Final Report

ADULT DAY CARE CENTRES IN BRITISH COLUMBIA:

THEIR OPERATING CHARACTERISTICS, ACTIVITIES AND SERVICES, CLIENTS, AND INTERFACE WITH THE LONG TERM CARE PROGRAM

by

G.M. Gutman, Ph.D.
S. Milstein, Ph.D.
J. Killam, B.Sc.N., Dip. Gero.
D. Lewis, M.A.

Gerontology Research Centre
Simon Fraser University
555 W. Hastings St.
Vancouver, B.C.
V6B 5K3

February, 1991

Final Report

ADULT DAY CARE CENTRES IN BRITISH COLUMBIA: THEIR OPERATING CHARACTERISTICS, ACTIVITIES AND SERVICES, CLIENTS, AND INTERFACE WITH THE LONG TERM CARE PROGRAM

by

G.M. Gutman, Ph.D.
S. Milstein, Ph.D.
J. Killam, B.Sc.N., Dip. Gero.
D. Lewis, M.A.

Gerontology Research Centre
Simon Fraser University
555 W. Hastings St.
Vancouver, B.C.
V6B 5K3

February, 1991

This project was carried out under contract to the Continuing Care Division, B.C. Ministry of Health. The views expressed are those of the authors and do not represent those of the Continuing Care Division.

ACKNOWLEDGEMENTS

The authors wish to thank the 49 Adult Day Care centres that contributed information concerning their operating characteristics, activities and services in Phase I of the study, and the 22 that were selected, in addition, to participate in Phase II.

We also acknowledge the important contribution of the Long Term Care Program case managers and the Adult Day Care staff who participated in focus groups in Phase III and the staff and clients who responded to questionnaires.

The study could not have been conducted without the very high level of cooperation these centres and individuals provided.

The assistance of Cathy Redgrave in serving as liaison between the study team and Continuing Care Division is also acknowledged and very much appreciated.

Additionally, we would like to express our thanks to Gerontology Research Centre Information Officer Monica Mori who retrieved the many articles that formed the basis of the literature review and to Lauri McKay, Aileen Murphy and Doug Talling who assisted with data processing.

Special thanks go to Centre Secretary Janet McNern who cheerfully typed the manuscript of this report through its many drafts and to Centre Administrative Assistant Michele Lemieux who assisted with typing, proof-reading and editing.

Gloria Gutman
Steve Milstein
Judy Killam
Doris Lewis

February 1991

EXECUTIVE SUMMARY

This report begins with a review of the literature focussed on ascertaining answers to eleven specific questions concerning the objectives, models of service delivery, operating characteristics, activities and services and clients of Adult Day Care centres. The main body of the report presents and discusses findings from a three-phase study of Adult Day Care centres in British Columbia.

The study, which was commissioned by the Continuing Care Division of the Ministry of Health, was designed to provide information concerning:

1. the activities and services provided by the 49 centres in operation in the province in Summer, 1989;
2. the characteristics of clients currently being served by Adult Day Care in British Columbia;
3. the reasons clients are referred to Adult Day Care;
4. the reasons some referred clients do not attend; and
5. the referral process and the interface between Long Term Care and Adult Day Care.

To obtain this information, in Phase I a questionnaire was sent, and responded to by all 49 centres, that asked questions about their operating characteristics, activities and services. In Phase II, 22 centres were asked to provide, with names removed, copies of the LTC-I form for all clients admitted between December, 1988 and November, 1989. Forms for a total of 479 clients were received, coded and analyzed. In Phase III, 67 case managers ranked 21 reasons for referral three times: once in terms of the frequency they had used each reason; a second time in terms of each reasons' importance to their decision making; and a third time in terms of the impact they felt Adult Day Care could have on the problems identified in the reasons. Questionnaires were also sent, in Phase III, to Long Term Care Program case managers, Adult Day Care staff and a sample of clients to ascertain reasons for non-attendance. Usable data were received from 58 case managers, 36 Adult Day Care staff and 73 clients who had been

referred but never attended. Additionally in Phase III, two focus groups were conducted, one with case managers and the other with Adult Day Care staff, to explore, from the perspective of each, the referral process and the interface between Long Term Care and Adult Day Care.

The data from Phases I and II were examined to ascertain if there were any key differences between the 13 centres serving from 1-29 clients, the 21 serving from 30-69 clients and the 15 serving from 70-121 clients (designated respectively as small, mid-sized and large centres). A cursory analysis was also performed to ascertain if there were key differences between centres affiliated with care facilities and those that were not since the literature review indicated that, in the United States, the auspices under which a centre operates has considerable impact on the type of clients served and on the services delivered. Additionally, comparisons were made between the 38 centres (77.6%) in urban locations (i.e. communities with a total population of over 10,000) and the 11 (22.4%) in rural locations. Findings from the centre size analysis are presented in full in this report. Important differences as a function of centre affiliation are summarized. The urban-rural comparisons are the subject of a companion report currently in preparation.

Key findings and recommendations:

Presented below is a summary of key findings and recommendations. In making recommendations, the intention was to identify ways in which the Adult Day Care Program in B.C. might be strengthened. It is recognized that significant strides have been made since Adult Day Care became part of the Continuing Care Program in 1979 and that a major expansion in the number of centres took place in 1990-91. Nevertheless, the Adult Day Care Program is still in the formative stage. It is hoped that the findings and recommendations of this study will contribute to its further development.

1. Compared to the United States and Great Britain, a higher proportion of B.C. centres (26.5%) are free-standing. Among those that are affiliated with another organization, more in B.C. than

in these other two countries are affiliated with a care facility but fewer with an acute hospital. There also are fewer in B.C. (only 2.0% of centres) that are of the Special Purpose variety -- that is, that serve a single client group. This latter finding is particularly noteworthy as regards dementia victims for at least three reasons: a) the prominence of centres specialized for their care in the recent literature on Adult Day Care; b) the finding that as many as 8.0% of the new admissions to B.C. centres are at the Intermediate Care III level, the level traditionally used to classify persons with significant cognitive impairment; and c) the finding that the proportion of B.C. clients with diagnoses falling within the International Classification of Diseases' "mental disorders" category (37.8%) is virtually identical to the United States. The establishment of at least some centres in B.C. specialized in caring for dementia victims is very strongly recommended. Reasons include the above findings, data from Phase III which indicates (see Section 6.3.2.) that B.C. Adult Day Care staff, like their American and British counterparts, find it difficult to program when they have a mixed clientele a substantial proportion of whom have serious cognitive impairment; their fear that centres will become mainly purveyors of socialization and respite if many more dementia patients are admitted; and the environmental design and staffing needs of dementia victims which can be met more easily in specialized centres.

2. Although most centres in B.C. are open five days per week, most clients only attend one or two days. Frequency of attendance per week is less than in the United States as is the average daily census. The average frequency of attendance per week appears, however, to have increased in B.C. in recent years. Several possible explanations for this are presented. To ascertain which, if any, is correct as well as to answer other questions raised by the study, it is recommended that a historical review of billing records and other data be undertaken. In particular, this review should ascertain if there has been a change over time in:

- the number of days Long Term Care Program case managers are recommending for new clients at each level of care;
- the disability level of new clients (distribution of levels of care; ratings on sub-categories of the LTC-I form);
- retention patterns for clients who deteriorate; and
- the proportion for whom, subsequent to admission, days of attendance are increased.

3. A total of 65.3% of centres were found to have a wait list. While this can be taken as a sign that Adult Day Care is a popular and needed service, both case managers and Adult Day Care staff respondents were concerned about the negative effect that having to wait can have on clients and their families. At large centres the average wait time is relatively short (1.6 months). However, in some centres the wait is as long as 12 months. Reasons why some centres have long wait lists and wait times, some moderate lists and waits, while still others have no lists and may be under-utilized need to be explored.

   Also needing to be explored are the reasons why the number on wait lists is smaller and the average wait time is shorter for care-facility affiliated as compared to other centres. For example, this could reflect client preferences -- some may prefer to wait for admission to a community-based centre rather than enter one affiliated with/located in a care facility. It could be a function of client characteristics. Clients may be more frail at time of admission to care-facility affiliated centres and, hence, deteriorate and become institutionalized more rapidly than clients of other centres. Or, they may simply be older at time of admission and, hence, closer to death. Alternatively or concomitantly, other factors may be involved. These could include case managers' referral patterns and practices, their level of

awareness of local centres' wait list size and turn-over rates as well as the supply of institutional beds in their geographic area. To explore these possibilities, at the minimum future studies should ascertain the reasons clients are discharged and the settings they are discharged to, as well as correlate rates of discharge from (and admission to) Adult Day Care centres with the institutional bed supply in their area.

4. It is also strongly recommended, both as an aid in estimating wait list time and for planning purposes, that accurate information be obtained concerning turn-over rates.

   For example, we need to know whether, in B.C. Adult Day Care centres, three months is the average length of stay, as is reported for British day hospitals, or whether the average stay is substantially longer. Additionally, we need to know the proportion and distinguishing characteristics of short-term vs. long-term attenders if, as British and American research suggests, both are represented in the Adult Day Care population.

5. Typically, in B.C. Adult Day Care centres, the staff consists of an administrator and a program worker. In more than two-thirds of the large centres, a nurse, a secretary/bookkeeper, a cook and a transport worker are also employed. However, although a variety of therapeutic activities are offered by most centres, few have therapists actually on staff. As a result, one is left with some nagging questions about the nature and depth of the therapies, activities, and services that are offered.

   In commissioning future studies of Adult Day Care, the Continuing Care Division might consider requesting that the research design include site visits and/or some other means of assessing the content and level of the programs offered, particularly the therapeutic programs.

6. Since there are no standard definitions for Adult Day Care activities and services, it is difficult to compare the present findings with those of other studies. To the extent that it is possible to do so, however, it appears that: a) the findings are essentially the same as those previously reported (Jarrell, 1989) for B.C. centres; and b) there are only three noticeable differences in service relative to what is offered in the United States. These were in providing breakfast and occupational therapy to clients and service to their families.

   For reasons outlined in the report (see Section 7.1.5.) it is recommended that service in the latter two areas be expanded and that the need for breakfast be explored.

   Based on the comments of the case managers, it is also recommended that expansion of service be considered in the following areas:

   - bathing of non-Adult Day Care clients;
   - take-home evening meals;
   - weekend programs and night respite/night care;
   - training/retraining in ADLS and IADLS; and
   - discharge planning.

7. In the United States, a majority of Adult Day Care clients are female, most do not live alone and few live in institutions. This proved to be characteristic of B.C. clients also. However, in addition to finding that B.C. clients are older than their American counterparts (the average age of new admission in B.C. was 78.9 years), two other differences were noted: a greater proportion in B.C. live with their spouse and a smaller proportion live with their children.

   It is possible that the greater proportion of married clients in the B.C. sample reflects a greater sensitivity among referral sources in this province to the respite needs of spousal caregivers, many of whom themselves are elderly and "at risk." It

is also possible that the lower representation here of clients living with their children reflects an underestimation, on the part of our referral sources, of these caregivers' needs. To ascertain which is the case it is recommended that the attitudes of Long Term Care Program case managers towards these two types of caregivers be explored in future studies.

8. When small, mid-sized and large centres are compared only one noticeable and meaningful difference emerges: small centres appear to be "carrying the load" as far as persons with dementia are concerned. This is indicated in three different ways:

   - by the higher proportion of clients of small centres who are at the Intermediate Care III level (15.4% compared with 10.7% in mid-sized and 4.3% in large centres);

   - by the higher proportion of clients in small centres (50.9%) then in mid-sized (34.0%) or large centres (37.3%) that have diagnoses falling within the ICD "mental illness" category; and

   - by the finding that in all five of the mental health status categories of the LTC-I (see Table 28) the proportion of clients showing impairment is highest in small centres.

Considering what is known about the needs of persons with dementia (see Gutman, 1989 and Gutman and Killam, 1989), a small scale environment is most appropriate for their care. The extra demands placed on the staff of these small centres must, however, be recognized. Support must be provided to them if services to clients with dementia are to be the best possible and if staff burn-out is to be prevented. Such support should include the development of various types and levels of educational material and programming that communicate the latest information concerning: the natural course of the most common dementias and their manifestations; effective client management techniques and

environmental adaptations; effective ways of working with and assisting families of dementia victims; and staff education techniques regarding the management of their particular type of 'on the job' stress. Toward this end, the establishment of a Dementia Care Resource Centre is recommended. Such a centre, which would serve both as a source of instructors, and a developer and repository of print and audio-visual materials, would be of value not only to Adult Day Care staff but also to staff of home support agencies and care facilities, all of which in future will be faced with increasing numbers of clients with dementia.

9. The reasons for referral data are encouraging in showing that those reasons which, in the opinion of case managers, are most <u>important</u>, and those they feel Adult Day Care is most likely to have an <u>impact</u> on, are the same ones they report most often having referred people to Adult Day Care for. As pointed out in Section 7.3.1., however, a problem with these data is that they are opinions only. Before-after studies are needed to ascertain if Adult Day Care has the positive impact on clients and their families that the case managers think it has. It is recommended that the Continuing Care Division commission the conduct of such studies.

10. It is recommended that the Continuing Care Division ask case managers, for a period of time, to check off on the form used in this study (or otherwise to systematically record) the reasons for every referral they make. It is only in this way that it will be possible to verify that clients are being referred for the reasons the case managers say they are and to ascertain whether their frequency estimates are correct.

11. Given the problem that was identified (see 6.3.2.), of Adult Day Care staff in some health units having difficulty obtaining information from case mangers, it is recommended that consideration be given to revising the LTC-I form (or to developing an accompanying form) so as to include space to record

the reasons for referral and the other information Adult Day Care staff respondents indicated they require (i.e. information describing the client's needs relative to the services Adult Day Care can provide, suggesting approaches that might be tried, and identifying any special concerns the case manager has about the client or any problems he/she feels the centre might anticipate experiencing).

12. It is strongly recommended that procedures be put into place to facilitate routine and timely transmission of the LTC-I form, to ensure that all relevant portions of it are sent (i.e. pages 1-4 inclusive), and to ensure that all portions of the form are completed. With regard to the latter, it should be noted (see Section 5.0) that there was much missing data in the 479 LTC-I forms analyzed in this study.

13. One of the more important findings of this study is that there appear to be some differences between the perceptions of case managers and Adult Day Care staff, and between the two types of staff and clients, as regards reasons for non-attendance.

    As indicated in Section 7.3.2. staffs' perceptions were that clients chose not to attend mainly for psycho-social reasons or because they feared Adult Day Care might be too physically and/or mentally taxing. The clients' responses, on the other hand, suggest that their primary concerns are practical ones -- about being able to see or hear well enough to participate, and about logistics and costs.

    It is important that the findings from this study be communicated to staff since they have implications for what case managers should focus on when initially approaching clients about attending Adult Day Care, and especially when they or Adult Day Care staff attempt to encourage a client to reconsider refusing a referral. The findings also have implication for the charges that are levied for meals and special activities and for the arrangements that are

made in regard to transportation. Additionally, they underscore the need to locate Adult Day Care centres in space that is clearly barrier-free and accessible.

14. The study indicated five very noticeable differences between what case managers and Adult Day Care staff thought were fairly important reasons for non-attendance. Analysis of these differences suggests that whereas case managers place the locus of the non-attendance problem primarily on the client, Adult Day Care staff place more emphasis on problems with the system -- in particular, that too often it requires clients to endure lengthy waits before being able to attend an Adult Day Care centre.

    To ascertain which groups' perception is the more correct, as well as to reconcile the difference between staffs' and clients' perceptions, it is recommended that reasons for non-attendance be systematically recorded over a period of time.

15. There was much discussion among both case managers and Adult Day Care staff about the problems that are created by extensive wait lists and lengthy wait times. Obviously, every effort should be made to reduce both. It is important, however, that in encouraging case managers to "move the wait list," it is made clear by the Continuing Care Division that this must not be at the expense of current clients who could continue to remain in the community if able to continue to attend Adult Day Care.

16. It is apparent that case managers are limited in who they can refer to what centres. Reasons are that not all centres are able to provide/arrange the transportation a particular client may require; not all centres provide the full range of services identified in Phase I of the study; not all centres accept clients at all care levels; and not all centres occupy appropriate physical space. If the Continuing Care Division desires that all centres serve all types of clients, it is necessary to ensure that all centres have the transportation, facilities and equipment,

physical space, and especially, the appropriately trained staff to do so. An alternative, and one that is recommended, is to encourage specialization. This would not have to mean, for example, that all persons with dementia would be cared for in Special Purpose centres. Such a policy would be neither desirable nor feasible. Being able to attend a specialized Adult Day Care centre would, however, certainly be the option of choice for some clients.

17. It was apparent from the focus groups that not all case managers are as familiar as they should be with the activities and services, facilities, and staff of the centres to which they refer clients. It is strongly recommended that the Continuing Care Division make every effort to ensure that full familiarity is achieved by all case managers.

18. The study indicates that in some health units there are some fairly serious problems in the area of information sharing. To ensure that information flows smoothly both from Long Term Care to Adult Day Care and vice-versa, it is recommended that the Continuing Care Division instruct/remind case managers and designated Adult Day Care liaisons: a) not to over-play their "gate-keeper" role as regards transmission of information; and b) to consult with Adult Day Care centre staff when clients are being reviewed or reassessed, prior to making major changes to a care plan, and when transfer to an institution is being considered. Further, it is recommended that the Continuing Care Division give serious consideration to formalizing and standardizing communication channels and reporting procedures and intervals. In addition to facilitating effective and efficient information transmission between Long Term Care and Adult Day Care, formalizing and standardizing the above practices and procedures would eliminate the changes that respondents report frequently occur when there is a change of administration in a local health unit, and it would facilitate Adult Day Care program monitoring both at the local and at the provincial level.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS..i

EXECUTIVE SUMMARY..ii

1.0. INTRODUCTION...1

2.0. LITERATURE REVIEW..3

2.1. Objectives and Definition of Adult Day Care..........................4

2.2. Urban-Rural Distribution..........................6

2.3. Models of Adult Day Care..........................7

2.4. Physical Space..........................12

2.5. Operating Characteristics..........................14

2.5.1. Hours of Operation..........................14

2.5.2. Utilization Pattern..........................15

2.6. Staffing..........................16

2.6.1. Staff Type..........................16

2.6.2. Client-staff ratio..........................18

2.6.3. Use of Volunteers and Students..........................18

2.7. Activities and Services..........................19

2.7.1. Educational and Counselling Services..21

2.7.2. Leisure Services..........................21

2.7.3. Liaison Services..........................22

2.7.4. Meal Services..........................22

2.7.5. Medical Services..........................23

2.7.6. Nursing Services..........................23

2.7.7. Personal Care Services..........................23

2.7.8. Referral Services..........................23

2.7.9. Rehabilitation Services..........................24

2.7.10. Transportation Services..........................24

2.7.11. One-on-One Services..........................25

2.7.12. Caregiver-related Activities and Services..........................25

2.8. Client Characteristics..........................25

2.8.1. Age..........................25

2.8.2. Other Socio-demographic Characteristics..........................26

2.8.3. Medical Conditions..........................27

TABLE OF CONTENTS (cont'd)

Page

2.8.4. Communication Ability....28

2.8.5. Level of Performance of Activities of Daily Living....29

2.8.6. Mental Health Status....30

2.9. Reasons for Referral and Non-attendance....31

3.0. STUDY METHODS....33

3.1. Commencement of the Study....33

3.2. Phase II....35

3.2.1. Sampling Procedure - Centres....35

3.2.2. Sampling Procedure - Clients....36

3.3. Phase III....36

4.0. PHASE I FINDINGS....40

4.1. Geographic Distribution of B.C. Centres....40

4.2. Affiliation Arrangements....41

4.3. Level of Care of Clients....42

4.4. Operating Characteristics....43

4.4.1. Hours of Operation....43

4.4.2. Transportation to/from Centre....44

4.4.3. Fees Charged....46

4.4.4. Average Daily Census....46

4.4.5. Average Frequency of Attendance per Week....47

4.4.6. Number of Clients Admitted in the Last 12 months....48

4.4.7. Wait lists....49

4.5. Staffing....49

4.5.1. Full vs. Part-time staff....49

4.5.2. Type of Staff Employed/Available for Consultation....49

4.5.3. Use of Volunteers....52

4.6. Activities and Services....52

4.6.1. Health Care Services....52

4.6.2. Personal Care Services....54

4.6.3. Transportation (other than to/from ADC)....55

4.6.4. Social Services....56

TABLE OF CONTENTS (cont'd)

Page

4.6.5. Therapeutic Activities................58

4.6.6. Recreational and Social Activities....60

4.6.7. Educational Programs..................62

4.6.8. Client Volunteer Activities...........63

4.6.9. Quiet Time Activities.................64

4.6.10. Meals................................65

5.0. PHASE II FINDINGS.........................66

5.1. Socio-demographic Characteristics of New B.C. Adult Day Care Clients..................67

5.2. Level of Care..............................69

5.3. Medical Conditions.........................69

5.4. Medication Consumption.....................71

5.5. Communication Ability......................72

5.6. Level of Performance of Activities of Daily Living.................................74

5.7. Self-Care Ability..........................78

5.8. Mental Health Status.......................81

6.0. PHASE III FINDINGS........................84

6.1. Reasons for Referral to Adult Day Care.........84

6.2. Reasons for Non-attendance.....................86

6.3. The Referral Process and the Interface Between Long Term Care and Adult Day Care.......88

6.3.1. The Long Term Care Case Managers' Perspective...............................89

6.3.2. The Adult Day Care Perspective.............97

7.0. DISCUSSION..................................107

7.1. Comparison of Findings with those of Prior Studies...................................107

7.1.1. Urban-Rural Distribution.................107

7.1.2. Models of Adult Day Care.................107

7.1.3. Utilization Pattern......................110

7.1.4. Staffing.................................113

7.1.5. Activities and Services..................115

7.1.6. Client Characteristics...................118

TABLE OF CONTENTS (cont'd)

Page

7.2. Summary of Differences by Centre Size.........122

7.2.1. Affiliation Arrangements.................122

7.2.2. Operating Characteristics................123

7.2.3. Staffing.................................124

7.2.4. Activities and Services..................124

7.2.5. Client Characteristics...................126

7.3. Phase III findings.............................127

7.3.1. Reasons for Referral to Adult Day Care....127

7.3.2. Reasons for Non-attendance................130

7.3.3. A Summary and Some Final Comments on the Referral Process and the Interface Between Long Term Care and Adult Day Care data...................132

REFERENCES..137

APPENDICES

Appendix 1 Medical Diagnoses Included in ICD Categories

Appendix 2 Information and Support Letters Sent to all Centres at the Start of the Study

Appendix 3 Request for Data for Phase I, Part I(all centres)

Appendix 4 Request for Data for Phase I, Part II (27 centres not selected to provide client demographic data)

Appendix 5 Request for Data for Phase I, Part II and Phase II (22 centres selected to provide client demographic data)

Appendix 6 Information Sheets and Consent Forms for Phase III Focus Groups and Information Letters and Questionnaires for Staff and Non-attending Clients

LIST OF TABLES

Table No.	Title	Page
1.	Geographic Distribution of Adult Day Care Centres in British Columbia, by Centre Size	41
2.	Affiliation Arrangements of Adult Day Care Centres in British Columbia, by Centre Size	42
3.	Level of Care of Clients Served by Adult Day Care in British Columbia, by Centre Size (December, 1989)	43
4.	Number of Days Per Week, Adult Day Care Centres in British Columbia are in Operation, by Centre Size	44
5.	Transportation to/from Adult Day Care Centres in British Columbia, by Centre Size	45
6.	Average Number of Clients Per Day Attending Adult Day Care Centres in British Columbia, by Centre Size	46
7.	Average Frequency of Attendance per week, Adult Day Care in British Columbia, by Centre Size	47
8.	Number of Clients Admitted in Last 12 Months, Adult Day Care in British Columbia, by Centre Size	48
9.	Type of Staff Employed by Adult Day Care Centres in British Columbia, by Centre Size	50
10.	Consultative Services Used by Adult Day Care Centres in British Columbia, by Centre Size	51
11.	Health Care Services Provided by Adult Day Care Centres in British Columbia, by Centre Size	53
12.	Personal Care Services Provided by Adult Day Care Centres in British Columbia, by Centre Size	54
13.	Transportation Services (other than to/from ADC) Provided by Adult Day Care Centres in British Columbia, by Centre Size	55
14.	Social Services Provided by Adult Day Care Centres in British Columbia, by Centre Size	57
15.	Therapeutic Activities Provided by Adult Day Care Centres in British Columbia, by Centre Size	59

LIST OF TABLES (cont'd)

Table No.	Title	Page
16.	Recreational and Social Activities Offered by Adult Day Care Centres in British Columbia, by Centre Size	61
17.	Educational Programs Provided by Adult Day Care Centres in British Columbia, by Centre Size	62
18.	Client Volunteer Activities at Adult Day Care Centres in British Columbia, by Centre Size	63
19.	Quiet Time Activities at Adult Day Care Centres in British Columbia, by Centre Size	64
20.	Meals Provided by Adult Day Care Centres in British Columbia, by Centre Size	65
21.	Socio-demographic Characteristics of New Admissions to Adult Day Care in British Columbia, by Centre Size	68
22.	Level of Care of New Admissions to Adult Day Care in British Columbia, by Centre Size	69
23.	Medical Conditions of New Admissions to Adult Day Care in British Columbia, by Centre Size	70
24.	Number of Medications Consumed by New Admissions to Adult Day Care in British Columbia, by Centre Size	71
25.	Communication Ability of New Admissions to Adult Day Care centres in British Columbia, by Centre Size	72
26.	Level of Performance of Activities of Daily Living, New Admissions to Adult Day Care in British Columbia, by Centre Size	75
27.	Self Care Ability of New Admissions to Adult Day Care in British Columbia, by Centre Size	79
28.	Mental Health Status of New Admissions to Adult Day Care in British Columbia, by Centre Size	82
29.	LTC Case Managers' Ranking of Reasons for Referral to Adult Day Care, by Type of Ranking (Frequency, Importance, Impact)	85
30.	Reasons For Not Attending Adult Day Care, by Type of Respondent (LTC case managers, ADC staff, clients)	87

1.0. INTRODUCTION

In 1979, Adult Day Care became a part of the B.C. Ministry of Health's Continuing Care Program. By 1989, there were 49 Centres in operation in the province and it was felt timely to undertake a comprehensive review of the Adult Day Care component of the Continuing Care Program. As part of that review and as an aid for future planning, the Simon Fraser University Gerontology Research Centre was commissioned to conduct a study that would provide information concerning:

1. the activities and services provided by the 49 centres;
2. the characteristics of the clients currently being served;
3. the reasons clients are referred to Adult Day Care;
4. the reasons some referred clients do not attend; and
5. the referral process and the interface between Adult Day Care and the Long Term Care Program.

