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HOSPITAL CARE AND OTHER SERVICES IN THE LONG-TERM CARE SYSTEM FOR OLDER ADULTS

The long-term care system for older adults includes a wide range of services; some services have been studied extensively, some have not. Nursing care is an integral component of certain aspects of long-term care and peripheral to others. Two factors guided the inclusion of studies in the following literature review. First, only studies in areas where nursing research and practice were presumed to be able to affect patient outcomes were included, though not all studies were done by nurses. Second, only "good" research studies were included, though most still are open to critique on conceptual or methodological grounds. The review is organized around the following topics: 1) hospital care; 2) special services (rehabilitation, respite care, hospice, counseling, and psychotherapy); 3) settings/environ-ments (residential care including continuing care retirement communities (CCRC's) and adult day care); and 4) personnel (volunteers and peer counselors.

State of the Science

Hospital Care

Although the legislative and policy changes of the last decade resulted in reduced use of hospital-based services, the hospital remains a major component of the health care system for older persons with chronic health problems. Older persons are hospitalized at a rate four times greater than the rate for younger persons (Brody, 1984). The average length of stay for persons over 65 years of age is 30 percent longer than for persons between 45 and 65 years of age. Thus, a large percentage of patients receiving care in hospitals are older adults. In a comprehensive overview of the hospital's role in the care of older persons, Eisdorfer, Mullner, and Cohen (1989) provided an analysis of the currently changing role of the hospital along with predictions about hospital care for older adults in the future. Hospitals may be the most appropriate place for acutely ill elderly, but it must be remembered that the risks of hospitalization are high in terms of cost and iatrogenic illness, for example, hospital-based infections, disorientation, and decubiti (Hospital Research and Education Trust, 1981; Eisdorfer et al., 1989). In particular, the use of hospitals for terminal care of acutely ill older persons has been questioned on the grounds of cost (Fuchs, 1984) and ethics (Eisdorfer et al., 1989). Enormous amounts of public funds are spent annually on care for older adults hospitalized for terminal care (Scitovsky, 1984; Roos, Montgomery, & Roos, 1987). As the knowledge base related to the negative consequences of hospitalization increased (Chisholm, Deniston, Igrison, & Barbus, 1982; Foreman, 1986, 1989; Roberts, & Lincoln, 1988), nurses began to develop interventions designed to reduce the incidence of such negative consequences (Nagley, 1986; Williams, 1988; Williams, Holloway, Winn, Wolanin, Lawler, Westwick, & Chin, 1979). These

nursing interventions have not been systemically evaluated.

Eisdorfer et al. (1989) suggest a model of acute care for older adults that includes both high-technology care and assessment of the biopsychosocial nature of many presenting problems of the ill older adult. Thus, the hospital would become an integral, not independent, part of the continuum of care. Further, hospitals may need to shift more resources from "high-tech" to "high-touch" approaches (including a focus on nursing, outreach, and community services) (Eisdorfer et al., 1989). Although these recommendations make intuitive sense, there has been little systematic research to indicate the patient care outcomes of a more "high-touch" approach to the hospitalized acutely ill older person. Several different approaches/models of care for the hospitalized older person reported in recent years in the literature include interdisciplinary geriatric units, interdisciplinary geriatric consultation teams, and discharge planning.

Interdisciplinary Geriatric Units. Rubenstein, Josephson, Wieland, English, Sayre, and Kane (1984) conducted a randomized clinical trial designed to evaluate the effects of an innovative geriatric evaluation unit on hospitalized older persons. Their findings indicate that the unit had a significant beneficial effect for the older person. Members of the experimental group had much lower mortality, were less likely to be discharged to a nursing home, and had fewer acute-care hospital stays, nursing home days, and acute-care readmissions than the control group.

Interdisciplinary Geriatric Consultation

Teams. During the past decade, geriatric consultation teams have been established in a number of institutions in this country and in Canada (Allen et al., 1986; Barker, Williams, Zimmer, Van Buren, Vincent, & Pickrel, 1985; Campion, Jette, & Berkman, 1983; Saltz, McVey, Becker, Feussner, & Cohen, 1988; Gayton, Wood-Dauphine, deLorimer, Tousignant, & Hanley, 1987; Hogan, Fox, Badley, & Mann, 1987; Wisensale, 1987). These studies are difficult to compare because each used different outcome criteria. Barker et al. (1985) evaluated the impact of a geriatric consultation team on the "back-up" of older persons in acute-care settings. "Back-up" refers to persons who are able to leave the hospital but for whom there is no appropriate placement. This study used a pre/posttest design with no control group. Findings included a 21 perecnt decline in the number of older patients "backed-up" in the acute-care settings after implementation of the geriatric consultation team. The decline was related to the number of discharges, not to a decrease in admissions. McVey, Becker, Saltz, Feussner, and Cohen (1989) report the results of a randomized clinical trial in which a randomly assigned group of hospitalized older veterans received the services of an interdisciplinary geriatric consultation team. The investigators concluded that the team did not alter the degree of functional decline in the members of the experimental group. This interpretation has been questioned by Wasserman (1989) who suggests that the conclusion may be wrong for two reasons--"small sample size and the influence of the ceiling effect on the Activities of Daily Living (ADL) measures" (p. 942).

