adult Day Respite Care	No age limit, but specifically elders affected by dementia, who need a safe and supervised environment - clients must be able to ambulate with assistance and be continent - Staff will work with behavior problems depending on nature	Helena	Private pay, Medicare waiver	No
Williamson House	Licensed Adult Foster Care- assisted living program, 24-hour unskilled supervision - 2 homes licensed for 8 adults	Seniors - Must be ambulatory with only minimal assistance, must be continent, must be oriented	Helena	Private pay	No

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Our House	Licensed Adult Foster Care - assisted living program, 24-hour unskilled supervision; licensed for maximum of 4 residents	Seniors who require minimal assistance with meals, bathing, dressing, feeding, ambulation, and medications	Helena	Private pay	No
Shelby House	Licensed Adult Foster Care - assisted living program, 24-hour unskilled supervision; licensed for 8 residents, currently has 6	Seniors - must be ambulatory or use assistive device, must be continent, may have some cognitive or memory impairment, but cannot wander or be combative	Helena	Private pay	No
Big Sky Care Center	Long-term care, Skilled rehabilitation, private for profit	Clients must meet eligibility for long-term care or skilled rehab services, must be referred by a physician	Helena, Lewis & Clark County	Private pay, Medicaid for long term care, Medicare for skilled rehab	No
Helena Nursing Home	Long-term care, Skilled rehabilitation, private for profit	Clients must meet eligibility for long-term care or skilled rehab services, must be referred by a physician	Helena, Lewis & Clark County	Private pay, Medicaid for long term care, Medicare for skilled rehab	No
Cooney Convalescent Center	Long-term care, not for profit, operated by Lewis & Clark County	Clients must meet eligibility for long-term care, must be referred by a physician	Helena, Lewis & Clark County	Medicaid, Private pay	No
Rocky Mountain Development Council (RMDC)	Operates human services programs for seniors, as well as children -see descriptions of programs that follow	Depends on program	Lewis & Clark, Jefferson, Broadwater Counties	Depends on program	Some programs are available in rural areas

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
RMDC Senior Nutrition Program	Provides nutritious noontime meals, Two programs - Daily Dinner Club at Senior Centers and Home Delivered Meals	60 years of age and older	Lewis & Clark, Jefferson, Broadwater Counties	no mandatory charge, but suggested donation $2.25/meal	Rural sites in Augusta and Lincoln
RMDC Retired Volunteer Program	Volunteer opportunities for retired seniors	60 years of age and older	Lewis & Clark, Jefferson, Broadwater Counties	N/A	N/A
RMDC Senior Citizens Center	Educational, social, and service activities	50 years of age and older	Lewis & Clark, Jefferson, Broadwater Counties	Membership - $10/year	Senior Centers located in Lincoln and Augusta
RMDC Foster Grandparent Program	Volunteer program for fixed income seniors to assist children with special needs	60 years of age, must be low income and meet income guidelines	Lewis & Clark, Jefferson, Broadwater Counties	Program is funded through ACTION, volunteers are paid a stipend of $2.45/hr, transportation/ and one meal	Foster grandparents are stationed in Lincoln
RMDC Senior Companion Program	Volunteer program for fixed income seniors to assist homebound elderly with support services so that they can remain independent	60 years of age, must be low income and meet income guidelines	Lewis & Clark, Jefferson, Broadwater Counties	Program is funded through ACTION, volunteers are paid a stipend of $2.45/hr, transportation/ and one meal	Senior Companions are currently stationed in Augusta

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
RMDC Senior Companion for the Visually Impaired	Volunteer program for fixed income seniors to assist homebound elderly who are visually impaired with support services so they can remain independent	60 years of age, must be low income and meet income guidelines	Lewis & Clark, Jefferson, Broadwater Counties	Program funded under Rehabilitation Act, volunteers are paid a stipend of $2.45/hr, transportation/ and one meal	Statewide area
Older Worker Program	Trains & finds jobs for 10 disadvantage persons 55 years and older/year	55 years of age and older, low income or disadvantaged	Lewis & Clark, Jefferson, Broadwater Counties	Program funded through JPTA	N/A
Transportation Program	Free transportation for seniors associated with Helena Senior Centers, Daily Dinner Club, Senior Companion Program, Foster Grandparent program, Retired Senior Volunteer Program	Must be connected with programs at RMDC	Lewis & Clark, Jefferson, Broadwater Counties	Free	N/A

