

Adult Day Services



in Rural Pennsylvania

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Adult Day Services in Rural Pennsylvania

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Introduction

One of every four Americans lives in a rural county with a disproportionate number of older adults making up the population of rural America. Pennsylvania's rural elderly population increased by 9 percent, according to the 2000 U.S. Census, and now totals 420,000 people. While the number of older adults residing in rural communities is increasing, their health outlook is not. In fact, the literature demonstrates that rural elders encounter far more biological, psychological and social factors that increase their vulnerability for physical and mental health difficulties (Kumar, Acanfora, Hennessy and Kalache, 2001). Physically, the rural elderly (age 60+) are more likely than their urban counterparts to have self-care deficits with Activities of Daily Living (ADL), such as eating, dressing, and walking, and are less able to perform instrumental activities of daily living, such as making telephone calls and shopping (Coward, Lee, Dwyer, 1993). Non-farm elders have the poorest health status (Coward, Lee, Dwyer, 1993). Rural elderly also have increased risk of developing a dementing illness, further limiting their abilities for self-care. High blood pressure, the single most predictive factor for vascular dementia, (Forette and Boller, 1991) is more prevalent and less aggressively treated in rural communities (Keefover, Rankin, Keyl, Wells, Martin and Shaw, 1996).

Over the years, considerable federal, state and local dollars have been spent to create a complex continuum of care for the elderly. Keeping elderly adults in the community is financially more cost effective than institutionalization (Krout, 1994). For this reason, community-based services have developed over time to meet the care, assistance, socialization, and supervision needs of older Americans. One such service is adult day care, known within the provider community as Adult Day Services (ADS). ADS is a structured, comprehensive community-based program that provides a variety of health, social, and related support services in a protected setting during any part of the day, but less than 24 hours (Beisevker and Wright, 1996).

Research on ADS supports positive outcomes for the elderly and their family caregivers. ADS provides more socially and behaviorally oriented care for elders, and emphasizes preventing harm to the elderly, while offering pleasurable activities. It also benefits caregivers by allowing them to pursue work and leisure activities, and it helps them to better deal with emotional stress (Biegel, Bass, Schulz, and Morycz, 1993). Respite services, like ADS, have also been shown to delay nursing home placement (Koslowski and Montgomery, 1995). Of the existing studies on ADS, however, few have included rural populations, significantly raising questions about the generalizability of studies to the elderly rural community and simultaneously creating a demand for rural-specific research.

In spite of the demonstrated need for extensive support services in the rural community and the positive outcomes of ADS, these programs are non-existent or limited in rural areas, including the rural counties of Pennsylvania. Several barriers to these services have been suggested, including geographic isolation of consumers, economic deprivation, poor human infrastructure (reduced staffing pool), and the realities of rural culture (Bull, 1998). Transportation has also become a key consideration given the geography of rural areas, along with the decrease of train and bus transportation over the years (Bull, 1998). Nationally, 26 percent of rural elders living alone have no private vehicles, and 40 percent of all automobile trips taken by rural elders involve a driver other than the patient (Damiano, Momany, Foster, and McLeran, 1994). Several innovative ADS programs have been piloted in rural areas to address geographic isolation. In Oklahoma, ADS programs offer 10 hours each day to allow for extended travel, and time to access multiple support services (Travis, 2001). In West Virginia and the Ottawa Valley of Ontario, Canada, mobile ADS has been introduced, bringing those services to the rural elderly (M. Splaine, Alzheimer's Association, personal communication, June 2002).

PROJECT GOALS AND OBJECTIVES

To address the gap in information on ADS, the Center for Rural Pennsylvania, in 2003, sponsored this research project to provide the following information: an inventory of current suppliers of adult day care, to include their capacity and services; a determination of rural adults in need of ADS; an analysis of the gaps between the supply of and demand for ADS; a review of funding and financing issues; and the identification of successful rural models applicable to rural Pennsylvania, in general.

Dr. Janet Melnick of Penn State-Worthington Scranton, Dr. Heather Shanks-McElroy of Keystone College and Dr. Doris Chectotka-McQuade

of Marywood University conducted the research.

The research model used for the project was consistent with the Adult Day Care Assessment Procedure (ADCAP) (Zank and Schacke, 2003). It measured three components of ADS: structure, process, and client population characteristics. *Structure* refers to the resources, such as physical environment and human environment that allow for service provision. *Process* refers to the delivery and receipt of services carried out at an ADS center. *Client characteristics* refer to the demographic, cognitive, functional, and participation status of ADS participants.