Discharge Planning. Discharge planning is one approach that nursing has used to account for the long-term-care needs of older persons in hospital settings. Only one study has evaluated a model of discharge planning (Neidlinger, Scroggins, & Kennedy, 1987). Results from their randomized clinical trial of discharge planning indicate that a comprehensive discharge planning protocol, implemented for hospitalized older persons by a gerontological clinical nurse specialist, reduced hospital costs for the experimental group by an average of $60 per patient day. This study needs to be replicated in other settings and should examine criteria for targeting high-risk individuals who could benefit from comprehensive discharge planning.

Special Services

Rehabilitation. The concept and practice of rehabilitation for older people has started to be

recognized only recently. Many reasons have been suggested for the absence of interest in this area, including ageism and the belief that older people cannot benefit from rehabilitation services (Ory & Williams, 1989). In a very insightful article on old age and rehabilitation, Becker and Kaufman (1988) note that negative cultural values related to aging directly affect medical decisions about how to treat elderly patients. Low expectations about older persons' adaptive abilities coupled with low expectations about what the level of functioning should be in old age determine the treatment elderly persons receive. The authors note that rehabilitation is becoming more relevant as the population ages, and as technology allows older people to survive major illnesses. They suggest that rehabilitation has not been applied widely to elderly persons because "The restoration of normal function and return to self-sufficiency is thought to be unlikely among elderly persons. Moreover, the failure of elderly persons to return to former levels of function is considered acceptable and even appropriate in American society" (Becker & Kaufman, 1988, p. 459; Brody & Ruff, 1986; Kemp, 1986). The health and functional status of older persons patient significantly affects the type of rehabilitation prescribed. Brody and Ruff (1986) noted that preexisting health conditions influence the rehabilitative process. The level of cognitive impairment influences whether or not older people are admitted to rehabilitation programs (Schuman, Beattie, Steed, Merry, & Kraus, 1981). Because of negative cultural attitudes about mental illness, less attention is given to physical rehabilitation of older persons mentally impaired population.

Although rehabilitation in old age has been a peripheral issue in gerontology, it is central to questions that haunt those who work with older people. For example, what should the quality of life be in old age? How much of society's resources should be used to achieve that quality of life? Becker and Kaufman (1988) raised a number of research questions. These include: What changes in the structure of rehabilitation would make it more manageable and more meaningful for older persons? What motivates older people? How can this knowledge be applied to treatment decisions? The patient's transition from hospital or rehabilitation facility to home or other setting has been studied very little. This transition period is perhaps the most problematic in the recovery process. How can the impact of this transition be decreased for the newly impaired person and his or her caretakers? What other strategies can be used in combination with rehabilitation to enable the person who lives alone to return home (Becker & Kaufman, 1988)?

Respite Care. Respite care represents a wide range of services designed to give the caregiver "time off" from day-to-day caregiving responsibilities for older patients. The form of the service varies and includes: day care, in-home respite, and overnight respite. Some respite care provides special services such as nursing care, physical therapy, and occupational therapy. Lawton, Brody, and Saperstein (1989) conducted a controlled study of respite service for caregivers of Alzheimer's patients. A baseline interview of 642 caregivers was conducted; half were offered formal respite care. Over a 12-month period, families with respite care maintained their impaired relative in the community significantly longer (22 days). Although respite care was found to be ineffective for caregiver burden and mental health, satisfaction was very high. Respite care can increase the quality of life for caregivers to a certain extent, although these authors suggest it is not a strong intervention. A study by Seltzer, Rheaume, Volicer, Fabiszewski, Lyon, Brown, and Volicer (1988) on the short-term effects of in-hospital respite on patients with Alzheimer's Disease showed that participation in a two-week, in-hospital respite program affected the cognitive status and level of daily functioning of Alzheimer's patients differently according to their functional levels on admission. Patients with initial scores indicating the most severe dementia tended to show improvement on some measures after two weeks in the hospital. In contrast, patients with higher initial levels of performance, suggesting milder dementia, showed worsening on some measures at the conclusion of respite. All changes were small, however, and largely restricted to tests on activities of daily living. No significant changes in cognitive status were found. Seltzer et al. (1988) reported that the program had little effect on patient status, and that respite is generally a harmless intervention.