In fulfilling the commission, a literature review was undertaken and a three-phase study was designed and conducted.

Chapter 2 of this report presents a summary of findings from the literature review. Chapter 3 describes the methods used to collect the study data. Chapters 4-6 present the study findings. These are compared and contrasted with findings from the literature review and discussed in Chapter 7, the concluding chapter.

As will be described in more detail later, findings from Phase I of the study, concerning the operating characteristics and activities and services offered by Adult Day Care Centres in British Columbia, derive from questionnaires sent and responded to by all 49 centres (i.e. a 100% sample). Findings from Phase II, concerning client characteristics, derive from a sub-sample of 22 Centres, each asked to provide information on new admissions for the period December, 1988 to November, 1989. Findings from Phase III, concerning reasons for referral and for non-attendance, derive from focus groups conducted with and questionnaires sent to Long Term Care Program and Adult Day

Care Centre staff and from questionnaires sent to a sample of non-attending clients. Information concerning the referral process and the interface between Adult Day Care and the Long Term Care Program, also from Phase III, comes solely from focus group discussions.

Since it was felt that centre size (i.e. number of clients served) might have an important bearing on operating characteristics, on the activities and services provided and/or on the type of client, data from Phases I and II of the study are presented separately for the three size groupings 1-29 (designated as small centres), 30-69 (designated as mid-sized centres) and 70-121 (designated as large centres). Data from Phases I and II were also subjected to a cursory examination to ascertain if there were differences between centres affiliated with care facilities and those that were not. In the United States, as the ensuing literature review will reveal, the auspices under which a centre operates appear to have considerable impact on the type of client served and on the services delivered. While data are not presented separately for centres that are vs. those that are not affiliated with care facilities, noticeable differences are highlighted and discussed in Chapter 7. Chapter 7 also attempts to meld the qualitative and the quantitative data gathered in the study and presents some recommendations.

A companion report, currently in preparation, compares the 38 (77.6%) centres in urban locations (i.e. in communities with a total population of over 10,000) with the 11 (22.4%) in rural locations.

It should be noted that in making recommendations, the intention was to propose ways that the Adult Day Care Program in B.C. might be strengthened. It is recognized that significant strides have been made since Adult Day Care became part of the Continuing Care Program in 1979 and that a major expansion in the number of centres took place in 1990-91. Nevertheless, the program is still in its formative stage. Hopefully, this report will contribute to its further development.

2.0. LITERATURE REVIEW

The literature review that was undertaken as part of this study was a focussed one, seeking answers to eleven questions. These questions were:

1. Is there a set of core objectives that most centres subscribe to? If so, what are these objectives? What other objectives do some centres articulate?

2. Does the term 'Adult Day Care' mean the same thing to all persons providing service to older people during the day?

3. Is Adult Day Care primarily an urban service?

4. What are the different service models that have been developed? Is their distribution equal or are some models more prevalent than others?

5. What type of physical space do Adult Day Care centres occupy? Are most facility-based or are the majority to be found in community settings?

6. What are the operating characteristics of Adult Day Care centres? Are many open seven days a week ? What is a typical client load and daily census? For how long do clients typically attend --- is it months or years?

7. How many and what type of staff are generally to be found in Adult Day Care centres? Are volunteers used in any great numbers? Do students assist?

8. Are there a common set of activities and services that most centres offer?

9. What are the characteristics of Adult Day Care clients? Are most of them "older-old"? Are they physically very frail? What proportion are demented?

10. Of the various possible reasons for referring people to Adult Day Care, which is the dominant one -- socialization, health maintenance or caregiver respite?

11. What is known about people who are referred but do not attend? What are their socio-demographic characteristics? Why don't they attend?

The sections that follow describe the answers that were found when the available literature was searched. Although material on costs/benefits was also found (Anand, Thomas, Osborne and Osmolski, 1982; Doherty and Hicks, 1975; Feingold, 1977; Gaertner, Sterling and Markisohn, 1982; Grimaldi, 1979; Hannah and O'Donnell, 1984; Knapp and Missiakoulis, 1982; MacFarlane et al., 1979; Riddings and Isdale, 1978; Robertson, 1985; Ross, 1976; Smith, Cantley and Ritman, 1983; Tucker, Davidson and Ogle, 1984; Wan, Weissert and Livieratos, 1980; Weissert, 1978), this material is not reviewed here.

2.1. Objectives and Definition of Adult Day Care

The literature review revealed five common objectives of Adult Day Care centres:

- to assist clients in maintaining the highest level of independence possible (Aaronson, 1983; Fisher et al., 1981; Goldstein, 1982; Neustadt, 1985);
- to maintain clients in the community for as long as it is possible and practicable to do so (Aaronson, 1983; Fisher et al., 1981; Lurie et al, 1976; Neustadt, 1985);
- to prevent premature or unnecessary institutionalization (Arling, Harkins, and Romaniuk, 1984; Fisher et al., 1981; Gibbons, 1984; Lurie et al, 1976; Szekais, 1985);
- to maintain, restore or improve the health and the social, physical and cognitive functioning of the individual (Arling,

Harkins and Romaniuk, 1984; Chappell, 1983; Gibbons, 1971; Goldstein, Sevriuk and Grauer, 1968; Hackman, 1979; Kirwin, 1986; Padula, 1981);

- to provide caregiver support and respite (Fisher et al., 1981; Greene and Timbury, 1979; Hackman, 1981; Neustadt, 1985; Sands and Suzuki, 1983; Szekais, 1985).

Among other objectives described, but with less frequency were:

- assessment and/or early detection of illness (Chappell, 1983; Fisher et al., 1981);
- earlier discharge from hospital (Fisher et al., 1981);
- assistance with the transition from hospital to nursing home or home (Weissert et al., 1989);
- assistance with the transition from home to institution when placement is unavoidable (Gibbons, 1971; Zarit, 1978);
- provision of in-home assistance to caregivers by way of information, counselling and care planning (Lindeman et al, 1987);
- provision of training opportunities for students, professionals and caregivers (Asbury and Merrill, 1989; Lindeman et al, 1987).

The literature review revealed that there are also differences between centres with regard to organizational and operational characteristics, activities and services, and clients served. Further, how Adult Day Care is defined appears to vary considerably.

As Padula (1981) notes, it seems to mean different things to different people.

> ...some private families receive [government] funds to provide day care .... Some long term care facilities accept day patients on an irregular basis and call it day care. Whether it is day care or only care given during the day (useful in its own way) is open to debate.

> Group programs are sometimes held in churches and schools, offering the aged a few (sometimes rather limited) activities, lunch, and perhaps some health education. Some senior centers provide or could provide transportation; some of them already provide specialized programs for the frail elderly (p.42).

The "catch-all" nature of the term Adult Day Care, which is at once its strength and its weakness, is further reflected in the definition developed by The National Institute on Adult Daycare (1985), a program of the U.S. National Council on the Aging. The Institute, which was established in 1979 to provide a national focal point for Adult Day Care as well as to develop standards and guidelines, defines it as follows:

> Adult daycare is a generic term for a variety of programs, each providing a gamut of services. These services range from social and health related to the provision of active rehabilitation and physical and mental health care. Various terminology is applied: daycare, day treatment, day health services, psychiatric day treatment, therapeutic center, day hospital, etc. It is coordinated with, and relates to, other agencies and services such as senior centers, in-home services, and institutional and hospital care. It is an innovative way to organize and blend the more traditional health and social services for disabled older persons.

2.2. Urban-Rural Distribution

The literature reveals that the majority of Adult Day Care centres are located in urban areas. This is illustrated, in the case of the United States, by a study conducted in 1986 by Conrad, Hanrahan and Hughes (1990). These researchers sent questionnaires to all 1,347 of the Adult Day Care centres listed in the National Institute on Adult Daycare's directory. Among the 924 (68.6%) centres that responded to a question about their location, 78% indicated that it was urban.

Jarrell (1989) obtained similar findings in British Columbia. She sent questionnaires to the 47 centres known to be in operation in the

province in February, 1989. Among the 34 (72%) that responded, 88% were in urban areas.

Conrad, Hanrahan and Hughes (1990) suggest several reasons why Adult Day Care centres might be less common in rural areas. One that applies equally to the United States and to Canada has to do with the population distribution of persons aged 65 and over. As indicated in Section 2.8.1., individuals in this age group constitute the vast majority of clients of Adult Day Care centres. In Canada, 78% of those age 65 and over live in urban areas; in B.C., the proportion is 84% (Statistics Canada, 1982). In order to be viable, Adult Day Care centres require a population base within reasonable travel distance (e.g. a 50-mile radius). A sparse and/or dispersed seniors population may preclude the establishment of centres in many rural areas.

2.3. Models of Adult Day Care

There are several systems for classifying Adult Day Care centres that can be found in the literature. For example, O'Brien (1982) identifies four models among centres in the United States. Day Hospitals are the first type. They are described as providing service to recently discharged hospital patients requiring extensive rehabilitation and medical care. Among clients typically served are those with new strokes, persons recovering from surgery and those with acute arthritis. In this model, physician services are provided. When higher levels of functioning are reached, clients are discharged home or referred to a day-treatment centre. Day-Treatment Centres, in contrast to day hospitals, are described as having no time limitation on service. Further, while offering such restorative medical and health services as physical therapy, occupational therapy and speech therapy, O'Brien states that they also offer social services. Clients are described as consisting primarily of the mentally ill and persons suffering from chronic health problems. Health Maintenance Programs constitute a third model. These centres are described as providing nursing, social activities, nutritional and health-promoting and health-maintaining services to "at risk" individuals in need of long-term care. Adult Day-Care Centres are the fourth type in this system.

They are described as providing a social program for the frail, slightly handicapped or slightly confused older person. O'Brien distinguishes these four models from Psychiatric Day-Treatment Programs. The basis on which she does so is in terms of the type of staff they employ as well as the degree to which clients are mentally impaired.

> ... In adult day-care centers, the population usually is physically disabled or mentally handicapped, but can be cared for by a rehabilitative team of various professionals. In contrast, the psychiatric day-treatment center is for chronically mentally ill persons, who are cared for by psychiatrically trained professionals.
>
> Although some adult day-care programs provide services for mentally disabled adults, these participants are usually in need of a much less concentrated psychiatric program and can readily take part in a program lacking the heavy psychiatric orientation (p. 243).

Another classification system is provided by Szekais (1985). This system identifies five models. The second model, while similar to the Day-Treatment model in O'Brien's system, differs in being time-limited; the fifth is very different from any of those identified by O'Brien. This system also is more explicit in differentiating centres by location (i.e. hospital vs. community-based). It is less explicit, on the other hand, about excluding psychiatric day-treatment programs from consideration as Adult Day Care centres. The five models in Szekai's system are as follows:

1) Day Hospitals which provide time-limited physical rehabilitation in a hospital setting for recently discharged in-patients;
2) A Restorative Health Care Model which, while similar to a day hospital in focussing on time-limited physical rehabilitation for recently sustained serious illness or disability, is not necessarily located in a hospital setting but rather, more usually, is community-based;

3) A Maintenance Health Care Model which is a community-based model that, while offering health supervision, limited rehabilitation and social services for long-term disability, places more emphasis on socialization and recreation;
4) A Psychosocial Care Model which emphasizes rehabilitation for acute or chronic psychiatric disability; and,
5) A Respite Care Model which provides families with relief from having to provide 24-hour care.

According to Szekais, what in the United States is called a Geriatric Day Hospital is embodied in Model 1; the Adult Day Health Centre has aspects of Models 2 and 4 and often, but to a lesser extent, Models 3 and 5; Adult Day centres centres most often provide Model 3 or 5 services or both. She goes on to state:

> It is not unusual, however, to find rehabilitation therapies in a center calling itself "adult day care," or to find a day hospital with social activities for a chronic maintenance group, or other such cross-combinations. The names of adult day programs do not always accurately reflect their range of services, and programs may add or drop service models in response to the changing needs of their population (p.159).

Hannah and O'Donnell (1984) take a different approach to classifying models of Adult Day Care. They first divide centres into Clinic Type or Day Care Type. Using the ratio of ancillary service costs to direct costs (the sum of ancillary and support service costs), they then identify three sub-types of the day care model: Support-oriented (ancillary intensity ratio less than .30), Ancillary-oriented (ratio of more than .50) and Mixed (ratio of .30 to .50). In this system, ancillary service costs include therapeutic, medical and such other costs as pharmacy and radiology. Support service costs include nursing, social services and leisure activities costs. It is interesting to note that of the 15 programs they examined, 6 were classified as support-oriented, 5 as mixed, 2 as ancillary-oriented and 2 as clinic type.

Probably the best known classification system to be found in the literature, however, is that of Weissert (1976; 1977; 1978). Based on a 1974-75 survey of 10 of the 18 Adult Day Care centres in operation in the United States at the time, Weissert indicated that centres could be categorized into two discrete types: health care oriented and social services oriented. The two categories were found to differ in terms of clients served, staffing, services, costs, sources of funding and the type of organization under whose auspices they operated. Auspice Model I centres were affiliated with nursing homes and rehabilitation hospitals. It was from these institutions that they drew their clients. Typically, these clients had suffered a stroke or serious fall resulting in a fracture. At the time they entered the day program, they had recovered sufficiently to be able to receive rehabilitative treatment on an ambulatory care basis in a setting providing other services. Typically, these other services included:

> ...a noon meal, an activity program, social work services, social interaction with staff and other participants and, depending upon the program, periodic medical evaluation (Weissert, 1978, p.11).

In contrast, Auspice Model II centres tended to be affiliated with community-based agencies (social services or housing). Clients typically were more independent than Model I clients in activities of daily living and had fewer medical problems. There were some, however, who were disoriented or showed aggressive or abusive behaviour or required day time supervision. Services focussed on meeting clients' needs for social services, meals, social interaction and activity.

A more recent survey, conducted in 1985 (Weissert et al. 1989) revealed that Auspice Model II centres now engage in more health-related activities and employ more health care staff than in 1975. They also now serve a higher proportion of individuals suffering from mental impairments. Additionally, the study indicated that a third model has emerged. Weissert et al. (1989) term this third type Special Purpose centres because they serve a single client group such as veterans, persons with cerebral palsy, the mentally ill, or the blind.

In the 1985 study, the Auspice Model I category still included centres affiliated with nursing homes and rehabilitation hospitals. The Auspice Model II category included centres affiliated with a general hospital, housing authority, seniors program, municipal agency, other social service agencies as well as free-standing centres.

Correlation of auspice type and case mix indicated that currently in the United States:

> AUSPICE MODEL I centres... typically provide services to a physically dependent, older, white population, most of whom do not suffer a mental disorder. Services provided include nursing, therapies, therapeutic diets, and other health and social services provided by a complement of staff approaching one staff member for every two participants. Revenues come heavily from philanthropic and self-pay sources rather than governmental sources.
>
> AUSPICE MODEL II centres... serve a predominantly unmarried, female, frequently racial minority population, most of whom are under 85, typically not dependent or only minimally dependent in activities of daily living, but more than 40% of whom may be suffering a mental disorder. Services they receive include case management, nutrition education, professional counselling, transportation to and from the centre, and frequently health assessment (Weissert et al., 1989, p.648).

While presenting a case study of one Special Purpose centre client (an elderly veteran), Weissert et al. (1989) refrain from presenting a description of "the typical" Special Purpose centre client. The reason, they say, is because although the population within a particular centre may be homogeneous, across centres included in the Special Purpose category, populations vary widely.

It is interesting to note that there is a growing literature concerning day centres specializing in care of persons with Alzheimer's disease or other dementias (Asbury and Merrill, 1989; Cherry and Rafkin, 1988; Frenkel et al., 1984; Jones and Munbodh, 1982; Keyes and Szpak, 1983; Lindeman et al, 1987; Panella, 1987; Panella et al., 1984; Rabinowitz,

1986; Sands and Suzuki, 1983; Steele, Lucas and Tune, 1982). It is also interesting to note the distribution of the three models. Of the 60 centres surveyed by Weissert et al. (1989) in 1985, 26.5% were found to be of the Auspice Model I type, 62.2% of the Auspice Model II type and 11.2% were Special Purpose models.

Finally, it should be noted that to date, Canadian researchers have not classified Adult Day Care centres into Weissert et al.'s three categories. However, after noting that all Adult Day Care programs in British Columbia are provided by non-profit societies, Jarrell (1989) classifies centres in terms of the services operated by their sponsors. She reports that 17.7% of the sponsoring societies operate Adult Day Care plus care facilities; 32.4% operate Adult Day Care, care facilities and community services; 20.6% operate Adult Day Care and community services while 29.4% operate Adult Day Care only. If centres sponsored by groups which also operate care facilities are classified as Auspice Model I centres and those sponsored by groups operating community services or Adult Day Care only are classified as Auspice Model II centres, it is apparent that a greater proportion of centres in British Columbia than in the United States are of the Model I type.

2.4. **Physical Space**

Another way of distinguishing between centres is in terms of the physical space they occupy.

Weissert et al. (1989) report that a large majority of the centres they surveyed were housed in multi-purpose facilities. "Common among those purposes were nursing homes, senior centres and churches" (p.647). As one would expect, Auspice Model I centres were most often located in nursing homes. It is interesting to note that although some centres were affiliated with hospitals, none are reported to have been physically located in a hospital building.

Wiessert et al. (1989) also comment on the interior space, noting that it ranged from one large room to multiple rooms and office space. The median square footage per participant was found to be 136 overall.

Compared to Auspice Model I and II centres, Special Purpose centres were found to have significantly more space (median sq. ft. per participant = 217). Model I centres, on the other hand, had more physical therapy and bathing facilities.

Lindeman et al. (1987) note that the eight California Alzheimer's Day Care Resource Centers they surveyed operate in a wide range of settings including a converted single family home, day care centres, an adult education centre, a rehabilitation centre, a converted elementary school and an acute care hospital.

Conrad, Hanrahan and Hughes (1990) note that in their sample of over 900 centres, over half shared a location with at least one other service. For example, 17.0% of centres shared a location with a nutrition site, 16.7% with a nursing home, 13.6% with a seniors centre and 8.9% with a child care centre.

Jarrell's (1989) study of British Columbia centres shows a somewhat different pattern than the U.S. studies. Jarrell reports a much higher proportion (47%) of facility-attached centres, that is, centres located in a care facility or hospital-based extended care unit. A further 38% were in a church auditorium or a building with other services or housing units, 3% were in a community centre and 12% were in a building used by the day care alone.

Her findings, in turn, contrast with data from Great Britain. For example, Brockelhurst (1979) states that 51% of centres in Britain are located within geriatric hospitals, 33% are in district general hospitals with the remainder being found in alternative sites. Only 4%, overall, are free-standing and independent of a large health care facility.

Dilworth-Anderson and Hildreth (1982) also note that in Great Britain, Adult Day Care centres are often annexed to "ordinary" hospitals.

2.5. Operating Characteristics

2.5.1. Hours of Operation

Brockelhurst (1979) reports that 83% of day care centres in England are open five or more days a week.

Most centres in the United States have been found to operate during week days only and between the hours of 9 a.m. and 3 p.m. (Sands and Suzuki, 1983; Panella et al., 1984). Weissert et al. (1989) note, however, that while in their sample:

> Centres were open for an average of almost 8.5 hours per day; the range was from 4 to 11 hours. Centres opened as early as 7:00 a.m. and closed anywhere from 12:30 to 6:00 p.m., but most scheduled activities between 9:00 a.m. and 3:00 p.m. creating a 6-hour structured day (p.645).

Conrad, Hanrahan and Hughes (1990) report that among the over 900 centres they surveyed, the average number of hours they were open weekdays was 7.8; on average, 5.1 hours were devoted to formal programming. What these data illustrate (Weissert, 1978) is that although clients are at a centre only 5 or 6 hours a day, most of the staff work a full-day shift.

While Jarrell (1989) also reports a week-day-only pattern for 88% of the British Columbia centres she surveyed, she notes that, "two-thirds reported a need to expand their services to additional/longer days, overnights and weekends" (p.6). Families and physicians interviewed by Jones and Munbodh (1982) expressed similar sentiments. Brockelhurst (1979) also suggests that consideration be given to operating day centres on weekends. Asbury and Merrill (1989) describe a variety of "after hours" services that are currently being offered to dementia victims and their families by 19 American Adult Day Care centres. All are part of a demonstration program, funded by grants from the Robert Wood Johnson Foundation, the Alzheimer's Association and the U.S. Administration on Aging.

2.5.2. Utilization Patterns

Weissert et al. (1989) report that in the 60 centres they surveyed, the daily census ranged from a low of 5.6 to a high of 42.2 with an average of just under 20 clients per day. Elderly clients attended, on average, 3.4 days per week for just under 6 hours per day. Differences between the three models were also noted. The average daily census was significantly higher for Auspice Model II (23 persons) than for Auspice Model I (15 persons) or Special Purpose centres (16 persons). Clients of Auspice Model II centres attended more frequently (3.7 days per week) than those of Auspice Model I and Special Purpose centres (3.1 and 2.5 days per week, respectively).

Conrad, Hanrahan and Hughes (1990) report data similar to Weissert et al.'s overall findings. That is, they report an average daily census of 19.5 clients and an average weekly attendance rate of 3.3 days.