METHODOLOGY

The research project covered Pennsylvania's 48 rural counties, as defined by the Center for Rural Pennsylvania. A county is rural when the number of persons per square mile within the county is less than 274.

Initially, multiple elder care stakeholders in each county were contacted to identify all ADS programs currently in operation. These stakeholders included the Pennsylvania Departments of Aging and Public Welfare, Area Agencies on Aging, AARP, county human development agencies, local chapters of the Alzheimer's Association, and others. From these contacts, the researchers compiled a mailing list of 128 ADS programs in Pennsylvania, and invited the program directors to participate in the study. Of that total, 32 agreed to participate in a telephone interview.

Based on information compiled from the telephone interviews, the researchers developed estimates of potential ADS participants in each rural county, as well as projections of eligible participants over the next five years. Using 2000 Census data for each county, the researchers also documented the total number of individuals who met the study criteria. From these totals, individuals who were likely to require assistance with one

or more ADL tasks, and therefore be viable candidates for ADS programming, were then identified using the standard Weiler Demand Model estimate of 1.25 percent of individuals over age 60 and those under the age 60 with a disability. This method was used to estimate the current number of individuals eligible for rural ADS services and to project potential participants over a five-year period. Once validated, these figures were used in conjunction with ADS center capacity and use data to calculate gaps and overages in service.

Additionally, the research team reviewed several state-of-the-art rural ADS programs in the United States and Canada and used those programs to help inform their policy consideration process. The researchers also solicited input from the Robert Wood Johnson Foundation on high quality programs, and the team visited two Pennsylvania ADS programs to gain further insight into the supply and demand for rural ADS.

Finally, the researchers held focus group sessions in Stroudsburg, Harrisburg, Williamsport, Uniontown, and DuBois, with elder care stakeholders and program providers, to explore issues of funding and other strengths and weaknesses of the current ADS network.

RESEARCH FINDINGS

Program Capacity

Overwhelmingly, rural ADS centers throughout the rural counties of Pennsylvania are operated in conjunction with other services, with only 6.3 percent of participating centers housed in independent, freestanding structures. The physical size of these facilities, specifically for ADS, range from a very small 500 square feet to an expansive 8,440 square feet. On average, the majority of programs operated in a space of approximately 1,800 square feet. Of the 32 centers studied, 75 percent occupied facilities shared with other social service, medical, long term care, and/or religious organizations. This suggested two important considerations regarding the physical environment: ADS programming may be designed to fit to available physical spaces rather than being driven by the client needs; and linkages with other providers of support services may be stronger than if the centers operated in independent facilities.

Nearly 91 percent of participating centers are operating as nonprofit entities that focus on providing socialization programs. On average, ADS programs were licensed for 29.38 clients per day and were providing services to 12.72 clients per day; clearly an underuse of available services. Participation was prearranged for clients and no centers operated on a “drop-in” basis. Waiting lists were almost nonexistent for most of the ADS centers in the study sample. During 2002, a total of 105 rural constituents occupied a waiting list position but for less than three days on average. Center directors, who are primarily responsible for marketing and recruitment, reported that word of mouth is their primary and best methods for referrals. However, many cited the lack of referrals from doctors, who may

not regard socialization programs like ADS as viable alternatives for their patients. Along the same lines, the failure of aging and mental health networks to refer clients to ADS early enough for dementia patients’ caregivers to fully benefit from participation negatively impacts recruitment.

Types of Services

Depending on the clients’ needs, a wide variety of ADS services are provided and may include: entertainment, personal care, recreation, transportation, family support, education, and physical therapy.

From January through December 2003, the time period of the research project, the 32 rural participating ADS centers provided services to 954 unduplicated clients, two-thirds of whom were female. Sixty-eight percent of both male and female clients were at least 80 years of age. Individuals eligible for participation in ADS programming met one of two criteria: the individual was age 60 years or more, required assistance with one or more ADL skills, and could not safely remain independent in a community setting; or, the individual was under age 60, required assistance with one or more ADL skills, and could not safely remain independent in a

Figure 1 – Types of Services

Service	% of Participating Rural ADS Programs Providing Each Service
Entertainment	100
Personal Care	93.8
Care Planning	84.4
Recreation	78.1
Transportation	59.4
Family Support (i.e., support groups)	53.1
Education	40.6
Physical Therapy	34.4
Speech Therapy	31.3
Occupational Therapy	31.3
Clinical Services (i.e., foot care, dental)	28.1
Counseling	28.1
Other**	28.1
Financial Planning	3.1

***Other services include: provision of meals, such as lunch and snack, beautician services, field trips, podiatry services, bathing services, exercise programs, health maintenance programs, socialization, and adult basic education classes.*

community setting due to a disability.