In another study, respite care was described as a partnership between a Veteran's Administration (VA) nursing home and families in caring for frail elders at home (Berman, Delaney, Gallagher, Atkins, & Graeber, 1987). A 10-bed respite program provided four weeks of in-patient care over a one-year period to frail older veterans who lived with an unpaid caregiver. Eight hundred and fifty families who received the program services were taught the health care delivery skills needed to maintain a disabled person at home and how to build community support systems. The program prevented premature or inappropriate placement by providing training and relief to sustain the in-home caregiver. Although the primary purpose of respite care is to relieve the caregiver, Berman et al. (1987) noted that some changes occurred in the nursing home facility. After the program began, the number of community persons coming into the nursing home increased dramatically, because veterans in respite were temporary patients and not permanent residents. Their families, friends, and neighbors entered the nursing home social system, causing it to expand and become more dynamic; isolation from the outside world was reduced. Respite offers positive role models for permanent nursing home residents, because many respite patients are frail elderly who improve their health and self-care skills while they are in the nursing home. In addition, the long-term residents gain emotional and intellectual stimulation from the presence of relatives and friends of the respite patients. Thus, the nursing home is transformed from a single purpose institution, where isolated elderly reside until they die, into a multipurpose geriatric facility providing services that help older families stay together in their own homes (Berman et al., 1987).

Kane and Kane (1987) reviewed six descriptive studies of respite care (Howells, 1980; Packwood, 1980; Crossman, London, & Barry, 1981; Nurick, 1983; Patten, 1984; Netting & Kennedy, 1985). Although these studies raise significant further research questions, comparisons across studies are not possible because definitions of respite care differ, characteristics of the users are vague, and settings for these studies vary. Clearly, respite care is an area in need of further, more definitive research. Other studies indicate that day respite programs alleviate caregiver stress and increase morale (Dunlop, 1980; Katz, Gallagher, Zielski, & Bruguera, 1978; Rathbone-McCuan, 1976). In general, the literature on respite programs is hypothesis-generating. It is time to begin testing models using experimental designs.

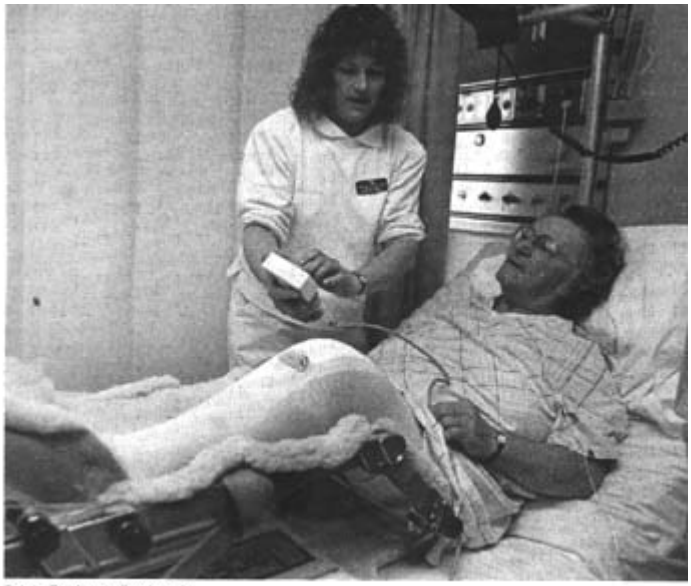

Photo by Tom Ferentz, Berkeley, CA

Hospice Care. Hospice care is character-ized by the following features: 1) the patient's disease is terminal (approximately six months or less until death), and no aggressive efforts to prolong life are used; 2) the patient and family are treated as an integrated unit; 3) services are provided by an interdisciplinary team with in-patient and home care components coordinated; 4) hospice care services are available 24 hours per day, seven days per week; and 5) pain control and psychological

well-being are prominent goals (Kane & Kane, 1987). Hospice promises compassionate care and improvement (over existing medical practices) in quality of life for the dying person and the family. Much of the enthusiasm for hospice care came from the assumption that it would be less costly although still being effective. Thus, in 1982, Congress passed a bill to cover hospice under Medicare. To qualify for Medicare coverage, hospices are required to include nursing care, medical social services, physician services, counseling, short-term in-patient care, medical appliances and supplies, homemaker/home health aide services, and rehabilitation therapy.