Attendance patterns in Jarrell's (1989) B.C. study were very different. She reported that 61% of all day care clients attend one day a week or less; 33% attend 2 days per week; 5% attend 3 days per week and only 1% more than 3 days. Chappell (1983) also reports a one day a week average attendance pattern. Subjects in her study were clients of 17 Adult Day Care centres in Manitoba. Data reported by Fisher et al. (1981) suggest that an attendance pattern of one or two days a week is also typical for Canadian day hospitals.

As far as duration of attendance goes, British studies of day hospital clients, by MacFarlane et al. (1979) and by Hildick-Smith (1980) show an average length of stay of three months. Hildick-Smith notes, however, that there seem to be two groups of day hospital clients. One group, which accounts for about half the clients, attend for short periods of up to three months. The second group are long term attenders.

Arie (1979) suggests that long-term attendance is the norm among elderly clients of psychiatric day hospitals. He reports that 40% of clients of a psychiatric day hospital in Birmingham, England, when

first followed up, had been attending for at least a year and 20% for at least two years. When followed up a year later, only 12% of these older persons had been completely discharged while approximately one-quarter of the men and 10% of the women had become in-patients. From these data as well as data showing that three-quarters of the clients had come to day care from in-patient care, he concludes that for most clients the day hospital was a "follow-on" to in-patient care rather than an alternative to it.

> ... findings suggest, and experience confirms, that psychogeriatric day hospital care is neither used mainly as a transitional stage of 'easing back into the community' nor mainly as a short-term alternative to other methods of treatment, though for some patients both these roles are important. The main function of day hospitals in geriatric psychiatry is evidently long-term care ... One might in the field of old age psychiatry, regard day care therefore as largely an interminable support system, or rather as a support system terminated mainly by death or by admission to inpatient care (p.89).

Goldstein, Sevriuk and Grauer (1968) draw a similar conclusion based on one year's experience with a psychogeriatric day hospital in Montreal. Data from a Day Care centre in the United States specialized for care of dementia victims also supports Arie's conclusions. Panella et al. (1984) followed up 69 clients admitted to the centre over a four year period. The average duration of attendance was found to be 12.6 months. The range was from three days to four years. At the time of the study, 28 (40.8%) of the 69 were still in the program. The average duration of attendance for these 28 was 15.2 months. Of the remainder, 13 (18.9%) had been institutionalized, 14 (20.2%) had died, while 14 (20.2%) were still living at home but no longer attended.

2.6. Staffing

2.6.1. Staff Type

Padula (1981) recommends that Adult Day Care centres include in their staff or have available as consultants: (1) occupational therapists qualified to conduct functional assessments of clients and their living

environments as well as to "direct" activities of daily living; (2) social workers with expertise in working with families and arranging referrals and (3) nurses to monitor health status, supervise health care procedures and consult with physicians. She suggests that other specialists such as podiatrists, physiotherapists and speech therapists may also be used.

Brockelhurst (1979) reports that the staff of day hospitals in Britain typically include one or more consultant geriatricians, nurses, an occupational therapist and occupational therapy aides, a physiotherapist, a social worker, a speech therapist, and a chiropodist. A small number also have dentists and hairdressers.

Staff at Toronto's Sunnybrook geriatric day hospital (Fisher et al., 1981) includes a nurse, who coordinates the program, provides nursing care and health supervision, selects clients who require medical treatment and coordinates case conferences. A social worker, in consultation with a physician, assesses new applicants, plans how often clients should attend and arranges transportation. The social worker also counsels clients and their families, conducts group activities and does discharge planning. An occupational therapist assesses clients' functional ability and provides therapeutic activities for individuals and groups. Other staff include a workshop instructor, a registered nurse's aide, a public health nurse who attends case conferences twice a week and a physician who attends daily. Physiotherapy, speech therapy and other special services of Sunnybrook Medical Centre are also available to clients on a referral basis.

Weissert et al. (1989) report that in the United States, among both the Auspice Model I and the Auspice Model II centres they surveyed, the staff typically included:

> ...a nurse or social worker director and an assistant plus some or all of the following: recreation/activity and nursing aides, nurses and therapists, custodial workers and van drivers, case managers and social workers, and administrative personnel and office staff(p.649).

In both types, most staff were paid employees. Where consultant agreements were entered into, they tended to be for physician's and/or therapist's services. In-kind staffing was typically for the business end of the operation (e.g., for a fiscal manager or bookkeeper).

2.6.2. Client-staff Ratio

The 1990 National Institute on Adult Daycare standard states that the client to staff ratio should be a minimum of 6:1;4:1 is recommended for centres serving a high percentage who are "severely impaired". The British Columbia Adult Day Care Policy and Development Guidelines (B.C. Ministry of Health, 1982) recommend a ratio of between 5:1 and 4:1 depending on the percentage of clients above the Personal Care level. Kirwin (1986) and Sands and Suzuki (1984) recommend a 5:1 ratio for centres serving a high proportion with Alzheimer's.

Among the eight California Alzheimer's Day Care Resource Centers Lindeman et al (1987) surveyed, the client to professional staff ratios ranged from a low of 2.3:1 to a high of 5:1, with an average of 3.5:1. Conrad, Hanrahan and Hughes (1990) report a U.S. national average ratio of 6.4:1. They note that 81% of the centres surveyed had ratios of 8:1 or lower. Weissert et al. (1989) report an average ratio that is considerably lower: 3:1. All three groups of researchers draw attention to the high degree of variability between centres, service models and different geographic regions. It should also be noted that there may be differences in the way client-staff ratios are calculated (e.g. some jurisdictions may include administrative staff while others do not).*

2.6.3. Use of Volunteers and Students

Conrad, Hanrahan and Hughes (1990) report that there is extensive use of volunteers and students in Adult Day Care centres in the United States. In their survey, 89.5% of the centres indicated that they had volunteers. On average, the number of volunteers per centre per week was 6.2; the average number of hours per week they contributed was 31.9.

---

* The 1990 National Institute on Adult Daycare standards states that "persons counted in the staff-participant ratio shall be those who spend 70% of time in direct service with participants" (p.70).

When asked specifically about student participation, 63.0% of the centres reported that they assisted. The average number of student volunteers per centre was 2.3; the average number of hours they contributed per week was 13.0.

Conrad, Hanrahan and Hughes (1990) summarize by noting that "Overall, the use of volunteers and students across the country was substantial, accounting for more than one full time position per centre" (p.48).

Jarrell (1989) also reports extensive use of volunteers. In her study of B.C. Adult Day Care centres, 97% were found to use volunteers. In 88% of these centres, they assisted with special activities; in 74% they assisted paid staff and provided one-to-one service; in 62% they helped with food preparation, serving and clean up; and in 24% they provided transportation or assisted the van driver.

McCarthy (1984) describes the way one centre recruits volunteers and some of the specific ways their services have enriched it. She also identifies some problem areas. These include the personal problems, prejudices and limitations volunteers may bring with them to the centre, absenteeism, and thoughtlessness in speech or behaviour, the result of which may be to lower the already low self-esteem of clients.

2.7. Activities and Services

In an attempt to ascertain typical activities and services offered by Adult Day Care centres, Weissert et al. (1989) examined the daily program schedules of the 60 centres in their sample, conducted site visits to each, and administered questionnaires to centre directors. From the data gathered using these techniques they concluded that:

> ...what centres most often do at a minimum is offer individuals a place to go during the day where social interaction, exercise, and a hot noontime meal is available and where nursing observation and supervision are provided (p.645).

They report that a typical daily activity schedule is as follows:

8:30 - 9:15 a.m.	Early arrivals/coffee/visiting
9:15 - 9:45 a.m.	More arrivals/reality orientation/ current events
9:45 - 10:45 a.m.	Late arrivals/exercise/therapies/ health monitoring
10:45 - 11:45 a.m.	Arts and crafts
11:45 - 1:00 p.m.	Lunch/rest
1:00 - 2:00 p.m.	Visiting speaker/musician/movie
2:00 - 3:00 p.m.	Games/individual activities/early departure
3:00 - 3:30 p.m.	Snack/departure

Under the heading of services, two sets are described: health services and social/supportive services. The types of services included in each set and the percentage of centres offering them, either directly or by contract, were as follows:

Health Services	% of centres offering
Nursing[1]	79
Health Assessment[3]	69
Therapeutic diets[1]	66
Physical therapy[2]	43
Bathing[2]	30
Occupational therapy[2]	26
Physician[3]	21
Speech therapy[2]	19
Drug consultation[3]	15
Dentist[3]	12

Social Support Services	% of centres offering
Case management[3]	71
Nutrition education[3]	68
Transportation to/from[1]	63
Professional counselling[3]	60
Church[3]	58
Music[3]	56
Hair care[3]	44
Breakfast[1]	32
Other transportation[3]	21
Meals-to-home[1]	10

Note: numbers beside services indicate frequency with which they had to be provided, either by program staff or on contract, in order to be counted: 1 = at least daily, 2 = at least weekly, 3 = at least monthly.

Other researchers group activities and services somewhat differently.

For example, Jarrell (1989) used the eleven categories of:

- educational and counselling services,
- leisure services,
- liaison services,
- meal services,
- medical services,
- nursing services,
- personal care services,
- referral services,
- rehabilitation services,
- transportation services,
- one-on-one services.

Examples of specific services included in each of these categories are described below. Also described are a range of services some centres offer to clients' families.

2.7.1. Educational and Counselling Services

Under the heading of educational and counselling services, Jarrell (1989) includes nutrition education and counselling and health care counselling which, she reports, were provided by 79% of the 34 B.C. Adult Day Care centres responding to her questionnaire. As indicated above, these same services were found by Weissert et al. (1989) to be offered by approximately two-thirds of the U.S. centres they surveyed.

2.7.2. Leisure Services

Included under Leisure Services in Jarrell's (1989) report were exercise programs, arts and crafts programs, games, birthday parties and celebrations of holidays and special events, all of which were offered by 100% of the responding centres. Examples of other leisure activities offered by these centres included: bowling, swimming, walks, overnight trips, gardening, music therapy, baking, men's programs, poetry, photography and drama clubs. Most Adult Day Care centres described in the literature, including those specialized for care of Alzheimer's patients, (c.f. Lindeman et al., 1987), offer similar leisure activities.

It should be noted that there are some suggestions in the literature as to ways these activities should be adapted if they are to be effective with dementia victims. For example, Rabinowitz (1986) recommends use of concrete objects when offering exercise programs. Dementia victims, she finds, are better able to follow a direction to stretch an elastic jump rope up and down or back and forth than they are to a direction to move a particular body part. She also finds a twelve-inch wooden dowel useful to stimulate movement. Here, clients are told to use it as they would if performing a familiar activity such as stirring soup, rowing a boat, leading an orchestra, or hitting a baseball.

2.7.3. Liaison Services

Jarrell (1989) reports that almost all the centres in her study liaise with other health service providers and with clients' families. Veterans Affairs and the Office of the Public Trustee were two government departments centres reported liaising with. As well, some centres were in contact with managers of apartment blocks clients lived in and/or with their neighbours.

2.7.4. Meal Service

A noon meal and at least one snack were provided by 97% of the centres in Jarrell's (1989) sample. Two centres (5.8%) also provide breakfast and one Centre (2.9%), dinner. Over 90% of the centres reported the availability of special diets. Those most frequently provided were: diabetic (88%), salt reduced (85%), calorie reduced (76%) and cholesterol reduced (56%). Other special diets at least 15% of the centres provided included: soft, vegetarian, allergy free and "according to client likes/dislikes".

The proportion of centres in Weissert et al. (1989) study reporting the availability of therapeutic diets was lower than in Jarrell's study (66%); more, however, provided breakfast (32%). Additionally, Weissert et al. (1989) report that 10% provide "meals-to-homes".

2.7.5. Medical Services

Under the heading "Medical Services," Jarrell (1989) includes three types of services: diagnostic services, physician services, and dental services. She reports that physician services were available at 6% of the British Columbia centres she surveyed and a dentist, at 3% of centres. She states that "few" centres provided diagnostic services. Weissert et al. (1989) report higher proportions both for physician and dentist services: 21% and 12% respectively.

2.7.6. Nursing Services

Similar to Weissert et al.'s (1989) findings, Jarrell (1989) reports that about three-quarters of the B.C. Adult Day Care centres in her study provided nursing services. The most common of these were client monitoring (e.g., blood pressure, pulse, weight, diet) and management of medical emergencies. Other nursing services offered by about two-thirds of the centres included: nursing care, health counselling and maintenance of client records.

2.7.7. Personal Care Services

Jarrell's (1989) data show that more than three-quarters of the centres in her sample provided clients with toileting assistance, approximately two-thirds provided assistance with feeding, two-thirds provided hairdressing services, half provided a bathing service, one-third provided podiatry, and about 15% provided laundry service. Weissert et al (1989) report data only for hair care and bathing. In both, proportions are lower than in Jarrell's study: 44% of centres provide hair care, 30% bath clients.

2.7.8. Referral Services

In Jarrell's study, 79% of centres referred clients to other health and social services.

Conrad, Hanrahan and Hughes (1990) report that in the United States, the three types of organizations clients are most commonly referred to are: visiting nurses/home health agencies, human services agencies and nursing homes.

2.7.9. **Rehabilitation Services**

The most common rehabilitative services provided or arranged for by the centres in Jarrell's (1989) study were training in activities of daily living and physiotherapy (just under half of the centres), followed by occupational therapy (about one-third of the centres). A small proportion of centres (under 10%) provided/arranged for speech therapy. Proportions were similar for physiotherapy (42%) and occupational therapy (26%) in the Weissert et al. (1989) study but higher for speech therapy (1990).

2.7.10. **Transportation Services**

Jarrell (1989) reports that over 90% of the centres in her B.C. sample arrange or provide transportation to and from the centre and that "a few" also arrange transportation to and from medical appointments. A smaller proportion of centres in the Weissert et al. (1989) study provide transportation to and from the centre (63%) but more (21%) provide "other" transportation.

In regard to transportation to and from the Centre, Conrad, Hanrahan and Hughes (1990) report that 55% of Adult Day Care clients travel less than 30 minutes one way and 90%, an hour or less which is the National Institute on Adult Daycare standard.

They also report that, on average, centres in the United States own three client transport vehicles, 1.7 of which have a wheelchair lift and can accommodate, on average, 3.5 wheelchairs.

Hackman (1978) feels centre-provided transportation is essential since, although encouraged, few families bring clients to the centre. The Regional Municipality of Niagara (1977) note the difficulties of transporting clients living in outlying areas. The wear and tear of very long van rides (between 1.5 to 2 hours) is one factor to be considered. Another is that long routes cut significantly into the time the client is able to spend participating in the centre's program.

2.7.11. **One-on-one services**

Jarrell (1989) provides no description of one-on-one services but one is provided by Cherry and Rafkin (1988) in relation to dementia patients. It includes removing agitated clients from the group, distracting and reassuring them, and walking with clients who might otherwise wander.

2.7.12. **Caregiver-related Activities and Services**

In addition to generally liaising with families, Lindeman et al (1987) describe a number of specific caregiver-related activities and services that are offered by the staff of the eight California Alzheimer's Day Care Resource Centres they surveyed. These include:

- attending support group/ADRDA meetings,
- providing family counselling and/or support,
- providing individual counselling,
- telephone contact,
- organizing seminars and community education programs,
- providing information and referral,
- sponsoring a newsletter,
- crisis intervention,
- providing training for caregivers,
- providing evening respite for a monthly community support group,
- making home visits,
- providing an Alzheimer's Respite Aide training program,
- providing holiday dinners for families and clients.

2.8. <u>Client Characteristics</u>

2.8.1. **Age**

The bulk of Adult Day Care clients are elderly. For example, Conrad, Hanrahan and Hughes (1990) report a mean client age of 72.2 years for their national sample of over 900 centres. Weissert et al. (1989) report that among the 60 centres they surveyed, on average, only 18% of clients were under age 65. Among these, the mean age was 55.4 years. Among the 82% of clients aged 65 or over, the mean age was 77.8; with almost 20% over the age of 84. Model I clients were older (mean age 79.2) than Model II clients (mean age 77.4) who, in turn, were older

than Special Purpose centre clients (mean age 75.8). However, the age differences between models were not statistically significant.

Brockelhurst (1970) reports that only 5% of British day hospital clients are under age 60. Fisher et al. (1981) report a higher proportion (25%), but note that this difference may reflect a lack of services for younger disabled persons in Ontario.

Jarrell (1989) notes that, although in British Columbia persons aged 19 and over are eligible for Adult Day Care, only two centres among the 34 responding to her questionnaire targeted their services to younger adults. The age distribution of clients in the responding centres was as follows:

Age	%
30-35	5.9
65-69	2.9
70-75	17.7
76-79	20.6
80-85	41.2
Missing data	11.8
	100.0

Chappell (1983), in her study of Manitoba Adult Day Care clients, also found that 40% were aged 80 and over.

2.8.2. **Other Socio-demographic Characteristics**

Conrad, Hanrahan and Hughes (1990) report that 68% of the clients of the centres they surveyed were female. The administrators also estimated that only 20% of all clients lived alone in the community, 29% lived with their children, 20% lived with a spouse, and 13% lived with other relatives or friends. An additional 7% were reported to live in a congregate setting while 7% lived in institutions.

Arling, Harkins and Romaniuk (1984) report that 69% of their random sample of 116 Virginia Adult Day Care centre clients were female, 75% were white, 62% were widowed and 89% did not live alone.

Weissert et al. (1989) also report that the majority of Adult Day Care centre clients, both those under and those over age 65, were white, unmarried females living with others.

There were, however, significantly fewer females among the Special Purpose centre clients than among clients of the other two centre types. Only 25.7% in Special Purpose centres were female compared with 64.2% in Auspice Model I and 70.5% in Auspice Model II centres.

Another significant difference between models was in the proportion who were white: 95% in Auspice Model I centres compared with 64.9% and 62.8% respectively in Auspice Model II and Special Purpose centres.

Special Purpose centres had a significantly greater proportion who were married; 53% compared with 39.5% in Auspice Model I centres and only 19.7% in Auspice Model II centres.

Arling, Harkins, and Romaniuk (1984) report that significantly more Adult Day Care clients were living with family members (spouse, adult child or other relative) than was true of a sample of individuals who had applied for nursing home care and were screened through the Virginia Nursing Home Pre-Admission Screening Program (PASP). These researchers report two other socio-demographic variables that differentiated between Adult Day Care clients and those who, subsequent to screening, were recommended for nursing homes or community-based (i.e. home) care. These variables were income and education. On both, Adult Day Care clients scored significantly higher. Chappell (1983), on the other hand, found Adult Day Care clients to be less well educated and to come from lower occupational groups than Manitoba home care recipients and community dwelling older persons not in receipt of home care.

2.8.3. Medical Conditions

Hildick-Smith (1980) lists the following diagnoses for 1026 British day hospital clients:

Diagnosis	% with condition
Hemiplegias and other CVAs	31
Arthritis	20
Heart Disease	17
Parkinsons and other neurological disorders	10
Persistent confusion	10
Fractures	9
Bronchitis, emphysema and other chest conditions	7
Diabetes	5
Falls (vertigo, postural hypotension)	5
Depression and other affective disorders	5
Disorders of the legs	5

Fisher et al. (1981) report that more than half of the clients of Toronto's Sunnybrook Hospital's geriatric day hospital had medical conditions falling within the International Classification of Diseases (ICD) categories "Diseases of the Circulatory System" and "Mental Disorders". The latter category (See Appendix 1) includes the various syndromes involving organic brain damage such as Alzheimer's Disease and multi-infarct dementia as well as affective psychoses, neuroses, and chronic alcoholism.

The most frequently self-reported diseases among Adult Day Care clients in Arling, Harkins and Romaniuk's (1984) study were: arthritis or rheumatism, heart and circulatory diseases, stroke, speech disorders, eye diseases and diabetes.

2.8.4. Communication Ability

Vision and hearing ratings for the Adult Day Care centre clients in the Arling, Harkins and Romaniuk (1984) study were as follows:

	Vision	Hearing
% Excellent	6	12
% Good	41	57
% Fair	32	20
% Poor	17	10
% Totally blind/deaf	4	0

In commenting on these findings Arling, Harkins and Romaniuk (1984) note that:

> Sensory loss limits social skills and functional abilities that may in turn inhibit social participation and compound other areas of disability. In order to benefit from adult day care the participants need some reasonable ability to communicate and to use the social and recreational programming available (p.239).

2.8.5. **Level of Performance of Activities of Daily Living**

Conrad, Hanrahan and Hughes (1990) asked the administrators of the over 900 centres they surveyed to estimate the percentage of clients able to perform eight activities of daily living (ADLs) and three instrumental activities of daily living (IADLs): without help, with some help or not at all.

The ADLs and IADLs enquired about and the findings were as follows:

ADLs	% independent	% needing some help	% unable to do
Eat meals	78.7	18.3	2.8
Transfer to/from bed	74.1	19.8	5.6
Get to/from bathroom on time	69.2	24.6	6.1
Dress and undress	59.0	31.0	10.2
Take a bath or shower	50.8	37.8	10.5
Walk	70.1	22.2	7.3
Make needs understood	72.0	19.7	8.1
Take care of own appearance	54.3	32.2	12.9
IADLs			
Handle own money	30.7	27.6	41.0
Use telephone	50.7	26.3	22.8
Go shopping	24.2	37.1	37.4

Weissert et al. (1989) report that 54.1% of the clients in their sample were functionally dependent for ADLs. When these individuals were classified according to their most severe level of dependency, 16.4%

were found to be dependent in eating, 12.9% in transferring, 11.9% in dressing, 9.9% in bathing and 3.4% in toileting.

Auspice Model I clients were found to be dependent in significantly more functions than Auspice Model II or Special Purpose centre clients. Between group differences are particularly noticeable with respect to eating. In this function, 33.2% of Auspice Model I clients were dependent compared with 12.4% of Auspice Model II clients and 14.2% of Special Purpose centre clients.

Arling, Harkins and Romaniuk (1984) found that while Adult Day Care clients in their study were <u>less</u> ADL impaired than nursing home applicants recommended for facility placement, they were <u>more</u> impaired than applicants recommended for home care. Chappell (1983) found the functional disability level of Adult Day Care clients to be higher than both home care clients receiving other services <u>and</u> a sample of institutionalized elderly.

2.8.6. **Mental Health Status**

The administrators in the Conrad, Hanrahan and Hughes (1990) study estimated that, on average, 40.2% of their clients were confused or disoriented and that 20.6% suffered from Alzheimer's disease.

Using ICD-9 codes 290-319 as criteria, Weissert et al. (1989) report that overall, 37.9% of the Adult Day Care clients in their sample had a mental disorder. The proportion was significantly smaller among Auspice Model I clients (24.6%) than among Auspice Model II (41.2%) or Special Purpose Centre clients (52.9%).

Jarrell (1989) found a smaller proportion with mental impairments in "facility-attached" centres. In these centres, 18.9% of clients were classified as "cognitively impaired" compared with 26.4% so classified in community-based centres. The proportions classified as "emotionally fragile" were, however, quite similar in the two types of centres (18.7% in facility-based centres and 14.0% in community-based centres).

A very small proportion (less than 1%) in each of the two types of centre were mentally retarded.

Arling, Harkins and Romaniuk (1984) administered the Kahn et al. (1960) Mental Status Questionnaire to their sample of 116 Adult Day Care clients in Virginia. The average score of 6 correct answers out of 10 did not differ significantly from scores obtained by a group of clients recommended for nursing home placement (5.1 correct answers) and a group recommended for home care services (5.6 correct answers).

Taken together the above findings concerning the medical conditions, communication ability, level of performance of ADLs and IADLs and the mental health status of Adult Day Care clients indicate that, as a group, they are frail and "at risk".

2.9. Reasons for Referral and for Non-attendance

The final topic examined in the literature review concerned the reasons older persons are referred to Adult Day Care and why some who are referred do not attend. In the case of reasons for referral, Leung and Ng (1984) report that of 477 individuals referred to a geriatric day hospital in Hong Kong, 349 (73.2%) were referred for rehabilitation, 104 (21.8%) for medical monitoring, 21 (4.4%) for physical maintenance, 1 (0.2%) for nursing care and 2 (0.4%) for "social relief".