Sixty percent of the participants exhibited moderate-to-severe cognitive impairment and 75 percent experienced mild-to-severe communications impairments.

The majority of centers reported limited hours of operation from about 6:30 a.m. to 4:30 p.m. Directors overwhelmingly would like to expand hours and thought that this would help with recruitment, but were not able to justify the staffing expense without the patients.

Staffing

The 32 centers responding to the survey reported 429 staff positions, with 320 being paid and 109 being staffed by volunteers. Of the 320 paid positions, just over 100 were full-time. Staff consists of nurses, aides, case managers, social workers, professional therapists, dietary personnel, and administrative workers.

Half of the rural ADS programs responding to the survey reported no volunteer assistance and expressed a great concern about their inability to access this beneficial human resource. For those centers reporting volunteer activity, the majority of volunteers generally served as nurses' aides and activity aides. The largest staffing group reported by the centers was that of consultant, with 120 individuals classified in this category. Generally, these individuals occupied the job categories of social worker/case manager, professional therapist, and dietitian.

It was surprising to find that,

given the age, functional and cognitive status of many ADS clients, minor roles were played by registered and licensed practical nurses.

Funding

There are numerous funding sources to help pay for ADS. Topping the list is private pay revenue, which was reported by 56 percent of the rural ADS centers. Other sources include the Pennsylvania Departments of Aging and Welfare, Area Agencies on Aging, county funding, Veteran's Administration funding, local agencies, and private donations. Cost sharing measures were adopted by the state for community-based services in 2002-2003.

The Robert Wood Johnson Foundation's Partners in Caregiving Program views cost sharing as a positive occurrence, resulting in centers developing more stable sources of revenue and allowing centers to expand and provide for additional services, regardless of the governmental fiscal outlook. However, unlike child day care users, ADS clients are not routinely charged for missed days.

The centers reported mixed outcomes, however. Many centers reported a loss in clients and client days, while others reported that clients and families made up the cost differential.

The focus group sessions highlighted the concerns that a significant reduction of client hours resulted from the state's cost sharing initiatives. Participants reported that the losses were not recouped either through revenues generated by the Pennsylvania Department of Aging's Waiver Program or

private pay funds. Indeed, these centers reported that the loss of client days resulted in a reduction of either service hours and/or staff. These centers were located in the more remote areas of rural Pennsylvania and relied more heavily on state funding.

Projected Need For And Supply Of ADS

To develop population projections for viable ADS candidates within two to five years throughout Pennsylvania's 48 rural counties, the researchers used two methods. For those aged 60 and over, the researchers used the Census Bureau's 2005 projections. For those aged 60 and under with a disability, the researchers used a constant rate. Because Pennsylvania rural counties have varying population growth rates, the researchers developed individual projections for each rural county to identify the total number of individuals over the age 60 and those under the age 60 with a disability.

According to the data, Pennsylvania currently has one of the largest populations of elderly individuals in the United States; however, total numbers are expected to decline over the next two to five years. (See Figure 2 on page 9.)

Having identified the potential population, the researchers later identified the number of centers necessary to meet current and projected need by using the Weiler Demand Model. This model was used in the 2002 Robert Wood Johnson Foundation's *Partners in Caregiving: National Study of Adult Day Services*.