As noted by Kane and Kane (1987), few good studies of hospice effectiveness have been reported in the literature. These authors described two well-designed, major evaluations of hospice care. The first evaluation, the National Hospice Study, used a quasi-experimental design to compare hospital-based and home-based hospice with conventional care in 40 sites across the country; 26 were funded with special Medicare demonstration waivers (Greer, Mor, Morris, Sherwood, Kidder, & Birnbaum, 1986). The second study, conducted by the University of California at Los Angeles, was a randomized, controlled trial of an in-patient and home-based hospice operated by a VA hospital (Kane, Wales, Bernstein, Liebowitz, & Kaplan, 1984; Kane & Kane, 1987). The measures used in these studies (not all measures were used in both studies) were divided into patient variables and caregiver variables. Patient variables included pain and symptoms, ADL's, quality of life, satisfaction, anxiety, and depression. Caregiver variables included anxiety, depression, satisfaction prior to death, and anxiety, depression, satisfaction, and morbidity during the bereavement period. Findings were fairly consistent for both studies; differences occurred generally in the area of satisfaction and not pain control or other symptoms. The National Hospice Study found that the cost of home-based hospice care was less than conventional care (Birnbaum & Kidder, 1984). In the UCLA study, where hospital-based care predominated, no cost differences were found. Given that satisfaction of either or both patient and caregiver was the only consistently significant finding in these studies, Kane and Kane (1987) raised the question as to whether satisfaction is enough evidence of success of hospice to warrant coverage by Medicare. They concluded that because, in the case of hospice, the objective of therapy is not to delay mortality but to improve the quality of time remaining, perhaps satisfaction is the truest test of all.

Settings/Environments

Residential Care. In a review of residential care for older persons, Mor, Sherwood, and Gutkin (1986) commented that residential care homes (RCH's) are becoming more important because of diminishing social and health service resources for older persons. RCH's provide room, board, supervision, personal care, and protective oversight for dependent adults. In this study, a national survey of RCH's and a five-state survey of RCH's and older persons they serve revealed that in 1980 there were 118 RCH programs; these programs regulated 29,282 facilities (371,734 beds) that served older persons. Most facilities were family-owned and family-operated. A provider survey revealed that homes regulated by departments of health were more institutional than homes regulated by integrated social service departments. Elderly residents had high satisfaction, and only 13.2 percent of the elders fit poorly into these homes. The national scope and size of this long-term care option is substantial, meriting considerably more research attention than it has been given to date. The lack of research in this area is surprising, given the fact that RCH's are the major outlet for deinstitutionalization programs for the mentally ill and developmentally disabled.

With the advent of diagnostically related groups (DRG's), there will be greater pressure for rapid hospital discharge. Nursing homes will be asked to accept sicker patients, which will intensify the mix of patients served and leave little room for non-medical supportive care patients. The RCH may be an appropriate vehicle for the population of frail elders who have minimal medical needs but can no longer remain at home alone (Mor et al., 1986). In general, residents of these homes have positive feelings about their living arrangements and are happy that they chose the RCH. A clinical review of the sample in a survey by Mor et al. (1986) revealed that the match between the resident

and the home was rated as adequate or good. Match adequacy was related strongly to the resident's reported satisfaction and negatively related to functional impairment, incontinence, or high personal care needs. Most RCH's are small, family-operated entities; however, the majority of beds are in larger, institutionally oriented homes. Although the RCH is a long-term care option, perhaps it is more appropriate as an alternative to continued care at home for elderly who have moderate social and psychological impairments and limited social supports. The larger homes, acclimated to the medical model under the department of health regulations, may be the most appropriate vehicle to respond to increased demand for nursing home beds. More research is needed on patient care outcomes in residential care facilities (Mor et al., 1986).

Continuing Care Retirement Communities. Although not generally considered to be part of the long-term care system, housing for older adults affects plans for long-term care in significant ways. Housing can be thought of as a continuum of resources or programs ranging from those geared toward enhancing the adequacy of independent living (equity conversion, home repair, shared housing) to those that are semi-independent and sheltered arrangements (congregate housing, board and care) and finally to intermediate and skilled nursing facilities (Harmon, 1982). One of the most rapidly developing options in housing for older adults is residence in CCRC's. Confusion over definitions is the rule rather than the exception in the CCRC literature. The terminology of CCRC and life care often are used interchangeably, making it difficult to compare studies. Winklevoss and Powell (1981) give the following definitions: 1) a life care community requires no additional charge for health services, and payment of a large fee upfront is probable; 2) a CCRC, in contrast, requires the resident to pay some or all health care expenses (Netting & Wilson, 1987). Winklevoss and Powell (1984) suggested the follow-ing more specific definition of CCRC's. A CCRC is an organization established to provide housing and services, including health care, to people of retire-ment age. At a minimum, the community meets the following criteria: 1) the campus consists of indepen-dent living units (it may also contain health care facilities such as congregate living, personal care, and intermediate or skilled nursing care); 2) the com-munity offers a contract that lasts for more than one year and guarantees shelter and various health care services; and 3) fees for health care services are less than the full cost of such services and have been partly prepaid by the residents. Kane and Kane (1987) report that about 300 life care com-munities serve 100,000 residents with an average age of 80 (1981 data). Later data (Pies, 1984) estimate that there are between 300 and 600 CCRC's in the United States. The median entrance fee for a one bedroom unit was $44,475. Because Kane and Kane (1987) use the terms life care and CCRC's interchangeably, it is difficult to interpret these data on the magnitude of the two housing options.