Jarrell (1989) reports that in a nine month period in 1988, two thirds of the referrals to Adult Day Care centres in British Columbia were because the client needed service; one-third were because the care-giver needed respite or support.

The only empirical data that could be found in the literature concerning reasons some referred clients do not attend Adult Day Care centres was in an article about a centre specialized for care of dementia victims.

Panella et al. (1984) report that of 314 persons with dementia evaluated by a diagnostic service and considered to be appropriate for

Adult Day Care, 245 (78.0%) were not admitted or chose not to attend. Reasons for non-admission/non-attendance were as follows:

Reasons	%
Geographic barriers (lived too far from centre)	30
Referral not accepted by family or patient	23
Currently in or seeking residential placement	14
Level of functioning too low for the program	8
Other means of care planned	7
Level of functioning too high	3
No transportation	2
One-day visit: poor adjustment	2
Financial	2
Non-English speaking	2
Transferred to acute/psychiatric care	1
Patient died	1
Family moved based on diagnosis	1
Other	3
	100

Taylor (1984), in speculating as to why Virginia Adult Day Care centres serve only a small proportion (less than 1%) of the impaired elderly of that state, mentions several reasons which apply also to refusing a referral. These include: the cost (per diem and meals); the physical and psychological effort involved in dressing and getting the client ready to go to the centre each day which, he notes, can be trying, especially to the caregiver; and transportation difficulty and cost. The latter he feels, especially, is a consideration in small communities located far from the nearest centre. Additionally, he notes:

> ...once transported, it is unrealistic for the client not to stay in the center most of the day, and some infirm find this duration physically and emotionally exhausting (p.150).

3.0. STUDY METHODS

As indicated in the Introduction, the Gerontology Research Centre at Simon Fraser University conducted a three phase study in order to provide the Continuing Care Division of the B.C. Ministry of Health with information concerning:

1) the activities and services provided by the 49 Adult Day Care centres currently in operation in the province;

2) the characteristics of clients currently being served;

3) the reasons clients are referred to Adult Day Care;

4) the reasons some referred clients do not attend; and

5) the referral process and the interface between Adult Day Care and the Long Term Care Program.

The idea for the study was first presented in March, 1987 when the Continuing Care Division invited Drs. Milstein and Gutman to attend a meeting of a Ministry Steering Committee to discuss information needs relating to Adult Day Care in British Columbia. Also in attendance at the meeting were representatives of regional health units and of the associations representing the province's Adult Day Care centres.

Several subsequent meetings of this group were held to discuss specifics concerning the information that was needed and the Gerontology Research Centre's proposed approach to collecting it.

3.1. Commencement of the Study

The study began in August 1989 with a letter being sent by the Executive Director of the Continuing Care Division to all Adult Day Care centres in the province. The letter (see Appendix 2) introduced the study, underscored its importance, and requested their cooperation with the Gerontology Research Centre. Under separate cover, letters of support for the study were sent by the B.C. Health Association and the Home Support Association of B.C. Several days after receipt of these letters Phase I data collection began. Each centre received a package of materials containing a letter from Dr. Milstein, a brief outline of

the study, a description of the expected outcome of Phase I and a request to provide the research team with the following information:

1. A copy of the job description for every position within the centre;

2. Any additional information available describing the activities, programs and services the centre offered;

3. A blank copy of all forms used to collect client information; and

4. The total number of clients who had attended the centre or received service in the preceding 90 days.

All of the centres forwarded the requested information. From the job descriptions and information about activities and services, a questionnaire was developed. As shown in Appendix 3, it contained a series of questions about the organizational structure and operating characteristics of the centre, and an exhaustive check-list of activities and services. The check-list was organized into the following ten categories:

1. Health Care;
2. Personal Service;
3. Transportation;
4. Social Services;
5. Therapeutic Activities;
6. Recreational and Social Activities;
7. Educational Programs;
8. Client Volunteer Activities;
9. Quiet Time Activities;
10. Meals.

This questionnaire was sent in November, 1989 to all 49 centres. As shown in the letter in Appendix 4, completion of it was the last task requested of 27 of the centres. The other 22, in addition to completing it, were asked to provide client data.

The client data of interest concerned their sex, age, marital status, housing, household composition, recommended level and location of care (home or facility), medical conditions, medication usage, communication ability, level of performance of activities of daily living, self care

ability, and mental health status. The clients of interest were new admissions to the centre in the prior 12 months.

Section 3.2.1. below describes the criteria used to select the 22 centres.

3.2. **Phase II**

To facilitate transmission of the required information, the 22 centres participating in Phase II were sent a list containing the names and identification numbers of all their new admissions for the period December, 1988 to November, 1989. For each client listed, they were asked to make and forward a photocopy of the B.C. Long Term Program Client Assessment Form (Form LTC-I). To ensure confidentiality, they were instructed to follow a procedure (see Appendix 5) that obliterated any identifying information.

3.2.1. **Sampling Procedure - Centres**

The 22 centres that participated in Phase II were selected so as to provide a regionally representative sample as well as one that reflected differences in centre size. The selection procedure involved first stratifying the 49 centres by region. The regional strata used were:

- Vancouver Island and Coastal Region,
- Fraser Valley and Lower Mainland, exclusive of City of Vancouver,
- Interior,
- City of Vancouver.

Within each region they were then stratified by size. The size groupings used, which were chosen because they reflected "natural" breaks in the size distribution, were:

- 1-29,
- 30-69,
- 70 and over.

Two centres were then randomly selected from each cell of the resulting 12 cell matrix, except in the case of one cell which only contained one

centre. One of the centres from the 23 drawn, was subsequently deleted because it had only one client. Hence, this procedure resulted in a final sample of 22 centres.

3.2.2. **Sampling Procedure - Clients**

The list of clients sent to each of the 22 centres contained the names of all persons admitted in the previous 12 months. Aggregated across centres, the number of new admissions totalled 632. However, because of transfers, deaths, etc. the final sample totalled only 479.

It is important to recognize that while these 479 constitute a representative sample of new admissions, they are not representative of all clients in Adult Day Care. In most centres, there are some clients who have been attending over a number of years. Due to anticipated difficulties in securing up-to-date functional assessments on continuing clients it was felt advisable, however, to restrict this study to new admissions. But even in this group, some confounding variables were unavoidable. For example, a small number of the clients in the sample were known to have been in Adult Day Care prior to the current admission (i.e. they had been discharged but were re-admitted within the twelve months preceding data collection for the study).

3.3. Phase III

Phase III began in April, 1990 with a series of four focus groups:

> **Focus Group I** was designed to determine the reasons why Long Term Care Program case managers refer clients to Adult Day Care. Participants, selected by the Continuing Care Division of the Ministry of Health, were ten case managers from ten different health units in the province with Adult Day Care centres within their catchment area;

Focus Groups II and III were concerned with the referral process and the interface between Adult Day Care and Long Term Care. Participants in Group II were the same ten Long Term Care Program case managers who participated in Focus Group I. In Group III, they consisted of nine staff members from Adult Day Care centres in the Lower Mainland selected by the research team to represent various municipalities and centre sizes. Both groups were asked to describe, from their own perspective, each step of the referral process and any difficulties they had experienced with any part of it; and

Focus Group IV was designed to determine staffs' perceptions of the reasons why some persons referred to Adult Day Care do not attend. Participants were five Long Term Care Program case managers and five Adult Day Care centre staff.

All four focus groups were held at the Gerontology Research Centre. Each lasted one and one-half to one and three-quarter hours. The groups were led by one member of the research team; a second member took notes. Additionally, and with the full knowledge and consent of participants, the discussions were tape-recorded. Participants were assured that all comments would be treated as confidential and that the tapes would be destroyed upon completion of the final report.

The information gathered in Focus Groups II and III was considered primary data. The information gathered from Focus Group I, on the other hand, was used to develop a questionnaire. This questionnaire was sent in May, 1989 to a sample of 75 Long Term Care Program case managers. The questionnaire (see Appendix 6) asked them to rank order a list of 21 possible reasons for referring clients to Adult Day Care three times. The first time, the list was ranked in terms of the frequency respondents had used each reason. The second time, the list was ranked in terms of the importance of each reason in the respondent's decision-making process. The third ranking was in terms of the likelihood that Adult Day Care could have an impact on the

problem reflected in the reason for referral. Case managers selected to receive the questionnaire were drawn from all 15 health units containing Adult Day Care centres to ensure the findings would not be unique to a particular geographic location. Of the 75 case managers sent questionnaires, 67 (89.3%) completed and sent them back.

Focus Group IV data were also used for questionnaire development. In this case, the questionnaires were sent (in November, 1990) to two groups. The first group consisted of 75 Long Term Care Program case managers and 49 Adult Day Care centre staff. The second group consisted of 280 Long Term Care Program clients who had been referred to Adult Day Care but who had not attended. The questionnaire contained 23 reasons for non-attendance (22 reasons in the case of clients), as well as space to write in reasons not on the list. Case managers and Adult Day Care centre staff were asked to select the three reasons they most commonly encounter. Non-attendant clients were asked to select up to three reasons that applied to them. (Appendix 6 contains a copy of the questionnaires and the letters introducing them). As will be noted, the wording of the clients' questionnaire differs slightly from that of the staff. The adaptations made to it were on the advice of the six seniors on whom the questionnaire was pre-tested.

A total of 111 (89.5%) of the Long Term Care Program case managers and Adult Day Care centre staff completed and returned questionnaires. Unfortunately, 17 of these individuals removed the identification number from their questionnaire, making it impossible to tell if it was from a case manager or an Adult Day Care staff member. Since assignment to one of these groups was necessary for the analysis of the data (see Table 30) 17 completed questionnaires had to be discarded. The final staff sample thus consisted of 94 respondents, 58 case managers and 36 Adult Day Care centre staff.

In the case of the non-attendant client sample, 73 of the 280 sent questionnaires (26.1%), completed and returned them; 39 were found to have moved with no forwarding address available; 8 were too ill to

complete the questionnaire or refused to do so; 8 were reported to have died; 6 were ineligible for the study because they had, in fact, attended Adult Day Care; 2 claimed they were never offered a space and 2, that they had never been Long Term Care Program clients. There was no response from and no information given about the remaining 142 clients, some of whom may have been deceased or too incapacitated to respond.

4.0. PHASE I FINDINGS

This chapter presents findings from the first phase of the study. It begins with an overview of the 49 Adult Day Care centres in British Columbia, describing their geographic distribution (Section 4.1), affiliation arrangements (Section 4.2) and the level of care distribution of the total number of clients they serve (Section 4.3). This is followed by a description of their operating characteristics (Section 4.4) and their staffing (Section 4.5). The chapter concludes with a detailed description of the activities and services they provide (Section 4.6). Data derive from a questionnaire sent to and completed by all 49 centres. Throughout the chapter findings are presented separately for small, medium and large centres as well as for all 49 centres combined.

4.1. Geographic Distribution of B.C. Centres

Table 1 shows the geographic distribution of the 49 Adult Day Care centres in B.C., cross-tabulated by size (i.e. by the number of clients served). As can be seen, exclusive of the City of Vancouver, 16 centres (32.7%) are located in the Lower Mainland and the Fraser Valley, 13 (26.5%) are located on Vancouver Island and the South Coastal Region, 12 (24.5%) are in the City of Vancouver, and 8 (16.3%) are in the interior region of the province.

In terms of size, 13 (26.5%) are small, serving from 1-29 clients; 21 (42.9%) are medium sized (30-69 clients), while 15 (30.6%) are large (70-121 clients).

Of the centres in the Lower Mainland-Fraser Valley and on Vancouver Island and the Coastal Region, approximately one-quarter are small, half are medium sized and one-quarter are large; in the Interior the three size groupings are fairly equally represented while in Vancouver one-sixth are small, one-third are medium sized and half are large.

When the urban-rural distribution of the centres was examined, it was apparent that 38 (77.6%) of the centres were in urban locations (i.e. in communities with a population of over 10,000).

Table 1

GEOGRAPHIC DISTRIBUTION OF ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%*	n	%*	n	%*	n	%**
Location								
L.M.-Fraser Valley	4	25.0	8	50.0	4	25.0	16	32.7
Van. Isl. & S. Coast	4	30.8	6	46.2	3	23.1	13	26.5
Vancouver	2	16.7	4	33.3	6	50.0	12	24.5
Interior	3	37.5	3	37.5	2	25.0	8	16.3

* row percentages
** column percentages

4.2. Affiliation Arrangements

As shown in Table 2, 13 centres (26.5%) are not part of or affiliated with any other organization. Among those with affiliation arrangements, 22 are affiliated with a facility offering Personal, Intermediate and/or Extended Care; 4 with a hospital-based Extended Care Unit; 4 with a Community Centre or Seniors' Centre; and 2 with a Home Support Agency. Of the remaining four, one is affiliated with the geriatric rehabilitation department of an acute hospital; one with a seniors' housing complex, seniors' recreation centre and a care facility; one with an agency offering multiple services to seniors; and one with a community centre, care facility and municipal health department.

Of the 36 centres affiliated with other organizations, 30 share space, 27 share programs, 26 share staff and 26 share other resources (e.g. equipment, meal and transportation services, board, volunteers) with these other organizations.

Table 2

AFFILIATION ARRANGEMENTS OF ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%**	n	%**	n	%**	n	%**
Affiliation								
No affiliation	2	15.4	5	23.8	6	40.0	13	26.5
Community care facility (PC, IC and/or EC)	10	76.9	8	38.1	4	26.7	22	44.9
Hospital-based extended care unit	0	0.0	4	19.0	0	0.0	4	8.2
Community/seniors centre	1	7.7	0	0.0	3	20.0	4	8.2
Home support agency	0	0.0	2	9.5	0	0.0	2	4.1
Acute hospital	0	0.0	0	0.0	1	6.7	1	2.0
Agency offering multiple services to seniors	0	0.0	1	4.8	0	0.0	1	2.0
Seniors housing complex, rec. centre & care facility	0	0.0	0	0.0	1	6.7	1	2.0
Community centre, care facility, & munic. health department	0	0.0	1	4.8	0	0.0	1	2.0

** column percentages

4.3. **Level of Care of Clients**

At the time of the survey (December, 1989) the 49 Centres combined served 2,642 clients.

As shown in Table 3, the care level distribution for the total sample and for all three centre size groupings is the same. In all, Intermediate Care I clients are most commonly represented, followed by Intermediate Care II and then Personal Care clients. While their representation is slightly higher in the small centres, clients at the Intermediate Care III and at the Extended Care level are a distinct minority.

Table 3

LEVEL OF CARE OF CLIENTS SERVED BY ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE DECEMBER, 1989

	Number of Clients Served							
	1-29		30-69		70-121		Total	
	n	%**	n	%**	n	%**	n	%**
Level of Care								
Personal Care	37	16.7	202	19.3	287	19.9	526	20.4
Intermediate Care I	91	41.2	385	36.7	503	37.1	979	38.0
Intermediate Care II	45	20.4	279	26.6	349	27.8	673	26.2
Intermediate Care III	29	13.1	90	8.6	85	7.7	204	7.9
Extended	18	8.1	71	6.8	47	5.2	136	5.3
Unclassified	1	0.5	22	2.1	32	2.3	55	2.1
Total # of clients	221		1049		1303		2573	

** column percentages

4.4. Operating Characteristics

4.4.1. Hours of Operation

Thirty, or approximately two-thirds (61.2%), of the centres operate five days a week, 4 (8.2%) are open four days a week, 6 (12.2%) three days and 9 (18.4%) only two days.

Of the 30 centres open five days a week, most operate regular business hours (i.e. 9-5). Of the 19 centres open less than five days a week, 4 are open 4-6 hours a day, 13 from 7-8 hours and 2 from 8.5-11.5 hours.

As shown in Table 4, the proportion in operation five days a week increases as centre size increases (i.e. from 23.1% among the small centres to 66.7% among the medium sized centres to 86.7% among the large centres).

Table 4

NUMBERS OF DAYS PER WEEK ADULT DAY CARE CENTRES IN BRITISH COLUMBIA ARE IN OPERATION, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%**	n	%**	n	%**	n	%**
<u>Days per week</u>								
2	6	46.2	3	14.3	0	0.0	9	18.4
3	4	30.8	1	4.8	1	6.7	6	12.2
4	0	0.0	3	14.3	1	6.7	4	8.2
5	3	23.1	14	66.7	13	86.7	30	61.2

** column percentages

4.4.2. **Transportation To/From Centre**

When asked explicitly "Do you provide transportation to and from the Adult Day Care Centre to some or all of your clients?" 42 centres (85.7%) said "yes." As shown in Table 5, a variety of transportation modes are used. These include HandyDART which is arranged for by 32 (76.2%) of the 42 centres providing transportation. In 29 (69.0%) of the centres, transportation is provided via a vehicle owned by the centre or by the facility/service it is affiliated with. Publicly supported transportation, other than HandyDART, is arranged for by 4 centres (9.5%). A small proportion of centres (4.8%) use a private transportation service. More than a third of centres (42.9%) report arranging other means of transportation including delivery and pick-up via private cars belonging to the client's family, to staff, or to volunteers.

It is interesting to note that 19 of the 42 centres (45.2%) providing transportation use one kind exclusively (usually the centre or affiliated agency-owned vehicle); 23 (54.8%) use two or more kinds of transportation.

It is also interesting to note that the proportion having a centre-owned vehicle or use of one owned by an affiliated organization was only slightly greater in large centres (71.4%) than in mid-sized (70.1%) and small centres (63.9%).

Table 5

TRANSPORTATION TO/FROM ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Transporation Provided								
Yes	11	84.6	17	80.9	14	93.3	42	85.7
Transporation Type***	(n=11)		(n=17)		(n=14)		(n=42)	
HandyDART	7	63.6	12	70.1	13	92.9	32	76.2
Centre vehicle	7	63.6	12	70.1	10	71.4	29	69.0
Other publicly supported transp.	1	9.1	0	0.0	3	21.4	4	9.5
Private service	1	9.1	0	0.0	1	7.1	2	4.8
Other (staff, family or volunteer car; Legion bus)	4	36.4	6	35.3	8	57.1	18	42.9

*** column cannot be summed as multiple responses were permitted

4.4.3 Fees Charged

Forty-five of the 49 centres (91.8%) charge clients a per diem fee. In the case of Long Term Care Program clients, the fee ranges from $1-$8 per day, with most centres (80.0%) charging $3-$4.

Twenty-four (49.0%) of the centres serve private as well as Long Term Care Program clients. One of these centres does not charge its private clients; two charge them the same rate as their Long Term Care Program clients ($3-$5 per day), while 21 have a differential fee for private

clients ranging from $24-$52 per day. It is interesting to note that only two (15.4%) of the small centres serve private clients, compared with 12 (57.1%) of the medium sized and 10 (66.6%) of the large sized centres and, that the fee charged to private clients increases with centre size (9 of the 10 large agencies charge private clients more than $40 per day).

4.4.4. Average Daily Census

The number of clients served per day varies considerably across centres, particularly among those in the small and medium size ranges.

Table 6

AVERAGE NUMBER OF CLIENTS PER DAY ATTENDING ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%**	n	%**	n	%**	n	%**
Average No.								
1-5	3	23.1	0	0.0	0	0.0	3	6.1
6-10	6	46.1	10	47.6	0	0.0	16	32.6
11-15	4	30.8	6	28.6	2	13.3	12	24.5
16-20	0	0.0	4	19.0	7	46.7	11	22.4
21-25	0	0.0	1	4.8	6	40.0	7	14.3
Mean	8.4		11.6		22.0		13.6	
Range	1-13		7-22		12-25		1-25	

** column percentages

As shown in Table 6, among the small centres, approximately one-third serve an average of 1-5 clients per day, one-third serve 6-10 clients per day and one-third serve 11-15 clients per day. Among the medium sized centres approximately half serve 6-10 clients, approximately one-quarter serve 11-15 and one-quarter 16-20. The large centres are more uniform, 86.7% serving between 16 and 25 clients per day.

4.4.5. **Average Frequency of Attendance per Week**

Table 7 shows the average number of days individual clients attend the centres per week. As can be seen, in 21 (42.9%) of the centres, clients attend an average of only one day per week, in 25 (51.0%) of the centres, they average 2 days per week, while in 3 (6.1%) centres, clients generally attend 3 days per week. Two of these latter centres are small and one is mid-sized.

Table 7

AVERAGE FREQUENCY OF ATTENDANCE PER WEEK, ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%**	n	%**	n	%**	n	%**
<u>Days per week</u>								
1	5	38.5	9	42.9	6	40.0	20	40.8
2	6	46.2	10	47.6	9	60.0	25	51.0
3	2	15.4	2	9.5	0	0.0	4	8.2
Mean		1.8		1.7		1.6		1.7

** column percentages

4.4.6. Number of Clients Admitted in Last 12 Months

Table 8 shows the average number of clients admitted to Adult Day Care centres in British Columbia in the twelve months prior to conduct of the study. As can be seen, approximately three-quarters (76.9%) of the small centres reported admitting from 5-25 clients. Among the mid-sized centres just over half (52.4%) reported admitting from 26-50 clients. The modal admission category among the large centres was 51-75.

Table 8

NUMBER OF CLIENTS ADMITTED IN LAST 12 MONTHS
ADULT DAY CARE IN BRITISH COLUMBIA,
BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%**	n	%**	n	%**	n	%**
No. Admitted								
5-25	10	76.9	4	19.0	0	0.0	14	28.6
26-50	2	15.4	11	52.4	5	33.3	18	36.7
51-75	1	7.7	4	19.0	7	46.7	12	24.5
76-100	0	0.0	1	4.8	2	13.3	3	6.1
101-125	0	0.0	1	4.8	1	6.7	2	4.1
Mean	20.7		42.1		63.7		43.9	
Range	7-66		5-121		31-125		5-125	

** column percentages

4.4.7. **Wait lists**

Nine (69.2%) of the small centres, 12 (57.1%) of the medium sized centres and 11 (73.3%) of the large centres have a wait list. The number on the wait list varies considerably across centres (from 2-46 persons) as does the average wait time (from 1-12 months).

The average wait time tends to decrease as size increases (mean wait time for small centres is 4.1 months, for medium centres 3.2 months and for large centres 1.6 months).

4.5. <u>Staffing</u>

4.5.1. **Full vs. Part-time staff**

Thirty-seven centres (75.5%) have one or more full-time staff. These include 7 (53.8%) of the small centres, 17 (81.0%) of the medium sized centres and 13 (86.7%) of the large centres.

4.5.2. **Type of Staff Employed/Available for Consultation**

As can be seen in Table 9, 45 (91.8%) of the centres have a designated administrator/coordinator. Of the four centres that do not, all are affiliated with another organization which provides direction for the workers.

Most centres (81.6%) employ one or more program workers (in some centres called a "bath aide" or "care aide"). Other staff employed by 36.7% to 59.2% of the centres include a nurse, a secretary/ bookkeeper, a cook and a transport worker. These latter three positions were much more likely to be present in large than in mid-sized or small centres.