According to the results, the

Figure 2 – Projections of Viable ADS Candidates 2000 and 2005

County	Total Persons Over Age 60, 2000	Total Persons Under Age 60 with a Disability, 2000	Total Likely Rural ADS Participants, 2000	Projected Persons Over Age 60, 2005	Total Persons Under Age 60 with a Disability – Constant Figure	Projected Likely Rural ADS Participants, 2005
Adams	16,418	7,028	293	17,571	7,028	307
Armstrong	16,421	8,372	310	15,603	8,372	307
Bedford	10,819	5,983	210	11,707	5,983	223
Blair	28,215	14,778	537	29,125	14,778	549
Bradford	12,877	7,419	254	12,951	7,419	255
Butler	31,646	10,910	532	32,116	10,910	538
Cambria	36,884	16,219	664	35,260	16,219	643
Cameron	1,472	737	28	1,383	737	27
Carbon	13,618	7,652	266	13,698	7,652	267
Centre	18,570	4,789	292	18,586	4,789	292
Clarion	8,287	3,930	153	8,461	3,930	155
Clearfield	18,038	9,415	343	17,477	9,415	336
Clinton	8,114	4,223	154	8,062	4,223	154
Columbia	12,997	5,209	228	12,370	5,209	220
Crawford	18,079	9,602	345	18,958	9,602	357
Elk	7,745	2,188	124	7,159	2,188	117
Fayette	33,635	29,594	790	32,241	29,594	773
Forest	1,361	618	25	1,280	618	24
Franklin	26,568	8,088	433	27,062	8,088	439
Fulton	2,821	1,924	59	3,068	1,924	62
Greene	7,807	7,501	191	7,652	7,501	189
Huntingdon	8,829	4,302	164	8,629	4,302	162
Indiana	17,069	11,001	351	16,728	11,001	347
Jefferson	10,466	3,964	180	9,720	3,964	171
Juniata	4,580	1,836	80	4,833	1,836	83
Lawrence	22,471	6,875	367	20,852	6,875	347
Lycoming	24,401	11,789	452	24,347	11,789	452
McKean	9,743	4,749	181	9,854	4,749	183
Mercer	27,167	9,333	456	26,370	9,333	446
Mifflin	10,145	4,850	187	10,471	4,850	192
Monroe	22,747	19,489	528	22,587	19,489	526
Montour	3,973	1,434	68	4,523	1,434	75
Northumberland	22,633	9,930	407	23,155	9,930	414
Perry	7,121	4,370	144	8,335	4,370	159
Pike	9,412	4,164	170	8,753	4,164	161
Potter	3,902	2,675	82	4,068	2,675	84
Schuylkill	36,655	14,696	642	35,469	14,696	627
Snyder	6,923	3,896	135	7,425	3,896	141
Somerset	18,242	9,299	344	17,100	9,299	330
Sullivan	1,847	536	30	1,616	536	27
Susquehanna	8,669	4,912	170	9,108	4,912	175
Tioga	8,715	4,844	170	9,416	4,844	178
Union	7,217	2,981	127	7,252	2,981	128
Venango	12,437	8,129	257	12,370	8,129	256
Warren	9,505	3,937	168	10,421	3,937	180
Washington	45,705	19,981	821	47,509	19,981	844
Wayne	10,841	4,503	192	9,725	4,503	178
Wyoming	4,929	3,633	107	5,538	3,633	115
TOTALS	682,068	340,199	13,211	707,964	340,199	13,215

need for rural ADS exceeds service capacity in all of Pennsyl-

vania's rural counties. The 2005 forecast for service need and

availability is similarly incongruent. (See Figure 3 below.)

Figure 3 – Service Capacity vs. Demand

County	# of Existing Rural ADS Centers, 2000	Total Over Age 60 and Under Age 60 With a Disability, 2000	Total Likely Rural ADS Participants, 2000	# of Rural Centers Needed to Serve Likely Participants, 2000	Projected Likely Rural ADS Participants, 2005	# of Rural Centers Needed to Serve Likely Participants	Additional Rural ADS Centers Required, 2005
Adams	2	23,446	293	10	307	11	9
Armstrong	1	24,793	310	10	307	11	10
Bedford	1	16,802	210	7	223	8	7
Blair	2	42,993	537	18	549	19	17
Bradford	4	20,296	254	9	255	9	5
Butler	5	42,556	532	18	538	18	13
Cambria	2	53,103	664	23	643	22	20
Cameron	0	2,209	28	1	27	1	1
Carbon	2	21,270	266	9	267	9	7
Centre	3	23,359	292	10	292	10	7
Clarion	1	12,217	153	5	155	5	4
Clearfield	2	27,453	343	12	336	11	9
Clinton	0	12,337	154	5	154	5	5
Columbia	1	18,206	228	8	220	8	7
Crawford	4	27,621	345	12	357	12	8
Elk	1	9,933	124	4	117	4	3
Fayette	2	63,229	790	27	773	26	24
Forest	1	1,979	25	1	24	1	0
Franklin	1	34,656	433	15	439	15	14
Fulton	0	4,745	59	2	62	2	2
Greene	1	15,308	191	6	189	6	5
Huntingdon	0	13,131	164	6	162	6	6
Indiana	1	28,070	351	12	347	12	11
Jefferson	0	14,430	180	6	171	6	6
Juniata	0	6,416	80	3	83	3	3
Lawrence	1	29,346	367	12	347	12	11
Lycoming	0	36,190	452	15	452	15	15
McKean	4	14,492	181	6	183	6	2
Mercer	2	36,500	456	15	446	15	13
Mifflin	0	14,955	187	6	192	7	7
Monroe	0	42,236	528	18	526	18	18
Montour	0	5,407	68	2	75	3	3
Northumberland	4	32,563	407	14	414	14	10
Perry	0	11,491	144	5	159	5	5
Pike	0	13,576	170	6	161	6	6
Potter	2	6,577	82	3	84	3	1
Schuylkill	6	51,351	642	22	627	21	15
Snyder	1	10,819	135	4	141	5	4
Somerset	2	27,541	344	12	330	11	9
Sullivan	0	2,383	30	1	27	1	1
Susquehanna	0	13,581	170	6	175	6	6
Tioga	0	13,559	169	6	178	6	6
Union	0	10,198	127	4	128	5	5
Venango	1	20,566	257	9	256	9	8
Warren	0	13,442	168	6	180	6	6
Washington	9	65,686	821	28	844	29	20
Wayne	2	15,344	192	6	178	6	4
Wyoming	0	8,562	107	3	115	4	4
TOTALS	74	1,056,923	13,211	448	13,215	488	321