Both life care and CCRC's have attracted a great deal of attention over the past few years. These long-term care options are attractive because they represent privately financed, community-based ser-vices for older adults (Ruchlin, 1988). Netting and Wilson (1987) report that there has been a prolifera-tion of literature on both life care communities and CCRC's. Much of the literature to date reports on the financial (Branch, 1987; Hartzler, 1984; Lublin, 1986; Topolnicki, 1985), social, political, and legal issues inherent in these housing alternatives (Leonard, 1985; Morrison, Bennett, Frisch, & Gurland, 1985; Winklevoss & Powell, 1984). Little, if any, research has been done on the health issues of residents of these communities. There is no research on the effects of structural or organizational factors on the health and well-being of residents. Similarly, there is no research that addresses the nursing care needs of residents of CCRC's. Long-term care in CCRC's is a wide-open area of research for nurse investi-gators who are interested in and concerned about the health status of older adults who are CCRC residents.

Adult Day Care. Adult day care in the United States, defined as "services provided in an outpatient setting to which clients are transported" (Kane & Kane, 1987, p. 143), has been only mini-mally evaluated for participant health outcomes. The enthusiasm for adult day care in the United States is based partially on the perceived success of adult day care in Great Britain, although the latter has not been rigorously evaluated. In general, two models of adult day care have emerged: day health

programs and social day care. However, the boundaries between the two are blurred, making evaluation studies diffi-cult. The most comprehensive review of descriptive and intervention studies of adult day care is reported in Kane and Kane (1987) and is the source for the following summary remarks. The focus is on studies that examined the effects of day care. In a study to test the feasibility of lowering costs of patient stroke care, Oster and Kibat (1975) showed that day care patients had fewer days in the hospital and thus incurred less cost than the comparison group. However, the findings were not statistically signifi-cant. Weiler and Rathbone-McCuan (1978) reported that day care clients compared favorably with comparison groups in the community and in nursing homes on maintenance or improvement of function-ing, and that the costs were much less. Kane and Kane (1987) suggested that this study was flawed because comparison groups were not comparable on need for improvement, and much judgment was used. Weiler, Kim, and Pickard (1976) report improved or maintenance of activities of daily living (ADL's) and instrumental activities of daily living (IADL's) for adult day care clients when compared with individuals on the waiting list for the day care center. However, those on the waiting list initially had greater indepen-dence in both ADL's and IADL's than those in the program; thus, the likelihood of their improvement was less than for those in the program. Weissert, Wan, Livieratos, and Katz (1980) conducted a well-designed and well-executed study in day care. However, the results were disappointing; the only significant difference was a positive impact on mortality. Also, day care costs were significantly higher than costs for controls. Because only about one-fifth of the controls used nursing home services, the authors concluded that day care was an additional benefit, rather than a substitute for nursing homes (Kane & Kane, 1987). Kane and Kane (1987) sug-gest that day care requires considerably more rigor-ous study to provide evidence of its value for participant outcomes. However, Weiler et al. (1976) suggest that even though the evidence for cost or outcome benefits has not been established, partici-pants and their caregivers are satisfied overwhelm-ingly with the care they receive; thus, day care seems to offer an important respite service to informal caregivers.

Personnel

Volunteers. Volunteering is a way of life in the United States (Kane & Kane, 1987). Volunteers are an especially important resource in the long-term care system; many long-term care programs are dependent either partially or wholly on volunteers. Of particular interest is the role of seniors as volunteers for programs directed toward older adults. Volunteerism may have a positive impact upon older persons volunteers themselves; it also may provide valuable long-term care services that would be unavailable without volunteers (Kane & Kane, 1987). ACTION, a federally funded program that includes the Foster Grandparent Program, Retired Senior Volunteers Program (RSVP), and the Senior Companion Program, was found to have a positive impact on the senior volunteers. ACTION (ACTION, 1985a) places senior volunteers in a variety of service arenas, including senior centers and nursing homes. Preliminary data showed that, when compared with a group of non-volunteers, the senior volunteers were found to be healthier and had experienced less deterioration on all five dimensions of the Older Americans Resources and Services instrument (OARS). Similarly, in the Senior Companion Program, ACTION (ACTION, 1985b) found that companions significantly increased in mental health functioning although controls decreased; clients (those receiving assistance from companions) had less decline in social resources, fewer areas of serious functional impairment, and less adjustment to health limitations than controls (Kane & Kane, 1987). Further studies need to be done using random samples of volunteers or companions to test preliminary findings.