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Area Agency on Aging	Advocates for the elderly, develops & coordinates programs for seniors, receives and distributes funds for senior dinner clubs, home delivered meals, senior centers, legal services, home health care, transportation, nursing home ombudsman	N/A	Lewis & Clark, Jefferson, Broadwater, Meagher, Park, & Gallatin Counties	N/A	N/A
Helena Dial-a-ride	Bus & van service	None, must call 24 hours in advance	Helena	Special rates for elderly	No
Sixty-plus Senior Program at St. Peter's Hospital	Health education programs, screenings, special benefits, Discount of hospital services, assistance with medical claims, notary services support groups- Better Breathers, Alzheimer's, Stroke, Parkinson's, and Widowed persons	60 years and older	Lewis & Clark County	free	No

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Nursing Home Ombudsman	Information, referrals, education, advocacy, re: long-term care services	Service for people living in nursing homes, personal care homes, retirement centers, relatives & friends of residents, community groups, public agencies, and administrators of care facilities	Lewis & Clark, Jefferson, Broadwater, Meagher, Park, & Gallatin Counties	N/A	Service extends to facilities in rural areas
Adult Protective Services	Emergency intervention service, investigates complaints regarding anyone 18 years or older who may be at risk for physical/mental harm due to abuse, neglect, including self neglect and exploitation	18 years and older	Statewide	N/A	Statewide
Montana Senior Citizens Association	Grassroots organization works for public policy changes, education	Organization for seniors, but no age requirement for membership	Statewide	Differing levels of membership ranging from $10-50/yr.	N/A
Alzheimer's Association	Voluntary health organization which supports research, advocacy, education, support, patient/family services	N/A	Lewis & Clark, Jefferson, Powell, Meagher, Gallatin, Madison, Silver Bow, Deerlodge, Beaverhead, Park	Dues for membership	N/A

Agency	Services	Client Eligibility	Geographic Boundaries	Financial Aspects	Rural Outreach
Elder-Serve, Inc.	Family counseling, Household assistance assessment information, referral, paper work assistance, conservator issues, advocacy & mediation	Senior citizens	Helena	Fee for service	No
Eagles manor	Retirement Apartments with meal plan	62 years and older	Helena	Rent subsidized, based on income	N/A
Helena Housing Authority	Apartments, no meal plan	Elderly & disabled	Helena	Rent subsidized	N/A
Serendipity	Apartments, no meal plan	Elderly & disabled	Helena	Rent subsidized	N/A
Sunset Capital	Apartments, with meal plan	Elderly & disabled	Helena	Rent subsidized	N/A
Vista Square	Apartments, no meal plan	Elderly	Helena	Rent not subsidized	N/A

APPENDIX D
Grouping of services in Lewis & Clark County by category

Acute Inpatient:	**Extended Inpatient:**	**Ambulatory Care:**	**Home Care:**	**Outreach/ Linkage:**	**Health & Wellness:**	**Housing:**
1. St. Peter's Community Hospital 2. St. Peter's Support Center	1. Big Sky Care Center, Helena Nursing Home, Cooney Convalescent Center 2. Mental Health Services, Inc., Helena Community Support Services' New Visions Program	1. Numerous physicians specializing in family practice, internal medicine, as well as other medical/ surgical specialties. One physician specializes in geriatrics. 2. St. Peter's Partial Hospitalization Program 3. Heritage House 4. Mental Health Services, Inc. - Outpatient Clinic and Helena Community Support Services 5. Numerous licensed professional counselors 6. Psychiatric Associates of St. Peter's Hospital 7. Boyd Andrews Chemical Dependency Care Center	1. West Mont, HomeLink of St. Peter's, and Lewis & Clark County Medicaid Waiver Program 2. Hospice of St. Peter's. 3. Rocky Mountain Development Council's Senior Companion Program 4. Senior Nutrition Program 5. Elder Serve, Inc.	1. Sixty Plus Senior Program 2. Lifeline of St. Peter's Hospital 3. Area IV Agency on Aging 4. Senior Citizens Association 5. RMDC Transportation Program 6. Dial-a-ride 7. S.W. Telepsychiatry Program 8. Alzheimer's Association	1. Sixty Plus Senior Program 2. Senior Citizens Association 3. RMDC Senior Center 4. RMDC Senior Nutrition Program 5. RMDC Retired Volunteers, Senior Companions, Senior Companions for the Visually Impaired, and Foster Grandparent Programs	1. Eagles Manor, Vista Square Apartments, Helena Housing Authority, Serendipity Apartments, Sunset Capitol Apartments 2. Williamson House, Shelby House, and Our House