CONCLUSIONS

From the research, and in their review of ADS practices and models, the researchers identified several key elements concerning the potential success of ADS in rural communities. Noteworthy is the role of community support for developing and sustaining a program. The community from which clients will be drawn must not only see the need for ADS, but also be part of the planning and resource pool. This necessitates the cooperation of multiple localities, and possibly counties, as well as professional service providers in the aging and mental health networks.

Another key element was transportation. An effective and reliable transportation network that prioritizes ADS equally with medical appointments and trains drivers to assist ADS clients appropriately is needed.

Other key elements are consistent annual funding that is not tied to a monthly head count and finally, the lead person or ADS center director must be knowledgeable of the client population, possess programming expertise, and have the requisite financial and marketing skills to successfully energize an interdisciplinary staff.

Model Programs

Though the word “successful” is often implied in the literature on ADS, in ADS organizational/mission statements, or in research documents, such as the Robert Wood Johnson *National Study of Adult Day Services 2001 – 2002*, criteria for a precise definition are never actually delineated.

It is clear, however, that the commonly understood use of the word successful is “a favorable or satisfactory outcome or result.” Therefore, the importance of identifying and analyzing long established rural ADS models to provide the criteria for common elements of successful service delivery cannot be overstated.

The researchers identified two such programs by using a review of both quantitative data and qualitative focus group data, along with suggestions from the Department of Aging. Both the Palmerton Hospital Adult Day Services Facility in Carbon County and the Tamaqua Area Adult Day Care Facility in Schuylkill County exemplified the standards of a “viable, cost effective, community based options” in the continuum of care of

keeping individuals in the community as long as possible, as identified in the Robert Wood Johnson *National Study of Adult Day Services 2001 – 2002* report.

Both centers also show the marketing and financial management knowledge that research reports note are predictors of successful operation. Further, both programs showed balanced integration of many of the Adult Day Care Assessment Procedure model’s major components, which are outlined below.

STRUCTURE

Physical Environment

- Well-marked/visible signage
- Accessible for all mobility levels
- Welcoming entry, appropriate to the local area
- Security system to prevent wandering
- Individually assigned “cubby” spaces
- Multifunctional spaces and furniture items
- Brightly lit spaces
- Client/caregiver-centered artwork, activity supplies

Human Environment

- Inviting, friendly atmosphere
- All staff and volunteers respect and enjoy working with the clients and caregivers
- Cooperative management style
- Active input and decision making by board of directors and community
- Flexibility and creativity in all program operations

PROCESS

Service Delivery

- Program hours that reflect client and caregiver needs and norms
- Programming that is primarily social and recreational
- Constant monitoring of transportation methods
- Fees and funding issues are acknowledged as daily challenges

CLIENT CHARACTERISTICS

Demographics

- Programs serve residents of multiple rural counties that are often not contiguous

- Majority of clients are 60+ and reflect the makeup of the communities
- Each program serves a few under 60 clients with varied mental health/mental retardation diagnoses

Cognitive, Functional, Participation Status

- Majority of clients are diagnosed with Alzheimer's disease or related dementia
- Clients with mental or emotional conditions are grouped for activity scheduling purposes
- Clients with physical limitations are functionally grouped to maximize participation
- Staff develops unique activities geared for the functional and cognitive status of clients
- Clients always have a choice about participation

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