Young, Goughler, and Larson (1986) report on a volunteer program for rural frail elderly that had an outreach component, a casefinding component, and a service delivery aspect. The authors suggest that community organizations can be used as the focus of volunteer services for the homebound frail elderly and can be particularly effective in rural areas where the population-at-risk is dispersed. "During the past decade, numerous policy conferences have concluded that

accessibility and availability of appropriate services are key issues in service delivery to the aged, particularly for those residing in rural areas. Advocacy organizations have taken the position that the rural elderly are an isolated population group with special needs. Numerous investigators have reported that support systems can fortify a person's physical and psychological coping mechanisms. In particular, the value of social support has been explored in projects that analyzed ways to strengthen natural or family supports of frail elders, and identified community groups as readily accessible and capable informal supports for the frail elderly" (p. 342).

The characteristics of volunteers influence the services performed. Clearly, a selection process occurs prior to the actual volunteer activity. For example, individuals aged 25 to 55 have numerous responsibilities related to child and parent care. They will not volunteer as often as the older age group. Intergeneration programs, supported by schools and churches, can be of great benefit to both volunteers and older persons who require assistance. In the past several years, the use of church-based volunteers to strengthen the informal support networks of disabled or frail elderly persons has been reported. One project, funded by the Robert Wood Johnson Founda-tion, was nationwide and involved 25 interfaith coalitions. This project used seed money to develop and sustain interfaith coalitions that provided services to older adults (Filinson, 1988). The program relied on a mental health center as the hub, the community link, and the catalyzing force in the project, rather than the church or a combination of church groups. The overall project goal was to assist frail elderly and their families by linking the formal and informal service delivery systems through the use of congregation volunteers. Program evaluation showed that the primary outcome of the program was education for the volunteers rather than service. However, the program's volunteers did provide a total of 55 services of seven different types, encompassing nursing home visitation, friendly visiting, transportation, telephone reassurance, respite, hospital visitation, and others, with the majority of volunteers providing more than 1 service over a 17-month period. The role of volunteers in the provision of care and respite for frail elders is not questioned. However, there is a need to evaluate projects using volunteers and to conduct controlled studies using random selection methods.

Peer Counselors and Peer-Led Support

Groups. Increased attention has been given in recent years to the potential salutary effects of peer counseling among older persons (Poser & Engels, 1983; Priddy & Knisely, 1982). Peer counseling, which has been defined as "the use of active listening and problem-solving skills to counsel people who are our peers, peers in age, status, and knowledge" (D'Andrea & Salovey, 1983) has been shown to be effective in assisting older adults to cope with such life transitions as retirement and widowhood (Bratter, 1986). Peer counselors may be particularly beneficial in helping older persons adjust to nursing home admission by providing new residents with needed information about their unfamiliar and often distressing surroundings, while also serving as an important source of social and emotional support (Scharlach, 1988). Peer support often is lacking in nursing homes where residents may live in proximity without knowing even the most basic information about one another. In a project described by Scharlach (1988), a model program was designed to increase social support for newly admitted nursing home residents through a structured program of peer counseling. New residents who received counseling improved somewhat on measures of social functioning, especially when compared to residents in the control group. In turn, peer counselor trainees improved with regard to appearance and grooming. There is a need for further efforts to understand and promote social support and social competence among institutionalized elderly. For nursing home residents who are volunteers in the peer support group, such meaningful and productive activity may increase self-perceived efficacy, thereby alleviating feelings of apathy and helplessness, and may protect against excess physical and psychological vulnerability (Scharlach, 1988).