Table 9

TYPE OF STAFF EMPLOYED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Type of Staff***								
Administrator/ coordinator	11	84.6	19	90.5	15	100.0	45	91.8
Program worker	9	69.2	18	85.7	13	86.7	40	81.6
Nurse	6	46.2	13	61.9	10	66.7	29	59.2
Sec./bookeeper	6	46.2	9	42.9	11	73.3	26	53.1
Cook	4	30.8	7	33.3	10	66.7	21	42.9
Transport worker	3	23.1	6	28.6	9	60.0	18	36.7
Asst. director	1	7.7	2	9.5	2	13.3	5	10.2
Music therapist	1	7.7	1	4.8	3	20.0	5	10.2
Occupat. therapist	1	7.7	2	9.5	0	0.0	3	6.1
Physiotherapist	2	15.4	0	0.0	1	6.7	3	6.1
Social worker	1	7.7	0	0.0	1	6.7	2	4.1
Housekeeper/janitor	1	7.7	1	4.8	0	0.0	2	4.1
Education officer	0	0.0	1	4.8	0	0.0	1	2.0
Fitness consultant	0	0.0	0	0.0	1	6.7	1	2.0
Dietician	1	7.7	0	0.0	0	0.0	1	2.0
Arts & crafts coordinator	0	0.0	0	0.0	1	6.7	1	2.0
Social/recreational coordinator	0	0.0	0	0.0	1	6.7	1	2.0

*** columns cannot be summed as multiple response were permitted

While some of the professionals listed in Table 9 are not highly represented in the actual staff of even the large centres, access to them on a consultative basis is common. For example (see Table 10), all centres not having a nurse on staff report having access to nursing services. While only one centre reports having a dietician as a regular employee, 46 indicate access to a consultant dietician. Similarly, 39 centres report access to a physiotherapist, 36 to a pharmacist, 31 to a social worker and 29 to an occupational therapist.

Table 10

CONSULTATIVE SERVICES USED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Type of Consultant***								
Dietician	10	76.9	21	100.0	15	100.0	46	93.9
Physiotherapist	9	69.2	19	90.5	11	73.3	39	79.6
Pharmacist	10	76.9	16	76.2	10	66.7	36	73.5
Social worker	8	61.5	14	66.7	9	60.0	31	63.3
Occupat. therapist	3	23.1	13	61.9	13	86.7	29	59.2
Recreational therapist	8	61.5	12	57.1	7	46.7	27	55.1
Psychiatrist	7	53.9	11	52.4	8	53.3	26	53.1
Audiologist	2	15.4	14	66.7	10	66.7	26	53.1
Speech Therapist	4	30.8	12	57.1	9	60.0	25	51.0
Psychologist	8	61.5	9	42.9	7	46.7	24	49.0
Nurse	6	46.2	9	42.9	5	33.3	20	40.8
Music therapist	5	38.5	8	38.1	7	46.7	20	40.8
Geriatrician	3	23.1	6	28.6	5	33.3	14	28.6
Art Therapist	3	23.1	6	28.6	2	13.3	11	22.5

*** columns cannot be summed as multiple response were permitted

4.5.3. **Use of Volunteers**

Nine of the small centres (69.2%), 15 of the medium sized centres (71.4%) and 14 (93.3%) of the large centres make regular use of volunteers. In some cases, these are individuals who were at one time themselves clients of the centre.

4.6. Activities and Services

In attempting to ascertain which services and activities the agencies offered, questions were grouped under ten broad headings: Health Care Services, Personal Care Services, Transportation Other Than To and From the Adult Day Care Centre, Social Services, Therapeutic Activities, Recreational and Social Services, Educational Programs, Client Volunteer Activities, Quiet Time Activities and Meals.

4.6.1. **Health Care Services**

Overall, the health care services most commonly offered by the centres were, respectively, podiatry/footcare (91.8% of the centres), nutrition counselling (87.8%), monitoring of blood pressure, heart rate, blood sugar, etc. (81.6%), changing of medical dressings (75.5%), arranging medical appointments (75.5%), and administering medications (73.5%).

The most noticeable differences between centres in the three size categories (see Table 11) were in the proportion administering medications (more than 76% in the mid-size and large centres compared with only 53.9% in the small centres); the proportion offering dental care and hearing screening (approximately half of the large centres, a quarter of the mid-sized and only 7.7% of the small centres), and in the proportion providing/arranging for Medic Alert bracelets, necklace etc. (60.0% of the large centres, 47.6% of the medium sized centres and 30.8% of the small centres).

Table 11

HEALTH CARE SERVICES PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Health Care Services***								
Podiatry/footcare	11	84.6	19	90.5	15	100.0	45	91.8
Nutrition counselling	12	92.3	19	90.5	12	80.0	43	87.8
Monitor blood pressure heart rate, blood sugar, weight, etc.	11	84.6	16	76.2	13	86.7	40	81.6
Change medical dressings	10	76.9	15	71.4	12	80.0	37	75.5
Arrange medical appointments	9	69.2	15	71.4	13	86.7	37	75.5
Administer meds.	7	53.9	16	76.2	13	86.7	36	73.5
Monitor compliance with med. schedule	9	69.2	12	57.1	12	80.0	33	67.3
Review clients' meds.	10	76.9	13	61.9	10	66.7	33	67.3
Skin care (rubs, etc.)	9	69.2	12	57.1	10	66.7	31	63.3
Obtain equipment for clients (wheel-chair, glasses, adaptive clothes, etc.)	7	53.9	11	52.4	10	66.7	28	57.1
Provide/arrange for Medic Alert bracelet, necklace, etc.	4	30.8	10	47.6	9	60.0	23	46.9
Maintain client equip. (wheelchair, clothing etc.)	5	38.5	12	57.1	5	33.3	22	44.9
Provide/arrange for Vial of Life	4	30.8	5	23.8	6	40.0	15	30.6
Dental Care	1	7.7	6	28.6	7	46.7	14	28.6
Provide emergency alert services (eg. Life Line)	2	15.4	6	28.6	4	26.7	12	24.5
Hearing Screening	1	7.7	4	19.0	7	46.7	12	24.5
Vision Screening	1	7.7	1	4.8	4	26.7	6	12.2

*** columns cannot be summed as multiple responses were permitted

4.6.2. **Personal Care Services**

As shown in Table 12, the personal care service most frequently offered is grooming: 77.6% of the centres offer this service. From half to just under three-quarters in all three size categories also bath clients and take them on shopping trips. A noticeable difference between centre size groupings is in the proportion mending/altering clients' clothes: 46.7% of the large centres offer this service compared with fewer than 15% of the mid-sized and small centres. Small centres, on the other hand, are more likely to offer bathing service to non-ADC clients.

Table 12

PERSONAL CARE SERVICES PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Personal Care Services***								
Personal grooming	10	76.9	15	71.4	13	86.7	38	77.6
Taking clients on shopping trips (for food, clothing, etc.)	7	53.9	12	57.1	11	73.3	30	61.2
Bath (ADC clients)	9	69.2	12	57.1	8	53.3	29	59.2
Mend/alter clients' clothes	2	15.4	1	4.8	7	46.7	10	20.4
Bath (non-ADC clients)	3	23.1	1	4.8	2	13.3	6	12.2

*** columns cannot be summed as multiple responses were permitted

4.6.3. **Transportation (other than to/from ADC)**

As shown in Table 13, approximately two-thirds of the mid-sized and large centres and all of the small centres transport clients to/from social and/or recreational events. Approximately half in each size category provide transportation for shopping. Half of the large centres and approximately a third of the mid-size and small centres also provide transportation for medical appointments. One of the large centres also transports clients from hospital in a wheel-chair equipped bus.

Table 13

TRANSPORTATION SERVICES (Other than to/from ADC) PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Type of Transportation***								
For social/recreational events	13	100.0	13	61.9	10	66.7	36	73.5
For shopping	7	53.9	9	42.9	7	46.7	23	46.9
For medical appointments	4	30.8	7	33.3	8	53.3	19	38.8

*** columns cannot be summed as multiple responses were permitted

4.6.4. **Social Services**

There was considerable similarity across size groupings in the social services most frequently offered.

As shown in Table 14, three-quarters or more in each grouping provide information and referral to other services; counsel clients, caregivers and/or their families; liaise between clients and other social service agencies; and follow-up clients after hospitalization. More than three-quarters of the mid-sized and large centres and two-thirds of the small centres provide telephone checks. More than 70% of the mid-size and large centres and just over half of the small centres advocate on behalf of clients.

While from 62-76% of the centres of all size groupings read letters for clients, a noticeably larger proportion of small centres (69.2%) than of mid-size or large centres (40-43%) write letters for clients. Pastoral services are also most frequently offered in small centres.

Table 14

SOCIAL SERVICES PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Social Services***								
Information and referral to other services	13	100.0	19	90.5	15	100.0	47	95.9
Counsel clients, caregivers and/or families	12	92.3	20	95.2	14	93.3	46	93.9
Liaise between client and other social service agencies	13	100.0	19	90.5	14	93.3	46	93.9
Follow-up clients after hospital.	10	76.9	18	85.7	14	93.3	42	85.7
Telephone check clients	9	69.2	17	81.0	14	93.3	40	81.6
Client Advocacy	7	53.9	15	71.4	12	80.0	34	69.4
Letter reading for clients	10	76.9	13	61.9	10	66.7	33	67.3
Coordinate various agencies involved with client	9	69.2	14	66.7	9	60.0	32	65.3
Visit client in his/her home	8	61.5	11	52.4	8	53.3	27	55.1
Visit client in hospital	8	61.5	11	52.4	8	53.3	27	55.1
Letter writing for clients	9	69.2	9	42.9	6	40.0	24	49.0
Pastoral services	8	61.5	9	42.9	6	40.0	23	46.9
Operate special interest groups (stroke, weight control, diabetic)	6	46.2	2	9.5	6	40.0	14	28.6
Set up client telephone network	4	30.8	6	28.6	3	20.0	13	26.5
Locate suitable housing	4	30.8	5	23.8	3	20.0	12	24.5
Other social services activities	3	23.1	3	14.3	5	33.3	11	22.4

*** columns cannot be summed as multiple responses were permitted

4.6.5. Therapeutic Activities

As shown in Table 15, all but one of the 49 centres reported offering exercise classes as a therapeutic activity.

Other therapeutic activities provided by 80% or more in each size grouping included: reminiscence therapy, assisting clients with management of incontinence, reality orientation, sensory stimulation, and physiotherapy.

While from 46-60% in each size grouping reported providing whirlpool therapy, only half of the large centres and fewer than one-third of the mid-sized and small centres offered swimming as a therapeutic activity. Stress management programs are also more common in large centres. Small centres, on the other hand, are more likely to offer music therapy, teach meal planning and cooking skills and offer training or retraining in activities of daily living than middle and large sized centres.

Table 15

THERAPEUTIC ACTIVITIES PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Therapeutic Activities***								
Exercise class (as therapeutic activity)	13	100.0	20	95.2	15	100.0	48	98.0
Reminiscence therapy	12	92.3	19	90.5	15	100.0	46	93.9
Management of incontinence/toilet training	11	84.6	18	85.7	15	100.0	44	89.8
Reality Orientation	12	92.3	17	81.0	13	86.7	42	85.7
Sensory stimulation	11	84.6	19	90.5	13	86.7	43	87.8
Physiotherapy (rehabilitation, assisting in mobility)	11	84.6	17	81.0	13	86.7	41	83.7
Music therapy	12	92.3	12	57.1	11	73.3	35	71.4
Training/retraining in ADL	10	76.9	14	66.7	7	46.7	31	64.6
Whirlpool therapy	6	46.2	10	47.6	9	60.0	25	51.0
Stress management	6	46.2	8	38.1	9	64.3	23	46.9
Teach meal planning & cooking skills	10	76.9	6	28.6	5	33.3	21	42.9
Swimming (as therapeutic activity)	4	30.8	6	28.6	8	53.3	18	36.7
Art therapy	4	30.8	7	33.3	6	40.0	17	34.7

*** columns cannot be summed as multiple responses were permitted

4.6.6. Recreational and Social Activities

As shown in Table 16, in the area of recreational and social activities, the centres were highly similar. Virtually all reported offering arts and crafts, games (eg. card, bingo), visiting entertainment, outdoor activities (eg. walks, picnics, barbecues) as well as special meals. More than three-quarters in each size grouping also reported offering baking and cooking as a social activity, physical recreation (eg. bowling, swimming), client socials and social activities involving families.

Other activities offered by two-thirds or more of each size grouping included pet visits to the centre, gardening, day excursions and activities involving community groups.

Table 16

RECREATIONAL AND SOCIAL ACTIVITIES OFFERED
BY ADULT DAY CARE CENTRES
IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Recreational and Social Activities***								
Arts and crafts	13	100.0	21	100.0	15	100.0	49	100.0
Games (cards, bingo, etc.)	13	100.0	21	100.0	15	100.0	49	100.0
Visiting entertainment at the centre	13	100.0	21	100.0	15	100.0	49	100.0
Outdoor activities (walks, picnics, barbeques, etc.)	13	100.0	20	95.2	15	100.0	48	98.0
Special meals (such as birthday parties, holidays	13	100.0	20	95.2	15	100.0	48	98.0
Client socials	13	100.0	19	90.5	13	86.7	45	91.8
Baking and cooking as a social activity	13	100.0	20	95.2	12	80.0	45	91.8
Day excursions	13	100.0	19	90.5	11	73.3	43	87.8
Social excursions involving families	12	92.3	17	81.0	13	86.7	42	85.7
Pet visits to the centre	12	92.3	15	71.4	13	86.7	40	81.6
Physical recreation (bowling, swimming, etc.)	10	76.9	17	81.0	12	80.0	39	79.6
Gardening	8	61.5	18	85.7	12	80.0	38	77.6
Activities involving community groups (regular school children visits, etc.)	10	76.9	14	66.7	13	86.7	37	75.5
Overnight excursions	4	30.8	4	19.0	4	26.7	12	24.5
Pet care (of pets at ADC)	2	15.4	4	19.0	5	33.3	11	22.4
Computer activities	1	7.7	2	9.5	1	6.7	4	8.2
Other recreational & social activities	6	46.2	6	28.6	8	53.3	20	40.8

*** columns cannot be summed as multiple responses were permitted

4.6.7. Educational Programs

Three-quarters or more of the centres in each size grouping offer information about community resources, provide current events programs, information about preventative health measures and information about safety in the home. More than three-quarters of the small and large centres and two-thirds of the mid-sized centres offer information about safety outside the home.

As shown in Table 17, information about wills and financial planning is more commonly provided by large centres than by mid-sized or small ones (eg. 53.3% of the large centres provide information about wills compared with 29-31% of the small and mid-sized centres).

Education of clients about living wills is relatively infrequent. Only from 15-24% of the centres in each of the three size groupings provide information on this topic.

Table 17

EDUCATIONAL PROGRAMS PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Educational Program***								
Information about community resources	13	100.0	18	85.7	15	100.0	46	93.9
Current events	12	92.3	18	85.7	15	100.0	45	91.8
Preventative health measures	12	92.3	17	81.0	14	93.3	43	87.8
Safety in the home	10	76.9	16	76.2	14	93.3	40	81.6
Safety outside the home	11	84.6	14	66.7	14	93.3	39	79.6
Wills	4	30.8	6	28.6	8	53.3	18	36.7
Financial planning	3	23.1	5	23.8	6	40.0	14	28.6
Living Wills	2	15.4	5	23.8	3	20.0	10	20.4
Other	4	30.8	3	14.3	8	53.3	15	30.6

*** columns cannot be summed as multiple responses were permitted

4.6.8. **Client Volunteer Activities**

As shown in Table 18, opportunities to participate in the running of the centre and to aid other clients are greater at large centres than at mid-sized or small centres. Small centres, on the other hand, appear to provide greater opportunity for doing volunteer work for the community.

Table 18

CLIENT VOLUNTEER ACTIVITIES AT ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
<u>Client Volunteer Activities</u>***								
Client participation in running the centre	8	61.5	14	66.7	12	80.0	34	69.4
Doing volunteer work for other clients	8	61.5	12	57.1	12	80.0	32	65.3
Doing volunteer work for the community	6	46.2	5	23.8	5	33.3	16	32.7
Other client volunteer activities	3	23.1	0	0.0	6	40.0	9	18.4

*** columns cannot be summed as multiple responses were permitted

4.6.9. Quiet Time Activities

Virtually all of the centres offer clients an opportunity to rest or to engage in quiet conversation.

A very noticeable difference between size groupings was in the proportion of centres reporting T.V. watching as a quiet time activity. As shown in Table 19, the proportion increases from 20% among the large centres to 48% of the mid-sized centres and to 69% among the small centres. Taken together with differences in "other" quiet time activities, the findings suggest that large centres have a greater variety of quiet time activities than small or mid-sized centres.

Table 19

QUIET TIME ACTIVITIES AT ADULT DAY CARE CENTRES
IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served						Total	
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		(n=49)	
	n	%	n	%	n	%	n	%
Quiet Time Activities***								
Conversation	13	100.0	21	100..0	15	100.0	49	100.0
Rest	12	92.3	20	95.2	14	93.3	46	93.9
Reading	11	84.6	19	90.5	15	100.0	45	91.8
Watching T.V.	9	69.2	10	47.6	3	20.0	22	44.9
Other	3	23.1	9	42.9	8	53.3	20	40.8

*** columns cannot be summed as multiple responses were permitted

4.6.10. **Meals**

As shown in Table 20 virtually all of the centres offer a hot meal. Most also offer snacks.

A noticeable difference between size groupings was in the proportion offering take-home meals (40% of the large centres compared with 19% of the mid-sized centres and only 8% of the small centres).

Table 20

MEALS PROVIDED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=13)		30-69 (n=21)		70-121 (n=15)		Total (n=49)	
	n	%	n	%	n	%	n	%
Meal***								
Hot meals at day care	13	100.0	20	95.2	15	100.0	48	98.0
Snack at day care	11	84.6	20	95.2	15	100.0	46	93.9
Take home meals	1	7.7	4	19.0	6	40.0	11	22.4

*** columns cannot be summed as multiple responses were permitted

5.0. PHASE II FINDINGS

This chapter describes the characteristics of a sample of 479 individuals admitted to 22 Adult Day Care centres in British Columbia between December, 1988 and November, 1989. First described (Section 5.1) are their socio-demographic characteristics -- age, proportion male and female, marital status, housing and household composition. Their level of care distribution is presented next (Section 5.2.). This is followed with descriptions of their medical conditions (Section 5.3.), the number of medications they consume (Section 5.4.), their communication ability (Section 5.5.), their level of performance of activities of daily living (Section 5.6.), their self-care ability (Section 5.7.) and finally, their mental health status (Section 5.8).

As in Chapter 4, data are presented separately for small centres (1-29 clients), mid-sized centres (30-69 clients) and large centres (70-121 clients). As will quickly be seen, however, there were very few differences in the characteristics of the clients each centre size grouping serves.

In interpreting the tables in this chapter it should be noted that percentages do not include missing data. The presentation format was changed from that used in Chapter 4 because the client data was less complete than the data describing the centres' operating characteristics and the activities and services they offer.

It should also be noted (see Section 3.0) that data concerning client characteristics derive from the Long Term Care Program's standard assessment form (i.e. Form LTC-I), the service provider's copy of which was photocopied and sent to the research team with the client's name and other identifying information removed.

The missing data problem stems from two sources. In some cases it is a result of centres having received incomplete copies of the LTC-I form. That is, instead of sending them pages 1-4 inclusive, one or more of these pages, most frequently page 4, has been withheld by Long Term Care. (Only page 5, in fact, needs to be withheld since it contains

confidential information concerning clients' financial status). This is an example of the information transmission difficulties respondents in Focus Group III indicated some centres experience in dealing with the Long Term Care Program. In other cases, the missing data problem derives from the form not having being fully filled out by the case manager. Evidence of this is contained in Tables 21-28. As can be seen, on all items for which columns can be added there is some missing data, including even the clients' sex (Table 21).

5.1. Socio-demographic Characteristics of New B.C. Adult Day Care Clients

As shown in Table 21, which presents clients' socio-demographic characteristics, approximately two-thirds of the clients in each centre size grouping were female. Just under half of all clients were widowed with the second most common marital status being married. Cross-tabulation of sex by marital status (not shown) indicated, as expected, that a higher proportion of males (73.2%) than females (22.6%) were married.

Overall, the mean age of clients was 78.9 years. In all three size groupings more than 70% were aged 75 and over. In the sample as a whole, 240 of the 446 for whom age data were available (53.8%)) were aged 80 or over. Further, although only 6.1% were under age 65, the broad age range represented within the Adult Day Care population (31 - 102 years) should be noted.

As far as housing and living arrangements are concerned, the data indicate that over half the clients in each size grouping lived in a house in the community; a further third lived in an apartment. Two percent or less lived in a care facility. Only approximately one-third of the clients lived alone.

Table 21

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Characteristic								
Sex								
Male	16	30.2	52	34.9	108	39.3	176	36.9
Female	37	69.8	97	65.1	167	60.7	301	63.1
Missing data			(1)		(1)		(2)	
Marital Status								
Single	1	2.0	11	7.9	14	5.3	26	5.7
Married	25	49.0	57	40.7	108	40.2	190	41.9
Widowed	24	47.0	65	46.4	126	48.1	215	47.5
Divorced/Separated	0	0.0	7	5.0	13	5.0	20	4.4
Other	1	2.0	0	0.0	1	0.4	2	0.4
Missing data	(2)		(10)		(14)		(26)	
Age								
<65	2	3.9	11	8.2	14	5.4	27	6.1
65-74	10	19.2	27	20.0	46	17.8	83	18.6
75-84	28	53.9	58	43.0	125	48.3	211	47.3
85+	12	23.1	39	28.9	74	28.6	125	28.0
Mean	78.6		78.3		79.3		78.9	
S.D.	6.9		10.6		9.4		9.5	
Range	57-92		44-101		31-102		31-102	
Missing data	(1)		(15)		(17)		(33)	
Housing								
House	28	58.3	62	53.9	132	56.9	222	56.2
Apartment	16	33.3	41	35.7	82	35.3	139	35.2
Room	0	0.0	5	4.4	1	0.4	6	1.5
Care facility	1	2.1	1	0.9	3	1.3	5	1.3
Other	3	6.3	6	5.2	14	6.0	23	5.8
Missing data	(5)		(35)		(44)		(84)	
Household Composition								
Lives alone	12	26.7	35	31.3	70	29.2	117	29.5
With spouse	17	37.8	46	41.1	100	41.7	163	41.1
Other adult male	1	2.2	9	8.0	25	10.4	35	8.8
Other adult female	4	8.9	11	9.8	27	11.3	42	10.6
Children	11	24.5	11	9.8	18	7.5	40	10.1
Missing data	(8)		(37)		(36)		(82)	

** column percentages

5.2. **Level of Care**

Similar to the level of care distribution for all Adult Day Care clients in the province (see Section 4.3), among this sample of new admissions, clients at the Intermediate Care I level were most highly represented (46.3%) followed respectively by Intermediate Care II (22.6%), Personal Care (18.4%), Intermediate Care III (7.7%) and Extended Care (5.0%). As shown in Table 22, this pattern was exactly reflected in the large and small centres. In the mid-sized centres, there was a slightly higher proportion at the Personal than at the Intermediate I care level.

Table 22

LEVEL OF CARE OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Recommended LTC Level								
Personal Care	5	9.6	27	18.1	52	20.4	84	18.4
Intermediate Care I	26	50.0	74	49.7	111	43.5	211	46.3
Intermediate Care II	11	21.2	25	16.8	67	26.3	103	22.6
Intermediate Care III	8	15.4	16	10.7	11	4.3	35	7.7
Extended Care	2	3.9	7	4.7	14	5.5	23	5.0
Missing data	(1)		(1)		(21)		(23)	

** column percentages

5.3. **Medical Conditions**

As shown in Table 23, in all three centre size groupings, clients' most common medical conditions were the ICD-9 categories "diseases of the circulatory system" and "diseases of the musculoskeletal system and connective tissue." From 43-61% of clients in each size grouping suffered from these conditions. The next most common conditions, exhibited in 34-51% of clients in each grouping, were "diseases of the nervous system and sense organs" and "mental disorders." (See Appendix 1 for a description of the specific diseases included in each of the ICD categories listed in Table 23.)