Maddox (1984) identified four functions of peer-led support groups for caregivers of older persons

with dementia: 1) to provide cognitive reframing of stressful and possibly stigmatizing experiences; 2) to assist in containment of powerful emotions; 3) to facilitate a practical exchange of goods and services; and 4) to provide participants with role models for reintegrating and reorganizing themselves in the face of a highly significant emotional loss. Research evaluating the effectiveness of peer-led support groups in the area of caregiving, or literature describing the dynamics of such groups, is rare. The literature related to other types of support groups is potentially quite useful for designing studies of peer-led support groups of caregivers of frail older adults. The role of peer counselors with elders has been studied in the past several years (Poser & Engels, 1983; Priddy & Knisley, 1982). Some researchers have noted that elderly peer counselors are provided with the opportunity to use their skills and life experiences to help other persons in a meaningful way (Bratter, 1986; Sharlach, 1988). Although there have been descriptions of the role of elderly peer counselors in institutional settings, descriptions of the activities of peer counselors in the community are virtually absent from the literature.

Professionally-Led Educational Support

Programs. These programs for caregivers are based on the assumption that education and support will reduce stress from caregiving. Most of the published work in this area has included a description of the educational and support program and then provided clinician assessment and/or anecdotal responses to the program (Aronson, Levin, & Lipkowitz, 1984; Steuer & Clark, 1982). Two clinical trials have added substantially to our knowledge base in this area. Kleeman and Baldwin (1988), nurse investigators, randomly assigned caregivers who were caring for older persons with dementia to one of two treatment conditions, a didactic/educative or a support/psycho-therapeutic program. The didactic/educative group offered a classroom format with a defined curriculum that focused on family systems and family dynamics, stress and stress management, and differentiation of normal from pathological aging. In the support/ psychotherapeutic group, topics and issues were introduced by the participants, with guidance, direc-tion and clarification by the co-leaders. Both groups were effective in reducing caregiver strain with the support group having the greatest and most lasting effect. Gallagher et al. (1989) conducted a random-ized clinical trial designed to compare the efficacy of classes designed to teach problem-solving skills versus classes designed to teach ways to increase life satisfaction. Results indicated that there was no significant effect on caregiver stress due to treatment conditions, based on a set of four stress measures. The level of depression declined and the level of morale increased for participants in both psycho-educational programs, but not for those on the wait list.

Counseling and Psychotherapy. Counseling and psychotherapy are used with individual caregivers who are experiencing distress. Cognitive, behavioral, and psychodynamic therapies have been used success-fully to treat problems experienced by caregivers (Gallagher et al., 1989). Zarit and colleagues developed and evaluated counseling-oriented inter-ventions for caregivers of persons with dementia (Zarit, Orr, & Zarit, 1985; Zarit & Zarit, 1982). The intervention strategies evaluated included individual counseling, family meetings, and support groups. Zarit, Anthony, and Boutselis (1987) reported that both the individual and family counseling group and the professionally-led support group were effective. In contrast, Haley, Brown, and Levine (1987) found that group participation did not lead to statistically significant improvement on measures of depression, life satisfaction, or coping techniques.

The four types of interventions identified by Gallagher et al. (1989) focus on reducing the stress of caregiving by concentrating on the intrapsychic and interpersonal needs of the caregiver. However, the literature is lacking in intervention studies designed to test the efficacy of various methods of actually giving care to an older individual at home. Even though most problems encountered by family caregivers relate to behavioral problems of the elder, and it appears that the greatest stress is caused by the need to provide personal care and by behavioral problems, little research has focused on interventions to alleviate the care problems that give rise to stress. In general, nursing is

concerned with personal care issues and largely focuses on behavior and behavioral management. A small but growing body of research (Athlin & Norberg, 1987; Beck, 1988; Backstrom, Norberg, & Norberg, 1987; Baltes & Zerbe, 1976; Bernier & Small, 1988; Melin & Gotestam, 1981; Mentes & Ferrario, 1987; Sandman, Norberg, Adolfsson, Axelsson, & Hedly, 1986; Winger, Schirm, & Steward, 1987) exists that describes behavioral problems and behavioral management from a nursing perspective. The majority of this research focuses on institutionalized elders, but there is potential for transferring findings to home care situations. Studies that test the body of knowledge that supports the treatment and management of nursing care problems encountered by caregivers at home are absent from the literature.

Research Needs and Opportunities

Hospitalization

Despite evidence that innovations in care (e.g., geriatric evaluation teams, geriatric units, discharge planning) have beneficial effects on the cost of acute-care services, there is contradictory evidence regarding the effects of such services on the older person or on families. Little attention has been given to the effectiveness of nursing interventions designed to reduce the negative consequences of hospitalization on older adults. What is known points to the need to develop and test additional innovative models for managing the nursing problems of chronically ill older persons in acute-care settings. This is an especially promising area for nursing research.

Rehabilitation

The studies reviewed in this paper point to a wide range of potential areas of study in long-term care and have implications for nursing as well as interdisciplinary research. For example, although certain conditions experienced by older adults, (e.g., stroke or hip fracture) receive considerable attention with regard to rehabilitation services, other events do not (e.g., arm or wrist fracture). Even though the latter are not disabling, failure to provide post-fracture rehabilitation can lead to functional disabili-ties. Research studies in which the nurse is a key component as a discharge planner or community health nurse could test the idea that a skilled, knowledgeable nurse-advocate or case manager would enhance the rehabilitation options for elders.

Respite Care

Respite care has been advertised within the aging network as an important, if not critical, service for caregivers. The extant literature does not support this assertion. Research needs to be directed at understanding why caregivers either do not use this service or wait until a crisis occurs before using it. Several approaches might be tried in situations where the nurse is the key contact (possibly the case man-ager) for the caregiver and thus establishes a trusting relationship. In addition, research does not show differences that might occur when respite workers are perceived by caregivers to be competent and caring.

Hospice

Very few good studies of hospice effective-ness have been reported in the literature. Nursing research on hospice care is particularly sparse. Yet, a strong component of hospice is maintaining or improving the quality of care for the dying person and the family, a focus that is clearly within the domain of nursing. Even less research has been directed to bereavement outcomes for the family. Nursing research should emphasize the development and refinement of measures to evaluate nursing interventions in the hospice setting. Additionally, the true cost of hospice care must be determined within the context of nursing interventions.

Residential Care Homes/Adult Day Care

Residential care homes and adult day care settings are particularly important options in long-term care. They both provide services that, in some cases, delay or prevent nursing home placements. Few studies have been conducted that focus on the health outcomes and family of the resident, and no nursing investigations have been done to show the economic, social, or health benefits of these housing options.

Continuing Care Retirement Communities

CCRC's and other retirement options have made possible an entirely new housing perspective for retirees. Research on CCRC's has focused on economic, social, political, and legal issues. It is time to investigate the health of residents of CCRC's, both within an organizational and a clinical context. Numerous questions remain to be answered. What health services are available to residents? What factors facilitate or inhibit the use of available services? Do the health services meet the health needs of the residents? What is the health history of residents across the stages of housing offered by CCRC's, that is, from independent living to assisted living to nursing home? What is the role of geriatric nurses in CCRC's?

Volunteers and Peer Counselors

The literature on volunteers and peer counselors in long-term care is included to point out the potential positive impact of these individuals. More controlled studies are needed concerning how these individuals might function to enhance the interdisciplinary team. It is important to think of peer counselors and other volunteers who work with older persons as adjunct personnel who can provide a variety of services to older people both within institutions and in the community. Research must be designed that addresses issues related to nursing care and its relationship to the use of volunteers in long-term care.

Outcome Indicators

The development of outcome indicators that consider both cost and quality is an important area for investigation. Nurses currently play important roles in teaching, providing services, and acting as case managers for older adults and their caregivers. Their roles require that they identify high-risk clients and use the major intervention strategies available (counseling, education, and support groups). Though they carry out these responsibilities, only scant research is available on which to base decisions about intervention and service provision, and evidence supporting a relationship between services rendered and outcomes achieved is conflicting. Furthermore, the outcome indicators currently being used to measure success of intervention (e.g., functional improvement of the elder, lack of institutional placement for the elder, cost-effectiveness, reduction of stress) are imprecise, at best, and probably fairly insensitive to the changes that are likely to result from intervention. This is a particularly important area for future research by nurse investigators.

Recommendations

Based on the foregoing assessment of research needs and opportunities in "Hospital Care and Other Services in the Long-Term-Care System for Older Adults," the Panel has made the following recommendations for research.

- Develop and test innovative models includ-ing, but not limited to, structural factors for managing the nursing problems of the chron-ically ill older person in the acute-care setting.
- Develop, test, and refine outcome indicators to evaluate nursing interventions in all types of

long-term care settings.
- Describe the effect of hospitalization on older persons and evaluate the effectiveness of innovative nursing practice strategies designed to reduce the negative consequences of hospitalization.
- Examine the cost and benefits of highly technical care at the end of life to assist in targeting such services to those who are most likely to benefit from them.
- Evaluate the effectiveness of the geriatric nurse case manager in both institutional and community-based long-term care. Special attention should be given to studies that involve particularly vulnerable populations: the very old, ethnic minorities, and those underserved, isolated, or in rural communities.
- Evaluate specific nursing care strategies used by the GNP in nursing homes to reduce falls, reduce use of psychotropic drugs, and reduce unnecessary admissions to the acute hospital.
- Evaluate specific nursing care strategies used to manage behavioral problems such as wandering or aggressive behavior in nursing homes. Special attention should be given to how these behaviors are managed in special care units and in nursing homes without special care units.

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