Table 23

MEDICAL CONDITIONS OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%	n	%	n	%	n	%
Medical conditions***								
Diseases of circulatory system	31	58.5	91	60.7	191	58.7	284	59.3
Diseases of musculoskeletal system & connective tissue	31	58.5	64	42.7	120	43.5	215	44.9
Diseases of nervous system & sense organs	19	35.8	72	48.0	99	35.9	190	39.7
Mental disorders	27	50.9	51	34.0	103	37.3	181	37.8
Endocrine, nutritional & metabolic diseases	14	26.4	28	18.7	51	18.5	93	19.4
Diseases of digestive system	15	28.3	34	22.7	44	15.9	93	19.4
Diseases of genitourinary system	6	11.3	21	14.0	42	15.2	69	14.4
Symptoms & ill-defined conditions	9	17.0	10	6.7	38	13.8	57	11.9
Diseases of Respiratory system	2	3.8	19	12.7	36	13.0	57	11.9
Accidents, poisoning & violence	1	1.9	10	6.7	20	7.2	31	6.5
Diseases of skin & subcutaneous tissue	1	1.9	7	4.7	17	6.2	25	5.2
Neoplasms	1	1.9	3	2.0	13	4.7	17	3.5
Diseases of blood & blood-forming organs	1	1.9	4	2.7	9	3.3	14	2.9
Infective & parasitic diseases	0	0.0	3	2.0	1	0.4	4	0.8

** columns cannot be summed as some clients had more than one medical condition

5.4. Medication Consumption

Table 24, shows the number of medications consumed by new admissions to Adult Day Care centres in British Columbia. As can be seen, only a minority (9.5%) of Adult Day Care clients consume no medications. Just over half (60.7%) consume from 1-4. A small proportion (6.8%) consume 8 or more.

Table 24

NUMBER OF MEDICATIONS CONSUMED BY NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Number of medications								
0	3	6.3	13	9.2	27	10.2	43	9.5
1	5	10.4	17	12.0	32	12.1	54	11.9
2	10	20.8	19	13.4	58	22.0	87	19.2
3	7	14.6	22	15.5	33	12.5	62	13.7
4	11	22.9	27	19.0	34	12.9	72	15.9
5	3	6.3	16	11.3	24	9.1	43	9.5
6	0	0.0	11	7.7	21	8.0	32	7.0
7	5	10.4	7	4.9	18	6.8	30	6.6
8+	4	8.3	10	7.0	17	6.4	31	6.8
Missing data	(5)		(8)		(12)		(25)	
Range	0-11		0-16		0-11		0-16	

** column percentages

5.5. Communication Ability

Among those for whom data were available, 89.4% were found to wear glasses and 15.2% to use a hearing aid.

Table 25 details the vision, hearing, speech and understanding abilities of new admissions to Adult Day Care in British Columbia. As can be seen, four-fifths (79.0%) of clients have some degree of visual impairment. However, with glasses, 95% have sufficient vision for personal safety. One-half (49.7%) have a hearing impairment, but again, most (99%) have sufficient aural sensitivity for personal safety.

Thirteen percent of the sample were impaired for speech and 14% for understanding.

Table 25

COMMUNICATION ABILITY OF NEW ADMISSIONS TO ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Wears glasses	39	86.7	129	92.1	212	88.3	380	89.4
Missing data	(8)		(10)		(36)		(54)	
Uses hearing aid	4	10.0	18	14.1	38	16.8	60	15.2
Missing data	(13)		(22)		(50)		(85)	
Vision								
Unimpaired	10	20.8	24	17.1	59	23.2	93	21.0
Adequate for personal safety	37	77.1	107	76.4	182	71.7	326	73.8
Distinguishes only light or dark	1	2.1	4	2.9	9	3.5	14	3.2
Blind - safe in familiar locale	0	0.0	5	3.6	2	0.8	7	1.6
Blind - requires assistance	0	0.0	0	0.0	2	0.8	2	0.5
Missing data	(5)		(10)		(22)		(37)	

Table 25 (cont'd)

COMMUNICATION ABILITY OF NEW ADMISSIONS TO ADULT DAY CARE CENTRES IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Hearing								
Unimpaired	19	39.6	65	46.1	141	54.7	225	50.3
Mild impairment	25	52.1	56	39.7	83	32.2	164	36.7
Moderate impairment but adequate for safety	3	6.3	18	12.8	33	12.8	54	12.1
Impaired - inadequate for safety	0	0.0	2	1.4	1	0.4	3	0.7
Totally deaf	1	2.1	0	0.0	0	0.0	1	0.2
Missing data	(5)		(9)		(18)		(32)	
Speech								
Unimpaired	39	79.6	123	87.9	227	88.3	389	87.2
Simple phrases intelligible only	4	8.2	8	5.7	13	5.1	25	5.6
Simple phrases partially intelligible only	1	2.0	3	2.1	8	3.1	12	2.7
Isolated words intelligible only	3	6.1	4	2.9	6	2.3	13	2.9
No speech or speech not understandable or no sense made	2	4.1	2	1.4	3	1.2	7	1.6
Missing data	(4)		(10)		(19)		(33)	
Understanding								
Unimpaired	38	84.4	116	85.9	217	86.8	371	86.3
Understands simple phrases only	2	4.4	15	11.1	26	10.4	43	10.0
Understands key words only	0	0.0	1	0.7	1	0.4	2	0.5
Understanding unknown	4	8.9	3	2.2	6	2.4	13	3.0
Not responsive	1	2.2	0	0.0	0	0.0	1	0.2
Missing data	(8)		(15)		(26)		(49)	

** column percentages

5.6. Level of Performance of Activities of Daily Living

As shown in Table 26, only one-half of the clients (47.6%) were rated as fully independent for ambulation. Approximately one-third (30.1%) use a cane, 13.2% use a walker, and 10.2% use a wheelchair; 3.2% require significant or continued assistance in order to move from place to place.

Transferring to/from bed, a chair or the toilet poses some degree of problem for 18.0% of the clients, with 5.5% requiring continued assistance and 0.5% being completely dependent for all movement.

Even with mechanical aids, only about two fifths (42.2%) are able to bath without supervision or assistance. For 24.1% of clients, continued assistance is required.

Almost one-half (42.8%) require supervision or help in order to dress; 6.3% require someone to dress them.

Almost half (43.4%) require a reminder or some degree of assistance with grooming and hygiene; 4.1% are totally dependent and 0.7% are resistive.

With mechanical aids, 93.9% can feed themselves independently. However, 5.7% require intermittent help and 0.5% are resistive.

Almost one-sixth (13.4%) are sometimes incontinent of bladder; 3.8% more then once per day. Bowel incontinence is a problem for 5.0% of clients; approximately 1% are bowel incontinent more than once per day.

Table 26

LEVEL OF PERFORMANCE OF ACTIVITIES OF DAILY LIVING, NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
<u>Ambulation</u>								
Independent in normal environments	23	47.9	53	40.2	132	51.4	208	47.6
Independent only within own home or care facility	17	35.4	53	40.2	72	28.0	142	32.5
Unsteady/requires supervision	6	12.5	12	9.1	30	11.7	48	11.0
Requires occasional or minor assistance	0	0.0	12	9.1	13	5.1	25	5.7
Requires significant or continued assistance	2	4.2	2	1.5	10	3.9	14	3.2
Missing data	(5)		(18)		(19)		(42)	
<u>Mobility Aids</u>***								
Uses cane	14	26.4	57	38.0	73	26.4	144	30.1
Uses walker	1	1.9	21	14.0	41	14.9	63	13.2
Uses crutches	0	0.0	0	0.0	2	0.7	2	0.4
Uses wheelchair	6	11.3	15	10.0	28	10.1	49	10.2
Other prosthesis or aid	0	0.0	4	2.7	2	0.7	6	1.3
<u>Transfer</u>								
Independent	44	89.8	116	82.3	201	80.4	361	82.0
Supervision (bed, chair, toilet)	1	2.0	8	5.7	15	6.0	24	5.5
Intermittent assistance	2	4.1	11	7.8	16	6.4	29	6.6
Continued assistance	2	4.1	6	4.3	16	6.4	24	5.5
Completely dependent for all movement	0	0.0	0	0.0	2	0.8	2	0.5
Missing data	(4)		(9)		(26)		(39)	

Table 26 (cont'd)

LEVEL OF PERFORMANCE OF ACTIVITIES OF DAILY LIVING, NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Bathing								
Independent in bath or shower	15	30.6	40	29.6	78	30.6	133	30.4
Independent with mechanical aids	6	12.2	18	13.3	28	11.0	52	11.8
Requires minor assistance or supervision	17	34.7	46	34.1	79	31.0	142	32.3
Requires continued assistance	8	16.3	31	23.0	67	26.3	106	24.1
Resists	3	6.1	0	0.0	3	1.2	6	1.4
Missing data	(4)		(15)		(21)		(40)	
Dressing								
Independent	34	70.8	82	59.0	136	53.5	252	57.1
Supervision and/or choosing of clothing	1	2.1	16	11.5	46	18.1	63	14.3
Periodic or daily partial help	7	14.6	32	23.0	59	23.2	98	22.2
Must be dressed	6	12.5	9	6.5	13	5.1	28	6.3
Missing data	(5)		(11)		(23)		(38)	
Grooming/hygiene								
Independent	30	61.2	71	51.1	146	57.5	247	55.9
Requires reminder motivation and/or direction	6	12.2	9	6.5	44	17.3	59	13.3
Requires assistance with some items	8	16.3	55	39.6	52	20.5	115	26.0
Requires total assistance	4	8.2	4	2.9	10	3.9	18	4.1
Resists	1	2.0	0	0.0	2	0.8	3	0.7
Missing data	(4)		(11)		(22)		(37)	

Table 26 (cont'd)

LEVEL OF PERFORMANCE OF ACTIVITIES OF DAILY LIVING, NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%***
Eating								
Independent	39	84.8	116	81.1	215	85.3	370	83.9
Independent with special provision for disability	4	8.7	16	11.2	24	9.5	44	10.0
Requires intermittent help	3	6.5	9	6.3	13	5.2	25	5.7
Resists	0	0.0	2	1.4	0	0.0	2	0.5
Missing data	(7)		(7)		(24)		(38)	
Bladder Control								
Totally continent	38	80.9	110	78.0	214	83.3	362	81.3
Routine toileting or reminder	3	6.4	7	5.0	13	5.1	23	5.2
Incontinence due to identifiable factors	2	4.3	16	11.3	11	4.3	29	6.5
Incontinent less than once per day	2	4.3	3	2.1	9	3.5	14	3.1
Incontinent more than once per day	2	4.3	5	3.5	10	3.9	17	3.8
Missing data	(6)		(9)		(19)		(34)	
Bowel Control								
Totally continent	41	85.4	126	90.6	231	92.0	398	90.9
Routine toileting or reminder	2	4.2	5	3.6	11	4.4	18	4.1
Incontinence due to identifiable factor	3	6.3	3	2.2	1	0.4	7	1.6
Incontinent less than once per day	1	2.1	3	2.2	7	2.8	11	2.5
Incontinent more than once per day	1	2.1	2	1.4	1	0.4	4	0.9
Missing data	(5)		(11)		(25)		(41)	

** column percentages
*** columns cannot be summed as multiple responses were permitted

5.7. **Self-Care Ability**

Table 27 shows clients' functional status with respect to what on the LTC-I are termed "self-care" abilities but which elsewhere are called Instrumental Activities of Daily Living (IADLs).

As can be seen, 37.0% were rated as physically or mentally unable to prepare food; 30.8% require regular help and supervision to perform even light housekeeping tasks; 62.4% must be accompanied or are physically or mentally unable to shop; 59.4% can travel in a car only if accompanied, are physically or mentally unable to travel or, require an ambulance; 27.5% are physically or mentally unable to use the telephone or can answer only; and 20.2% are physically or mentally unable to administer their own medications and treatments even if these are prepared in advance.

In four of the six self-care categories the proportion fully independent was lower in the small then in the mid-sized and large centres.

Table 27

SELF CARE ABILITY OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Food Preparation								
Independent	11	22.9	24	18.2	39	17.5	74	18.4
Adequate if ingredients supplied	8	16.7	20	15.2	41	18.4	69	17.1
Can make or buy meals but diet inadequate	4	8.3	21	15.9	20	9.0	45	11.2
Physically or mentally unable	17	35.4	52	39.4	80	35.9	149	37.0
No opportunity or does not participate by choice	8	16.7	15	11.4	43	19.3	66	16.4
Missing data	(5)		(18)		(53)		(76)	
Housekeeping								
Independent with help for heavy tasks	7	15.6	16	12.1	32	14.2	55	13.6
Can perform only light tasks adequately	10	22.2	39	29.5	65	28.8	114	28.3
Performs light tasks but not adequately	3	6.7	14	10.6	21	9.3	38	9.4
Needs regular help and supervision	16	35.6	42	31.8	66	29.2	124	30.8
No opportunity or or does not participate by choice	99	20.0	21	15.9	42	18.6	72	17.9
Missing data	(8)		(18)		(50)		(76)	
Shopping								
Independent	4	8.7	13	9.7	30	13.7	47	11.8
Independent only for small items	5	10.9	23	17.2	40	18.3	68	17.0
Must be accompanied	19	41.3	56	41.8	76	34.7	151	37.8
Physically or mentally unable	15	32.6	34	25.4	49	22.4	98	24.6
No opportunity or does not participate by choice	3	6.5	8	6.0	24	11.0	35	8.8
Missing data	(7)		(16)		(57)		(80)	

Table 27 (cont'd)

SELF CARE ABILITY OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Travelling								
Independent	4	8.5	17	12.9	41	18.6	62	15.5
No public transport uses private vehicle or taxi	9	19.1	27	20.5	64	29.1	100	25.1
Car travel only if accompanied	30	63.8	84	63.6	106	48.2	220	55.1
Physically or mentally unable	4	8.5	4	3.0	7	3.2	15	3.8
Requires ambulance	0	0.0	0	0.0	2	0.9	2	0.5
Missing data	(6)		(18)		(56)		(80)	
Telephone								
Independent	22	48.9	75	54.7	127	57.5	224	55.6
Dials well known numbers	5	11.1	22	16.1	22	10.0	49	12.2
Answers telephone only	8	17.8	19	13.9	38	17.2	65	16.1
Physically or mentally unable	7	15.6	11	8.0	28	12.7	46	11.4
No opportunity or does not use phone	3	6.7	10	7.3	6	2.7	19	4.7
Missing data	(8)		(13)		(55)		(76)	
Medications and Treatments								
Completely responsible for self	14	31.8	48	37.8	90	42.7	152	39.8
Requires reminder or assistance	12	27.3	41	32.3	62	29.4	115	30.1
Responsible if meds prepared in advance	6	13.6	12	9.4	15	7.1	33	8.6
Physically or mentally unable	11	25.0	22	17.3	44	20.9	77	20.2
Resists	1	2.3	4	3.1	0	0.0	5	1.3
Missing data	(9)		(23)		(65)		(97)	

** column percentages

5.8. Mental Health Status

The LTC-I utilizes a 4-point system for rating comprehension, memory, self-direction, reality orientation and emotional stability. As shown in Table 28, overall, approximately three-quarters (71.8%) of the clients received the highest rating for reality orientation (i.e. they were rated as responding appropriately most of the time). Approximately two-thirds (64.5%) received the highest rating for comprehension (i.e. they were rated as having good comprehension). Only just over half (56.1%), however, received the highest rating for self-direction (i.e. they were rated as having some initiative, persistence, and ability to organize themselves as well as to assume responsibility). Only just over half (58.2%) received the highest rating for emotional stability (i.e. they were rated as able to cope reasonably well with the ordinary stresses of everyday life). More than half (58.9%) were rated as having less then a good memory, with 1.3% showing severe loss of memory.

In all five of the mental status categories of the LTC-I, the proportion of clients showing impairment was higher in the small then in the mid-sized or large centres.

Table 28

MENTAL HEALTH STATUS OF NEW ADMISSIONS TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Comprehension								
Good comprehension	29	56.9	88	60.7	176	68.2	293	64.5
Understands fairly complex instructions	15	29.4	40	27.6	61	23.6	116	25.6
Understands only simple language	4	7.8	15	10.3	20	7.8	39	8.6
Needs demonstration	3	5.9	2	1.4	1	0.4	6	1.3
Missing Data	(2)		(5)		(18)		(25)	
Memory								
Good	15	30.0	56	38.9	113	44.5	184	41.1
Forgetful	23	46.0	69	47.9	100	39.4	192	42.9
Some loss of memory	10	20.0	16	11.1	40	15.7	66	14.7
Severe loss of memory	2	4.0	3	2.1	1	0.4	6	1.3
Missing data	(3)		(6)		(22)		(31)	
Self-Direction								
Some initiative & responsibility	25	50.0	85	58.6	142	55.9	252	56.1
Does not initiate self-direction	14	28.0	45	31.0	94	37.0	153	34.1
Dependent	6	12.0	10	6.9	16	6.3	32	7.1
Continually dependent	5	10.0	5	3.5	2	0.8	12	2.7
Missing data	(3)		(5)		(22)		(30)	

Table 28 (cont'd)

MENTAL HEALTH STATUS OF NEW ADMISSIONS
TO ADULT DAY CARE IN BRITISH COLUMBIA, BY CENTRE SIZE

	Number of Clients Served							
	1-29 (n=53)		30-69 (n=150)		70-121 (n=276)		Total (n=479)	
	n	%**	n	%**	n	%**	n	%**
Reality Orientation								
Responds appropriately most of the time	26	52.0	108	74.5	192	74.1	326	71.8
Indifferent to environment	16	32.0	29	20.0	50	19.3	95	20.9
Periods of disordered thinking	6	12.0	8	5.5	16	6.2	30	6.6
Fairly constant disordered thinking	2	4.0	0	0.0	1	0.4	3	0.7
Missing Data	(3)		(5)		(17)		(25)	
Emotional Stability								
Copes reasonably	23	46.0	84	58.3	149	60.6	256	58.2
Insecure; excitable	22	44.0	54	37.5	82	33.3	158	35.9
Mood changes; behaviour erratic	4	8.0	6	4.2	15	6.1	25	5.7
No emotional control; behaviour unpredictable	1	2.0	0	0.0	0	0.0	1	0.2
Missing data	(3)		(6)		(30)		(39)	

** column percentages

6.0 PHASE III FINDINGS

Presentation of findings from Phase III, the subject of this chapter, begins (Section 6.1) with a description of Long Term Care Program case managers' ranking of 21 reasons for referring an individual to Adult Day Care. Attention then turns (Section 6.2.) to reasons why some referred clients chose not to attend. The chapter concludes (Section 6.3.) with a summary of focus group findings concerning the referral process and the way in which Long Term Care Program case managers and Adult Day Care centre staff interface with one another.

6.1. Reasons for Referral to Adult Day Care

Table 29 shows the list of reasons for referral to Adult Day Care that was sent to Long Term Care Program case managers for ranking. The reasons are shown in the order in which they were ranked for frequency. (See Appendix 6 for the presentation order).

The list, it will be recalled (see Section 3.3), was generated from a focus group discussion with 10 case managers. It was subsequently ranked by 67 other case managers. Each ranked the list three times: first, in terms of the frequency the respondent had used each reason to make a referral; second, in terms of each reason's importance to his/her decision making; and third, in terms of the impact he/she felt Adult Day Care was likely to have on the problem reflected in each reason.

As can be seen, there was considerable similarity in the way the items were ranked under the three sets of instructions. For example, "client social isolation", "caregiver burden/need for respite" and "the emotional/mental status of the client (e.g. depression)" were ranked first, second or third regardless of whether the ranking was for frequency, importance or impact. At the other end of the scale, one finds the same five reasons ranked 17th to 21st when the ranking was for frequency and importance. Four of the same five appear at the bottom of the ranking for impact. The five reasons were: "a client's need for ambulation/a walking program", "a client's need for

Table 29

LTC CASE MANAGERS' RANKING
OF REASONS FOR REFERRAL TO ADULT DAY CARE,
BY TYPE OF RANKING (Frequency, Importance, Impact)

Reason	Freq.*	Impt.**	Impact***
Socially isolated	1	2	1
Caregiver burden/need for respite	2	1	3
Emotional/mental status (eg. depression)	3	3	2
Need for bathing	4	7	5
Lives alone	5	8	11
Need for further assessment/ monitoring of clients	6	6	9
No caregiver	7	5	4
Care required too heavy for family or one homemaker	8	4	7
Need for nutrition/meal	9	9	6
Specific condition matches an available program	10	12	15
Unable to access other community resources	11	10	12
Need for physiotherapy	12	16	13
Assigned level of care (eg. PC, IC)	13	11	17
To assist client prepare for facility placement	14	13	8
Only alternative to facility placement	15	14	10
Age of client	16	15	14
Need for ambulation/walking program	17	19	18
Need for podiatry	18	18	20
Recently bereaved & otherwise eligible	19	17	16
To assist family accept facility placement	20	20	19
Unable to get along with any homemakers	21	21	21

* A rank of 1 indicates reason used most frequently.
** A rank of 1 indicates reason considered most important.
*** A rank of 1 indicates reason Adult Day Care is thought to have greatest impact on.

podiatry", "a recent bereavement", "a client's inability to get along with any homemakers" and "to assist the family to accept facility placement." While differences are greater between the way reasons are ranked for frequency and for impact, when frequency and importance rankings are compared, 17 of the 21 reasons differ in rank by no more than two positions.

6.2. <u>Reasons for Non-attendance</u>

Table 30 shows the 23 reasons for non-attendance that were sent to Long Term Care Program case managers and to Adult Day Care centre staff. Instructions were as follows:

> Attached is a list of reasons clients do not proceed to attend adult day care following referral to such a program <u>and</u> being offered a space.
>
> You are being asked to choose the three (3) most common reasons you encounter for such clients <u>never</u> attending adult day care.
>
> In any given situation, several reasons may be involved. You are being asked here to consider each factor in isolation and to make your decision based on <u>your</u> experience with many clients.

As was the case with reasons for referral, the list of reasons for non-attendance (see Section 3.3) was generated from focus group discussions held with individuals representative of potential respondents (i.e. with Long Term Care Program case managers and Adult Day Care staff).

With one exception, the same list of reasons was sent to a sample of Long Term Care Program clients who had been referred to Adult Day Care but who had never attended. Instructions in this case were to indicate up to three reasons why they had chosen not to attend. (If more than three reasons applied, the instruction was to chose the three most important reasons).

The one reason deleted from the non-attenders list, and for obvious reasons, was "When a space becomes available the client is deceased."

Table 30

REASONS FOR NOT ATTENDING
ADULT DAY CARE, BY TYPE OF RESPONDENT
(LTC case managers, ADC staff, clients).

Reason(%)***	LTC case managers (n=58)	ADC staff (n=36)	Clients (n=73)
Client does not believe he/she is like others who attend ADC	51.7	41.7	2.7
Client does not enjoy groups	48.3	16.7	1.4
Too much effort required	39.7	36.1	16.4
Day too long	25.9	2.8	4.1
Too early to be ready in the morning	17.2	13.9	17.8
Client is not interested in the activities offered	17.2	11.1	8.2
When a space becomes available the client is no longer interested	15.5	25.0	0.0
Hearing or vision difficulties	13.8	5.6	39.7
Physical barriers (eg. steps) at home	13.8	2.8	24.6
The trip is too long	8.6	5.6	24.6
When a space becomes available the client is to ill to attend	6.9	30.5	12.3
Transportation is not available	6.9	5.6	32.8
Family does not want him/her to go to ADC	5.2	13.9	0.0
When a space becomes available the client is in a LTC facility	3.4	19.4	2.7
When a space becomes available the client is in an acute care hospital	3.4	2.8	1.4
Client fears it will lead to placement in a facility	3.4	11.1	0.0
Suitable alternate arrangments made	3.4	11.1	1.4
Client does not like the term "Adult Day Care"	3.4	2.8	0.0
Cost of transportation	3.4	0.0	26.0
Waiting for facility placement so not worth starting	0.0	2.8	1.4
Physical barriers (eg. steps) at ADC centre	0.0	0.0	23.3
Cost of meals	0.0	0.0	24.6
When a space becomes available the client is deceased	0.0	5.6	N/A

*** columns cannot be summed as up to three responses were permitted.

The order in which the reasons are presented in Table 30 reflects the frequency with which they were selected by the case managers. (See Appendix 6 for the presentation order, which was the same for both staff and clients).

As can be seen, while there was some similarity between the selections of the Long Term Care Program case managers and the Adult Day Care centre staff, at least at the extremes of the distributions (i.e. in the reasons most and least frequently selected), their selections differed radically from those of the clients. For example, among clients "vision and hearing difficulties" was the most frequently chosen reason for not attending followed by concern about the availability and cost of transportation, the length of the journey to the Adult Day Care centre, physical barriers at home, the cost of meals and physical barriers at the centre. None of these reasons were chosen by more than 13.8% of the case managers and 5.6% of the Adult Day Care staff. Two, in fact, (physical barriers at the centre and cost of meals) were not chosen by any member of either of the two groups of staff respondents.

Rather, among staff, the most frequently chosen reason for non-attendance was "client does not believe he/she is like others who attend Adult Day Care." Case managers selected as the next two most frequent reasons for non-attendance "client does not enjoy groups" and "too much effort required." Corresponding choices among Adult Day Care staff were "too much effort required" and "when a space becomes available client is no longer interested."

6.3. <u>The Referral Process and the Interface Between Long Term Care and Adult Day Care</u>

As indicated in Section 3.3. a focus group discussion was held with ten Long Term Care Program case managers in order to ascertain, from their perspective, the process of referring clients to Adult Day Care and their perception of the interface between the two systems. The Adult Day Care perspective was addressed in a comparable focus group

discussion held with nine Adult Day Care staff. In both groups, the discussion was guided by a set of questions posed by a member of the research team. Presented below are the questions that were asked and a summary of the responses that were given.

6.3.1. The Long Term Care Case Managers' Perspective

Question 1: Where do you get the names of the people you assess?

In response to this question a variety of sources were mentioned. These included physicians, friends, Home Care nurses, apartment managers, hospitals, staff of various provincial and federal departments and agencies (e.g. the Department of Veterans Affairs, the Ministry of Social Services and Housing, Mental Health Services), B.C. Hydro and B.C. Telephone Company staff, the Fire Department, and the Quick Response Team. Another frequently mentioned source of referrals were families who, several respondents noted, often contact the physician, who in turn, contacts the Long Term Care Program. Additionally, respondents noted that some clients self-refer.

Other points mentioned were that referrals often come from several sources when a crisis is reached and that sharing space with other agencies such as Home Care Nursing, the Quick Response Team, Environmental Health and Facilities Licensing facilitates communication and "moving people through the resources."

Question 2: When a referral is made are you given reasons and recommendations and are these carried out?

The answer to this question was that sometimes the referral source calls with a specific request such as homemaker service or admission to Adult Day Care. When this happens, the case manager must decide if the recommendation is appropriate. Respondents noted a need for education of other professionals regarding wait lists and to inform them that they cannot just refer clients directly for service, but rather, that clients must be assessed first by Long Term Care.

Question 3: What are the next steps in the process?

The following procedures were among those described:

- Office staff telephone the client and obtain initial information which is then given to a case manager who telephones the client within 48 hours to three weeks, depending on the health unit. Respondents noted, however, that generally, if the situation is reported to be urgent, a case manager will assess this by telephone as soon as possible;

- Each case manager takes a turn doing intake for a day. This includes obtaining the initial information, deciding if the person is eligible for service, and talking to physicians. The information is then passed on to another case manager and the client is told when to expect a call from him/her; and

- One professional does intake on an ongoing basis. The case manager reporting this procedure noted, however, that this was a temporary arrangement and that no decision had been made as to whether it will continue. While this procedure has the advantage of providing a consistent approach, respondents recognized that it could prove difficult to find case managers willing to act in this role on a continuing basis.

There was considerable discussion regarding intake procedures. Although some health units with long-standing, experienced clerical staff use them for screening clients, it was generally agreed that the complexity of the decision making process and necessary knowledge of resources requires the professional expertise of an experienced case manager.

Question 4: What do you do when you have completed an interview or assessment with a client and how do you reach a decision regarding what recommendation you make?

Respondents indicated that if the client is cooperative, the case manager will usually complete the assessment during the initial interview and be able to offer recommendations immediately. However, since initially the case manager is a stranger in the client's home, it sometimes takes more time to build a rapport and a second visit may be needed, particularly if the client is reluctant to disclose information.

Respondents noted that in some cases further investigation may be required before a decision can be made. This can involve contacting the physician, the family and the rest of the informal support network (e.g. friends, neighbours). It may also be helpful to confer with co-workers and/or administrators before making final recommendations. In one health unit, it was reported case managers meet weekly with representatives of agencies in the community to discuss all assessments from that week. In this unit, agencies are considered a part of the health care team and consensus is reached regarding the utilization of resources. This, it was felt, was a good procedure and one which "keeps everyone on track", and helps prevent over or under-utilization of resources. It was noted, however, that it may only be feasible in health units with few facilities and agencies.

In some units, when an assessment is completed and recommendations have been made, respondents indicated that the administrator or supervisor signs each one while in other units the office manager "signs them off."

Some units routinely notify family physicians about the assessed care level and recommendations.

Specifically as regards Adult Day Care, sometimes the decision to refer is made initially and sometimes it is made later. Initially, the case manager may deal only with the most obvious and pressing problems

and/or start with the services the client will most readily accept. An example cited was to begin with a homemaker every two weeks and then "as they come to accept you, they may agree to more needed services."

Question 5: Are there factors over which you have no control which influence your decisions regarding Adult Day Care?

Responses to this question included transportation, services offered (e.g. bathing service may not be available), wait lists and the type of client the Adult Day Care centre will accept and can serve.

Question 6: Do individual health units provide guidelines or rules to you as case managers which further influence your decision making process?

Respondents indicated that, in some health units, each Adult Day Care centre has a specific catchment area. Transportation restrictions exist in some locations and with some centres. They reiterated that client's care level is also a factor in that some centres accept only certain levels.

Question 7: What is the next step in the process after the forms are completed and a decision has been made to refer the client to Adult Day Care?

The answer to this question was that it depended on whether or not there is a wait list. If there is no wait list, the client information is immediately provided to the Adult Day Care centre which then contacts the client. Where there is a wait list, procedures differ across health units. In some, the wait list is kept at the health unit with names passed on, in chronological order, by the Long Term Care Program clerk when the centre requests them; the case manager is notified at that time. In other units referrals are communicated to Adult Day Care centres by a member of the Long Term Care Program staff designated as the Adult Day Care liaison.

Question 8: What problems occur in the stage between making the recommendation for Adult Day Care, a space becoming available and the client attending?

The case managers noted that wait lists create several problems. While waiting for a space the client's health may deteriorate necessitating acute care admission or institutionalization, or the dementia may worsen to a level an Adult Day Care centre cannot handle. If the wait is long, it is also common for clients to lose interest or to forget that they had been referred to Adult Day Care. Case managers reported frustration at working hard to pique clients' interest and then having to tell them they will have to wait.

Respondents indicated that even if a space is offered almost immediately, the client may be reluctant or unwilling to attend. When this happens, some centres send a staff member to visit the client while others immediately hand responsibility back to the case manager. In this situation, the case manager may or may not contact the client and attempt to convince him/her to attend. The case managers in Focus Group II generally agreed that it is preferable and more successful if the Adult Day Care centre assumes some responsibility for client follow up.

Another scenario described is where the caregiver refuses to allow the client to attend. Frequently, in this situation, the referral was made to provide caregiver respite. However, while the caregiver may have agreed to/desired that the client be admitted to Adult Day Care when the idea was originally proposed, he/she may be reluctant to "let go" when the time comes for the client actually to attend. This is expressed in the presentation of such excuses as "my husband/wife is too ill to attend right now" or "they won't be able to handle him/her." Case managers attribute this behaviour to guilt feelings similar to those experienced by families of clients entering care facilities. They report that a strategy that is sometimes successful is to have the caregiver attend the centre with the client for a period of time.

Question 9: What can happen after the client gets to the centre?

Respondents indicated that the centre may encounter problems they, as case managers, had not anticipated, in part due to being insufficiently familiar with the centre's program and facilities and, in part, because of the difficulty of predicting client behaviour on the basis of a relatively brief home interview (e.g. the client may act out when in a large group).

Question 10: Are there people who could benefit from Adult Day Care who are not getting into the program?

The case managers in Focus Group II immediately singled out two groups in response to this question - younger disabled adults and persons with dementia. The need for psychogeriatric care within Adult Day Care was particularly stressed, with several respondents noting a "desperate" need for respite among caregivers. Respondents felt, however, that many centres do not have the physical space, staffing or programs to adequately serve this population although some are attempting to do so by having separate days for the confused.

It was also felt that there are insufficient spaces for Extended Care level clients and that half-day programs should be tried for clients who feel they cannot cope with being at the centre a whole day. It was noted, however, that centres that have tried the half-day option have found that transportation difficulties often prove insurmountable.

Other areas in which they felt service was needed or could be expanded included:

- bathing of non-Adult Day Care clients. It was not believed necessary that an Adult Day Care space be allocated if the only service required was a bath. However, more centres than now do so could offer bathing service to non-clients, having them, as is the current practice at some centres, pay the

cost of hot water, soap and towels and come to the centre at a time when demands on bathing facilities are low;

- take-home evening meals; and
- weekend programs and night respite/night care which few, if any, of the centres now provide.

The case managers also identified a need for separate days or programming for men, for specific language groups, for the non-verbal, for younger adults and, especially, for the confused. "Experience has shown", they indicated, "that the cognitively alert need different programs than the confused or they will not continue attending."

Additionally, the case managers recommended that there be more rehabilitative focus in Adult Day Care centre programming. Suggestions included placing more emphasis on teaching/reteaching skills, helping clients get in touch with reality as it is today (e.g. prices and current events) as well as active rehabilitation for clients such as those with multiple sclerosis or who had recently sustained hip fractures. The group felt, generally, that more could be done to encourage/maintain clients' independence. This, they felt, would be facilitated if more centres had occupational therapists and physiotherapists on their staff, on a regular part-time basis.

Questions were raised regarding the appropriateness of some of the activities and services offered by Adult Day Care. Some activities, it was felt, clients would never have engaged in when younger and are not about to start now. It was also noted that there can be "an insidious taking-over of functions" that were, until recently, performed by clients and perhaps still could be done by some (e.g. making medical appointments). Respondents recommended that centres examine the activities and services they offer and ensure that they are relevant to the client group they serve and that none, inadvertently, promote dependence on centre staff.

The need for discharge planning was also discussed. While discharge from Adult Day Care to other community programs may not be a viable

option for many clients, for some it is. Situations were described where clients had shown major improvement such as following bereavement or where social isolation had been relieved. In such cases, some centres allow clients to become volunteers and help with the program. In this way, they are still able to attend but the Long Term Care Program no longer pays for them and a space is opened up for a new admission. The case managers also noted that some centres accept clients on a temporary basis (eg. for rehabilitation; while the caregiver is ill or takes a vacation) and see discharge as a goal to plan for. There also may be a change in the clients' home situation (e.g. daughter moves nearby) which results in a decreased need for the program.

In addition to identifying the above gaps in service, both during and at the end of the discussion, the group put forth a number of other recommendations they felt the Continuing Care Division should consider in regard to Adult Day Care. Among these were recommendations concerning:

- guidelines and standards. It was believed that with centres being run by volunteer boards, programs and policies frequently change "at the whim of the board." Suggested areas to be addressed in such guidelines included: programming, staffing (number and qualifications), transportation and physical space and equipment;

- accounting and accountability. They felt that a strict accounting of funds should be required of all centres to ensure that monies were being used for the purposes for which they had been allocated. They also queried why there appears to be a marked variation across centres in the costs per day per client and recommended that this be looked into;

- rental allowances. The concern here was that these generally are insufficient and as a result, centres are forced to locate in less than desirable space. It was noted that as a

result of space restrictions some centres are severely limited in the number of wheelchair-bound clients they can accommodate on any given day. Others lack adequate space for ambulation programs. In addition to recommending that the rental allowance be increased, a need was identified for some purpose-built centres;

- case manager input. Respondents felt that case managers should have some input into the type of activities and services Adult Day Care centres offer given their knowledge of Long Term Program clients; and

- ways of improving communication and cooperation between the Long Term Care Program and Adult Day Care. Respondents recognized that case managers should provide Adult Day Care centre staff with a clear statement of their reasons for referral and objectives for the client. It was noted that one health unit's quality assurance program requires the case manager to state his/her goals and record them on the care plan. There was agreement that this practice should be more widespread. It was also agreed that regular meetings should take place between case managers and Adult Day Care centre staff and that this should happen in all health units, rather than as now, in only some.

6.3.2. The Adult Day Care Perspective

Presented below are the questions asked Adult Day Care centre staff and the answers that they gave.

Question 1: How do you receive referrals to your centre from Long Term Care?

The answer to this question was that referrals come either by telephone or in writing. It was reported, however, that in one health unit the client is given the centre's telephone number by Long Term Care and is

asked to make the initial contact. If the centre, which is also given the client's name, does not hear from him/her in a week or two it will call the client.

Question 2: If there is a wait list for your Adult Day Care centre, who keeps this list and what information is included?

In all the centres with wait lists represented in the focus group, the list is maintained by Long Term Care with a copy given to the centre. There was considerable variation, however, in the amount of client information centres were reported to receive from Long Term Care and in when they received it. For example, it was reported that in some health units, centres receive copies of the client's LTC-I form at the time the client's name is placed on the wait list. In other units, only basic information (name, referring unit, level of care) is provided at that time with the LTC-I form being forwarded when the client's name nears the top of the wait list. In still other units, the LTC-I form is forwarded, if at all, only after much pressure from the centre and/or many months have elapsed from the time the client commenced attending Adult Day Care.

In some health units, as previously mentioned (see Section 5.0), centres are sent pages 1-4 of the LTC-I form. In other units, even though information contained in them is relevant for preparing the client's care plan, some of these pages are omitted.

Similarly, in some health units centres routinely receive from case managers, at the time of referral, in writing, information concerning the reasons for referral, describing the client's special needs, suggesting approaches that might be taken and outlining any special concerns he/she might have or problems the centre might anticipate experiencing with the client. In other units, it was reported that centres must pressure case managers for information about why a referral was being made, about the client's care level and for suggestions about the care plan.

The Adult Day Care staff represented in the focus group indicated that most centres would appreciate routinely receiving such information from case managers. Additionally, when the client's name nears the top of the wait list, they would appreciate up-dated information, particularly regarding medical history, diagnosis and medications.

Question 3: What do you do when you receive the names of referred clients?

The answer here was that with extensive wait lists, which were typical of the majority of the centres respondents represented, there was little or no contact with clients until their name approached the top of the list. At that time, some centres contact Long Term Care to up-date their information, or if it was not provided at the time the referral was first made, to obtain information concerning the client's personal and medical background and functional status, and advice on what to include in their care plan.

Question 4: Who contacts the client when a space becomes available and what kind of contact do you have with him/her at this time?

Respondents indicated that when a client's name nears the top of the wait list some centres offer the choice of an intake interview either at home or at the centre; some routinely have the nurse or the coordinator make a home visit, with the family present if this seems indicated; others undertake a home visit only if the client is reluctant to attend or there is some question as to his/her suitability for the program.

Question 5: Given your choice, what kind of contact would you like to make with a referred client?

There was consensus that home visits by centre staff are desirable, although not always feasible given staff time constraints. One reason for endorsing home visits by Adult Day Care staff was that respondents felt that often the Long Term Care assessment was too brief and hurried for the case manager to obtain all the needed information. A second

reason was that they felt clients perceive the Long Term Care assessment process and the case manager to be "official" since financial information is requested and forms need to be signed. This can lead them to withhold information and not indicate what the true problems are. Adult Day Care personnel, on the other hand, can be more informal in their approach and hence, are less threatening. Respondents also felt that Long Term Care case managers are not always aware of the type of information Adult Day Care staff need. Being able to see the client in his/her home environment and make their own evaluation of needs, functional status and interests was felt to be invaluable in developing a care plan. Additionally, home visits were seen to promote attendance and to reduce stress for clients. When there is a long wait, many elderly clients forget that Adult Day Care was recommended. Hearing about the program and meeting one person they will know when they arrive, tends to reduce their apprehension. Finally, it was noted that if the centre provided transportation, they were reluctant to send their transport worker into an unknown situation, both regarding physical barriers and other factors that could pose difficulties.

Question 6: What happens if a client does not want to come or is reluctant?

Respondents indicated that in such circumstances most centres will maintain contact with the client for a period of time, after which he/she is referred back to Long Term Care. It was noted, however, that the longer the wait list, the less persistent the Adult Day Care centre will be in attempting to persuade the client to attend and the more quickly it will move on to other names on the list. The amount of effort expended on overcoming the client's reluctance also depends on the reason for referral. For example, if it was for caregiver respite, the centre may enlist the aid of the Long Term Care case manager, the homemaker or others in attempting to convince the client to attend.

Question 7: In your experience, what problems and difficulties have arisen during the referral period, that is, between the time a client is recommended for Adult Day Care and the time they actually start to attend?

The consensus was that the wait time is the biggest problem with several typical situations being cited. For example, clients who have been at a Short Stay Assessment Treatment(STAT) centre tend, at time of discharge, to be motivated and ready to come to an Adult Day Care program. If they then have to wait three to twelve months, they lose interest and/or regress. At least three of the centres represented in the focus group give priority to those coming from acute hospital or a STAT centre.

In another common situation, while on the wait list, persons with dementia deteriorate beyond the point of being able to adapt to an Adult Day Care program. In the experience of focus group participants, persons who are referred and attend at an early stage in the disease, are able to continue in the program for a considerable period of time despite deterioration in their condition. Those at the Intermediate Care III level at the time of entry, they stated, often cannot adapt to the centre with its unfamiliar physical space, people and routines.

A third scenario described the situation where the referral is for respite, but where, before the client's name reaches the top of the wait list, a crisis occurs. The usual outcome is that the client enters a long term care facility and/or the caregiver enters acute care.

Respondents noted "it is difficult for the family when Long Term Care gets their hopes up and then tells them they must wait." Typically, caregivers phone frequently to see where the client is on the wait list.

Respondents noted that "jumping" the wait list occurs more frequently in some health units and with some case managers and centres than with others. Generally, they supported the policy of admitting clients in

chronological order. Otherwise, they feared there would be an even greater tendency than there is now for case managers to refer only those in desperate need of service.

Question 8: What suggestions do you have which might improve the referral system and the transition of the client?

The most frequent response to this question was for more Adult Day Care spaces to be made available thus reducing wait time and addressing many of the problems described above.

Another suggestion was that all centres should routinely receive all relevant Long Term Care Program forms and up-dated information prior to the client commencing to attend the centre.

Respondents also felt that greater efforts needed to be directed towards ensuring that case managers are familiar with local Adult Day Care centres' programs and with their staffs' information needs. Respondents described several ways in which some centres have endeavored to do this (e.g. by inviting case managers, and STAT centre staff, to their annual "birthday party"; going to the health unit to speak to case managers about their program and to answer questions). It was stressed by respondents, however, that such activities must be done on an ongoing basis in order to be effective.

Question 9: What further suggestions do you have regarding the interface between Long Term Care and Adult Day Care?

A number of important recommendations were forthcoming in response to this question. Among these were that:

- Adult Day Care staff should have input into reassessments. The rationale for this recommendation was that case managers sometime change clients' level of care or make important changes to their care plan, including changes in homemaker hours and in days of attendance at Adult Day Care centres,

without consultation with centre staff. This was seen as inappropriate considering, that in some cases, the client is seen only the required once per year by Long Term Care compared with from 1-3 days per week by centre staff;

- <u>consideration should be given to standardizing reporting procedures and reporting intervals</u>. Respondents noted that in some health units reports concerning clients' health, functional status, progress in Adult Day Care, etc. are routinely sent to case managers on a monthly basis. In some units, and in fact most, reporting is quarterly. In some it occurs only once per year and in others, not at all, because case managers have made it clear they do not want reports, saying "we need no more paper." Where routine reporting is in place, in between reports, phone calls and/or special forms are utilized to inform the Long Term Care Program of important changes in the client. Even here, however, there appear to be variations between health units in the procedures followed. For example, in one unit the centre will telephone if a situation is emergent, otherwise an information sheet is completed and sent through the Long Term Care liaison at the weekly meeting;

- <u>there should be greater information sharing throughout the Long Term Care system</u>. Here, respondents were thinking both about information they would like to receive and information they could contribute. As an example of the former, they pointed out that most centres would like to know the results of STAT centre evaluations and where Adult Day Care is seen to fit with regard to recommendations and the care plan. In some health units, centres may obtain this information by communicating directly with STAT centre personnel. In other units, all information must come through the Long Term Care Program case manager who may chose to present only a brief summary, giving the centre less information than it would like. As an example of what they could contribute,

respondents stated that they have valuable information that could and should be shared with care facilities. As an illustration, one respondent cited the case of a client with Alzheimer's Disease who could not be communicated with in English but who could be, the centre had discovered, if German, her mother tongue, was used. Unfortunately, this information did not accompany her to the facility. While one of the centres represented in Focus Group III does routinely send a report of the last care conference whenever one of its clients is transferred to a facility, there was consensus that this is not a widespread practice. It was noted that one reason for this is that some facilities discourage it (as well as the sending of other information) in, what respondents described as, the mistaken belief that it might bias their assessment;

- <u>care plan development should be a team effort</u>. Respondents felt that the care plan should be jointly developed by all staff involved with the client (e.g. the case manager, Adult Day Care staff, the Home Care nurse, the homemaker). Homemakers were singled out as a particularly under-utilized resource as regards Adult Day Care. It was felt that in some cases, these individuals may be better able than the case manager to inform the centre about the client's behaviour patterns, needs and preferences. However, consultation with them was reported seldom to occur; and

- <u>there should be better coordination between Adult Day Care and Home Care</u>. For example, respondents noted that Home Care nurses visit some Adult Day Care clients daily, including days they attend the centre, to administer medications, or visit them monthly to give injections, when these tasks could be performed by the centre nurse. If and when they become aware of situations of this type, centres will generally contact Long Term Care and arrange to take over responsibility on their days. Respondents felt, however,

that procedures should be put in place that would routinely check for this type of overlap and prevent unnecessary duplication of service.

Additionally, in response to this question (and elsewhere in the discussion), the centre staff in Focus Group III recommended that the Long Term Care Program consider centre specialization. Respondents identified a need for centres specialized in the care of persons with dementia. The special needs of the medically frail and of persons recently discharged from STAT centres were also mentioned. Another possibility voiced was that perhaps some centres should specialize in providing socialization/respite, others preventive health care and, still others, rehabilitation.

Underlying this recommendation were two concerns:

- the difficulty of coping with a mixed case load. It was noted that some centres currently are attempting to do so by reserving certain days for certain client groups. Respondents reported, however, that logistically this proves to be very difficult; and

- the fear that increasingly Adult Day Care centres are being used as "holding places" until facility placement is possible. In addition to being voiced directly, this fear was reflected in the concern expressed about what they perceive to be the increasing numbers of Intermediate Care III and Extended Care level clients that are being referred to Adult Day Care. In their view, the group they are best able to serve are persons at the Personal Care and Intermediate Care I and Intermediate Care II levels. They fear that these individuals are being displaced by higher care level clients for whom they are providing mainly socialization and caregiver respite. While quick to add that this type of service is worthwhile, they stated that "Adult Day Care has the capability to do much more", and that many centres "are not really functioning as day programs should."

Two contributing factors to the perceived increase in Intermediate Care III and Extended Care level clients were identified. One was that case managers are identifying problems sooner but are waiting longer before referring clients, possibly because of the limited number of Adult Day Care spaces. The other factor identified was the funding formula which, they stated, necessitates centres taking a certain percentage of "heavier care" level clients in order to justify additional staffing.*

A final recommendation concerned clients already in Adult Day Care. Respondents recommended that if they deteriorate or other circumstances change, greater consideration than now be given by case managers to increasing the number of days they may attend. In respondents' view, too often "moving the wait list" is paramount in case managers' minds when they should be focussing on enabling clients to remain in Adult Day Care and thus avoid or postpone facility placement.

Question 10: We have tended to focus on problems, but is there anything you would care to comment on that you find particularly positive about the referral process?

Some respondents expressed appreciation for the support their centre receives from Long Term Care. They believe that in their health unit, Long Term Care staff value the service they provide. One respondent said, "LTC believe we are really filling a need of theirs and so they are very cooperative and instrumental in working with us." Another stated that once clients enter an Adult Day Care program "much of the flak is removed from the case manager, that is, distress calls and panic from the client and/or family are reduced or eliminated. Some case managers really appreciate this." Respondents also reported that cooperation and support is enhanced when case managers have an opportunity to meet and get to know Adult Day Care staff and visit the centre. They strongly recommended that every effort be made to ensure this happens.

---

* It should be noted that in the Continuing Care Division staffing formula (See Sections VII.2 and VII.3 of the guidelines) additional staff resources are allocated on the basis of the number of clients at the Intermediate Care I level and above, not just on the basis of those at the Intermediate Care III and Extended Care levels.

7.0. DISCUSSION

The foregoing chapters have presented a review of the literature and findings from a three-phase study of British Columbia Adult Day Care centres.

This chapter begins by comparing and contrasting the findings from Phases I and II of the current study with those described in the literature review. A summary of the differences between small, mid-sized and large B.C. Adult Day Care centres is then presented. The focus of attention then shifts to the Phase III findings. Throughout this chapter, where appropriate, recommendations for the Continuing Care Division and for future research are presented.

7.1. <u>Comparison of Findings With Those of Prior Studies</u>

7.1.1. Urban-Rural Distribution

The findings are similar to those from the United States (Conrad, Hanrahan and Hughes, 1990), as well as from a previous study of B.C. centres (Jarrell, 1989), in showing that the vast majority of centres (77.6%) are located in urban areas (i.e. in communities with populations of over 10,000). This is not surprising since, as previously noted, the majority of seniors in both the United States and Canada live in urban areas.

The findings do not, however, mitigate against the need for Adult Day Care in rural areas. In recognition of this need it is understood, in fact, that in 1990-91 the Continuing Care Division substantially increased the number of Adult Day Care centres in rural areas. It is hoped that these new centres will ensure an adequate supply of transportation and overcome the other obstacles the literature suggests may be entailed in providing Adult Day Care in non-urban, low-population settings.

7.1.2. Models of Adult Day Care

Weissert et al. (1989), it will be recalled, differentiate between centres on the basis of the type of organization under whose auspices

they operate and the homogeneity of the client population. Those serving a single client group are called Special Purpose centres. Those affiliated with a nursing home or rehabilitation hospital are termed Auspice Model I centres. Those affiliated with a general hospital, housing authority, seniors program, municipal agency or other social service agency are termed Auspice Model II centres. Although ostensibly different, free-standing centres are also classified with Auspice Model II centres.

When Weissert et al.'s classification system is applied to the 49 B.C. centres, at least four major differences are apparent. The first of these is that there appear to be a greater proportion of centres in B.C. than in the United States that are affiliated with a care facility or a hospital-based Extended Care Unit (53.1% in B.C. compared with 26.5% in the U.S.). To the extent that what the B.C. centres call "affiliation" is equivalent to what Weissert et al. (1989) call "auspices", the data show a greater proportion of Auspice Model I centres in B.C. than in the United States.

A second difference between B.C. centres and those in the United States and, as well, in this case, as those in Great Britain, is the higher proportion of B.C. centres that are free-standing. In this study approximately one-quarter (26.5%) of the centres reported having no affiliation arrangements. The data correspond closely with Jarrell's (1989) findings. In her study 29.0% of centres reported being sponsored by a society that provided Adult Day Care services only.

In Weissert et al.'s (1989) study, free-standing centres constituted such a small proportion that they were grouped in with other community-based centres in the Auspice Model II category. Brockelhurst (1979) reported that in Britain only 4% of centres are independent of a large health care facility. In British Columbia, on the other hand, free-standing centres, by their numbers, appear to constitute a separate and distinct category.

A third difference, this time more with British than with American centres, is in the proportion affiliated with general hospitals. Even if one includes in this category centres affiliated with Extended Care Units, the total for B.C. is only 5 out of 49 or 10.2%. In contrast, and as was noted previously in the literature review, Brockelhurst (1979) reported 33% of centres in Britain to be operated in conjunction with district general hospitals. A clue to one possible source of the difference comes from an article entitled "Comprehensive Geriatric Care in a Day Hospital: A Demonstration of the British Model in the United States" (Morishita et al., 1989). In this article the authors state that the North American concept that is closest to the British day hospital is the inpatient or outpatient Geriatric Evaluation Unit. If this is true, than either we should be including what, in this province, are termed Short Stay Assessment/Treatment centres within our analysis of Adult Day Care centres or, we should be excluding American and British centres which are equivalent to Short Stay Assessment/ Treatment centres from any comparisons that are made with our Adult Day Care centres.

The fourth difference is that, depending on one's definition, a smaller proportion of centres in B.C. than in the United States appear to be of the Special Purpose type. In comparison to the 11.2% of this type identified by Weissert et al., only one of the B.C. centres (2.0%) meets the criterion of serving a single client group - that is, if religion and/or ethnicity are excluded from consideration as they seem to have been by Weissert et al. (1989). This centre describes itself as a "therapeutic, recreation/leisure day program for young adults." It targets its service to physically disabled adults (aged 19-60) living in the community, who must be alert, able to understand the spoken word and able to communicate their needs and wishes.

Whether centres catering to specific religious and/or ethnic groups should or should not be included in the Special Purpose centre category needs to be considered further. Future studies should perhaps examine whether there are distinct differences between these and other centres, if not in what they offer, then in how services are delivered.

In regard to Special Purpose centres, the absence of centres in B.C. catering exclusively to dementia victims also bears comment. The present researchers were surprised at the lack of them in this province for at least three reasons: first, considering their relative prominence in the recent gerontological literature on Adult Day Care; second, because of the finding that in both the total Adult Day Care population (see Table 3) and in the sub-sample of new admissions (see Table 22) fully 7.7% of clients were at the Intermediate Care III level, the level traditionally used in B.C. to classify persons with significant cognitive impairment; and third, because of the finding that the proportion of B.C. clients with diagnoses falling within the ICD "mental disorders" category (37.8%) was virtually identical to the proportion Weissert et al. (1989) report for the United States (37.9%).

The need in B.C. for Special Purpose centres for dementia victims is underscored by the Phase III data which, as will be discussed more fully later, suggests strongly a) that B.C. Adult Day Care staff, like their American and British counterparts, find it difficult to program effectively when they have mixed clientele, a substantial proportion of whom have serious cognitive impairment and b) that while there is a serious need in the community for caregiver respite, to provide it in the context of conventional Adult Day Care centres, may be inappropriate.

7.1.3. **Utilization Pattern**

The average daily census in B.C. Adult Day Care centres appears to be lower than in the United States. Both Weissert et al. (1989) and Conrad, Hanrahan and Hughes (1990) report an average for U.S. centres of just under 20 clients per day. The average daily census for B.C. centres found in the present study was 14.6 clients. The range was also smaller. Whereas Weissert et al. (1989) report a range of from 5.6 to 42.2 clients per day, in B.C. the range was from 1 to 25.

Findings from this study contrast both with data from the United States and, to a lesser extent, with data obtained previously in British

Columbia when it comes to the average frequency of attendance per week. American data (Weissert et al., 1989; Conrad, Hanrahan and Hughes, 1990) show clients attending Adult Day Care, on average, 3.3 days per week. Jarrell's (1989) B.C. study shows 60% of clients attending one day or less per week, 33% two days per week, 5% three days per week and only 1% more than three days. The present study, on the other hand, shows 42.9% of the centres estimating that their clients attend, on average, one day per week, 51.0% place their average attendance pattern estimate at two days per week, and 6.1% at three days per week. When these estimates are combined, they yield an average attendance pattern of 1.7 days per week.

One explanation for the differences between B.C. centres and American centres may relate to the relatively higher proportion of Auspice Model I centres in B.C. than in the United States. Weissert et al. (1989) noted that Auspice Model I centres have a lower average daily census than Auspice Model II centres and that clients of Auspice Model I centres generally attend fewer times per week. Support for this explanation comes from a comparison of B.C. centres that are affiliated with a care facility and those that are not. Among care facility-affiliated centres, the average daily census is 13.0 clients compared with 16.0 clients per day for centres that are affiliated with community agencies or are free-standing. Average frequency of attendance per week is 1.6 days for care-facility affiliated centres compared with 1.8 days for centres with other types of affiliation arrangements or which are free-standing.

The difference between the data obtained by Jarrell (1989) and data reported here on the other hand, may reflect an increase in the supply of Adult Day Care spaces in the interim since her study was conducted. Alternately, it could reflect a change in Long Term Care Program policy such that case managers are now recommending new clients at any given care level for more days than they did before. The difference could also reflect a change in clients such that those now entering Adult Day Care are more disabled than those who entered previously, thus requiring more days. Another possible explanation, but one that seems

unlikely given the comments of Adult Day Care staff concerning case managers' pre-occupation with "moving the wait list", is that with the increased emphasis on keeping people in the community, more clients are being retained in Adult Day Care but with their hours increased. An examination of previous years' billing data and other statistics may enable the Continuing Care Division to ascertain which, if any, of these explanations is correct. Such an analysis, which it is strongly recommended be undertaken, is, however, beyond the scope of the present study.

Also beyond the scope of this study, but needing to be examined, are lengths of stay within Adult Day Care. We need to know whether, in B.C. Adult Day Care centres, three months is the average length of stay, as is reported by McFarlane et al. (1979) and by Hildick-Smith (1980) for British day hospitals, or whether the average is substantially longer, as Arie's data, also from Britain, but from a psychiatric geriatric day hospital, would seem to suggest. Additionally, we need to know the proportion and distinguishing characteristics of those who are short-term and those who are long-term attenders, if as British and American research suggests (Arie, 1979; Greene and Timbury, 1979; Hildick-Smith, 1980; Panella et al. 1984) both are represented in the Adult Day Care population.

Also needing to be explored are the reasons why some centres have large wait lists and long wait lines, some have moderate lists and waits while still others have no list and, in fact, may be under-utilized. Further, the reasons for differences in the number on wait lists and in the average wait time for care-facility affiliated as compared to other centres needs to be ascertained. What the present study shows is that numbers on wait lists tend to be fewer for care-facility affiliated centres than for centres affiliated with community agencies or free-standing centres. Wait time is also shorter for care-facility affiliated centres.

These differences could reflect client preferences. Some may prefer to wait for admission to a community-based centre rather than attend one

located in a care facility. The reason could lie in client characteristics. For example, clients may be more frail at time of admission to care-facility affiliated Adult Day Care centres and hence, deteriorate and become institutionalized more rapidly than clients of other centres. Or, they may simply be older at the time of admission and hence, closer to death. Alternatively or concomitantly, other factors may be involved. These could include case managers' preferred referal patterns and practices, and/or their level of awareness of local centres' wait list size and turn-over rates as well as the supply of institutional beds in the geographic area. To explore these possibilities, at the minimum, future studies should ascertain the reasons clients are discharged and the settings they are discharged to, as well as correlate rates of discharge from (and admission to) Adult Day Care centres with the institutional bed supply in their area.

7.1.4. Staffing

Examination of Table 9 shows quite clearly that the staffing pattern of B.C. Adult Day Care centres is more reflective of what Weissert et al. (1989) describe as typical in U.S. centres than it is of British or Canadian day hospitals. Typically, in B.C. Adult Day Care centres, the staff consists of an administrator and a program worker. In more than two-thirds of the large centres, a nurse, a secretary/bookkeeper, a cook and a transport worker are also employed. Although, as indicated in Table 15, a variety of therapeutic activities are offered by most centres, few have therapists actually on staff. While many centres report having access to these (and other health care and social service) professionals on a consultative basis (see Table 11), it seems likely that many of the therapeutic activities listed in Table 15 are led by the "core" staff.

This situation is obviously not unique to British Columbia. For example, in describing staffing of American Adult Day Care centres, Szekais (1985) notes that:

> Staff roles in day services settings can be characterized as "fluid". Professional boundaries may be much less strict, as day services attempt to

> deal in one program with the physical, mental and social aspects of the older adults' lives (p.160).

Greiff and McDonald (1973) make a similar point. They go on to argue that having several staff members from different disciplines share a function or substitute for one another leads to a strong team spirit. It also means that activities do not have to be cancelled if one staff member is absent. Given the importance to the frail elderly of maintaining continuity and stability, this is an important consideration. Still, one is left with some nagging questions about the nature and depth of therapies, activities, and services that are offered by individuals not specifically trained to offer them. For example, are the music therapy programs of the 71.4% of centres which state they offer them, really music therapy when led by a person other than a qualified music therapist? Would they be better labelled as simply music programs with the word therapy left out?

In commissioning future studies of Adult Day Care, the Continuing Care Division might consider requesting that the research design include site visits and/or some other means of assessing the content and level of the programs offered. Client-staff ratios also need to be computed. The questionnaire sent to all centres in this present study asked that in addition to indicating which staff positions they had in their centre, F.T.E.'s be provided for each position. Unfortunately, some centres did not comply with the request for F.T.E.'s while others provided incomplete or ambiguous information. As a result, meaningful client-staff ratios could not be calculated.

A final point that should be commented on with regard to staffing concerns volunteers. As in the United States, a majority of the B.C. centres (77.6%) reported using them on a regular basis. All should be encouraged to do so, both as a means of augmenting the activities and services Adult Day Care centres provide and as a means of assisting clients in maintaining contact with the broader community. The specific purposes for which they are used needs, however, to be examined as does their training and coordination. Additionally, it

would be interesting to ascertain the extent to which centres, like one of those described in Focus Group III, enable clients whose condition has improved, to continue to attend, but in the role of volunteer rather than client.

7.1.5. Activities and Services

To the extent that it is possible to do so, comparison of the activities and services data obtained in this study with findings obtained by Jarrell (1989) indicates only one major difference. Jarrell reported roughly a third of centres to be providing podiatry/footcare. The present study suggests the proportion is considerably higher: 91.8%. It also is apparent that there is a high degree of similarity in the types of activities and services offered by Adult Day Care centres in British Columbia and in the United States. One of the few exceptions identified to date is in regard to breakfast. Weissert et al. (1989) report that 32% of the centres in their study provide breakfast. This meal was not mentioned by any of the 49 B.C. centres when, at the outset of Phase I, they were asked (see Appendix 3) to provide job descriptions for every position in their centre and information concerning their activities and services. Jarrell (1989), too, found little evidence of this meal. She reported only two B.C. centres as offering breakfast. Perhaps this difference reflects an unidentified need in British Columbia. Alternatively, it may be that programs start later in the morning here or, that fewer clients than in the United States arrive at centres before programming begins (i.e. before about 9:30 or 10:00 a.m.).

Most of the other differences between B.C. and American centres are in the proportion offering a particular activity or service. For example, Weissert et al. (1989) report that 15% of the centres in their study provide drug consultation. In the present study, centres reported three activities related to drugs: administration of medications, monitoring compliance with medication schedule and reviewing clients' medications. The latter activity, which could perhaps be construed as drug consultation, was reported by 67.3% of the B.C. centres. There also appear to be a greater proportion of centres in B.C. than in the

United States that: provide dental care (28.6% of centres in this study as compared with 12% in the Weissert et al. study); bath clients (59.2% in this study vs. 30% in the Weissert et al. study); provide transportation to and from the centre (85.7% vs. 63%); provide transportation for such other activities as social/recreational events, shopping and medical appointments (73.5%, 46.9% and 38.8% respectively vs. 21% in the Weissert et al. study); provide music therapy (71.4% vs. 56%) and provide physiotherapy (83.7% vs. 42%).

While the above findings place B.C. in a favorable position as far as providing services thought in the United States to be needed by Adult Day Care clients, the limitations of these comparisons must be recognized. Since there are no standard definitions for Adult Day Care activities and services, we may be comparing different things. For example, what Weissert et al. (1989) define as "drug consultation" may include only client-pharmacist and/or client-physician interactions. If so, comparison of this service with what centres in this study have self-defined and self-labelled as "medication review" may be inappropriate.

With this caveat in mind, two other areas of service should be mentioned. In both, B.C. centres seem to place less emphasis than American centres. One is occupational therapy which was seldom mentioned when the centres were asked about the therapeutic activities they provide. The other area concerns family-related activities and services.

In regard to the latter, while a number of B.C. centres report that they counsel families and provide social activities and excursions involving families, noticeable by their absence were reports of centres sponsoring caregiver training programs, Respite Aide training programs, or a number of the other types of family-related activities described in section 2.7.12 of the literature review.

To be sure, the activities and services listed in section 2.7.12. derive from a document describing the California Alzheimer's Day Care

Resource Center Program. It may be that if and when more Special Purpose centres are developed in B.C., particularly centres for dementia victims, we will see more family-related services offered. It is worth noting, however, that the theme of needing to consider the family also as a day care client and to treat them as such in program planning and service delivery is not restricted to the dementia day care literature. Rather, it is a theme that is quite broadly reflected. For example, in an early article entitled "Geriatric Day Care - a Family Perspective" Rathbone-McCuan (1976) underscores the importance, at time of admission, of considering the needs of the client and family as being equally important.

> ... too frequently, workers perceive simply that the family is to be categorized as a resource either available or not available to the aged person; that there is malfunction in the applicant-family relationship; or that the family is seeking a depository for the aged person (p.520).

Rathbone-McCuan feels it is only to the extent that the worker can avoid "taking sides" and can identify the family as part of the client system, that an accurate assessment can be made. She also argues that there is a need for provision of case and group work services to families on a continuing basis. Kostick (1972), Dix (1982) and other authors similarly argue for strong communication links with and the provision of services to the families of Adult Day Care clients. It is recommended that the Continuing Care Division follow the lead of these authors and encourage Adult Day Care centres in B.C. to increase their service to clients' family members.

With regard to occupational therapy, the American Occupational Therapy Association (1986) describe a number of roles and functions that occupational therapists may perform in Adult Day Care settings. These include screening, referral, assessment, individual program planning and individual program implementation. While the first three overlap the functions of Long Term Care Program case managers, certainly, the last does not. Included in it are individual treatments to improve

motor planning, self-care skills, strength, endurance, cognition, perception and psychosocial skills. It should be noted that while some of the activities involved in these treatments may be able to be initiated by individuals from other disciplines working under the direction of a consultant occupational therapist, others may require specialized occupational therapy training. As shown in Table 9, very few Adult Day Care centres in B.C. (only 6.1%) have an occupational therapist as part of their regular staff. The relative absence of occupational therapy in our Adult Day Care centre programs may be a direct result of this. Alternatively, its absence may be because the roles and functions listed above, as noted by the Association in their article, are primarily found in restorative (medical) and maintenance (health maintenance) day care settings which appear to be less common in this province than in the United States. Another possible explanation is that occupational therapy is, in fact, being offered in our centres but is not recognized as such by centre staff or goes by another name. Ascertaining which of these explanations is correct is beyond the scope of this study but is something which the Continuing Care Division, in consultation with the B.C. Occupational Therapy Association, should consider doing. Aside from being of general interest a primary reason for doing so is that (see Section 6.3.1.) greater use of occupational therapists and a more rehabilitative focus were two of the recommendations of the case managers in Focus Group II.

7.1.6. **Client Characteristics**

Comparison of data obtained in the present study with data reported in the literature indicates some similarities and some differences in client characteristics. In terms of socio-demographic characteristics, similarities are apparent between the United States and British Columbia in the sex distribution of the Adult Day Care population, in the proportion living alone and in the proportion living in institutions. Conrad, Hanrahan and Hughes (1990), it will be recalled (see section 2.8.2), reported that 68% of the clients of the over 900 American centres they surveyed were female. The proportion female in the present sample of new admissions to Adult Day Care centres was

63.1%. Conrad, Hanrahan and Hughes (1990), Weissert et al. (1989) and Arling, Harkins and Romaniuk (1984) found that most American Adult Day Care clients do not live alone. This proved to be characteristic of the B.C. sample also (only 29.5% were found to be living alone). Another similarity is in the small proportion of clients living in institutions: 7% in the Conrad, Hanrahan and Hughes (1990) study and 1.3% in the present study.

Where B.C. clients differ most noticeably in socio-demographic characteristics from their American counterparts is in age, marital status and, among those not living alone, in household composition. Compared to American clients, B.C. clients are older. For example, Conrad, Hanrahan and Hughes (1990), report an average client age of 72 years. Weissert et al. (1989) report 18% of clients to be under age 65. In contrast, in the present sample of new admissions, the average client age was 78.9 years; 240 (53.8%) of the 446 for whom age data were available were aged 80 and over; as in Jarrell's (1989) study, only approximately 6% were under age 65.

There also appears to be fewer widowed persons and more living with a spouse among B.C. Adult Day Care clients. Arling, Harkins and Romaniuk (1984) found 62% of clients to be widowed compared with only 47.5% widowed among the new admissions in this study. Conrad, Hanrahan and Hughes (1990) reported only 20% of clients to be living with a spouse; 41.1% were found to be doing so in this study. Another difference was in the smaller proportion in this sample living with their children (10.1% compared with 29% in the Conrad, Hanrahan and Hughes study).

It is possible that the greater proportion of married clients in the B.C. sample reflects a greater sensitivity among referral sources in this province to the respite needs of spousal caregivers, many of whom themselves are elderly and "at risk". It is also possible that the lower representation here than in the United States of clients living with their children reflects an underestimation on the part of our referral sources to these caregivers' needs. The attitudes of Long

Term Care Program case managers towards these two types of caregivers is perhaps a topic that should be explored in future studies.

Turning now to client characteristics other than socio-demographic, it should be noted that quite striking similarities are found (see below) when the proportions of clients in this study classified as able to independently perform selected ADLs and IADLs are compared with the proportions reported by Conrad, Hanrahan and Hughes (1980).

	% Able to Perform Independently	
ADLs	CHH Study	This Study
Take care of own appearance	54.3	55.9
Take bath or shower	50.8	42.2*
Dress/Undress	59.0	57.1
Make needs understood	72.0	87.2
Walk	70.1	80.1**
Get to bathroom on time	69.2	81.3
Transfer	74.1	82.0
Eat meals	78.7	83.9
IADLs		
Go shopping	24.2	28.8***
Use telephone	50.7	55.6

Note: In addition to the proportion fully independent in the activity:
* Includes LTC-I category "independent with mechanical aids"
** Includes LTC-I category "independent only within own home/care facility"
*** Includes LTC-1 category "independent only for small items"

The medical conditions of American and B.C. Adult Day Care clients are also similar. For example, Arling, Harkins and Romaniuk (1984) found that the most frequently self-reported diseases among the Adult Day Care clients in their study were: arthritis and rheumatism, heart and circulatory diseases, stroke, speech disorders, eye diseases and diabetes. These conditions fall, for the most part, within the three ICD categories most frequently represented in the present sample of B.C. Adult Day Care clients (i.e. diseases of the circulatory system; diseases of the musculo-skeletal system and connective tissue; and diseases of the nervous system and sense organs).

Most important, however, and as noted earlier in this chapter, there is a striking similarity between the proportion of clients in the present sample with diagnoses falling within the "mental disorders" category (37.8%) and the proportion so classified in the Weissert et al. (1989) study (37.9%).

Given the similarities in ADL and IADL functioning, it would be surprising if, when the diseases included in the "mental disorders" category are disaggregated, it was found that there were a smaller proportion in B.C. than in the United States with a diagnosis of dementia.

When this is considered in conjunction with a) the difficulties Chodosh, Zeffert and Muro (1986), Fisher et al. (1981), Taylor (1984) and the focus group participants report in integrating dementia victims with other clients, b) the apparent substantial number of persons with dementia not currently being served by Adult Day Care and c) the psychological distress apparent in the comments of the Adult Day Care staff when they spoke about centres providing mainly socialization and respite if many more with dementia were to be admitted, establishment of Special Purpose centres for these individuals would seem to be a priority.

Designating one or more days a week exclusively for dementia victims is, of course, another alternative and one that is, we were told by focus group participants, being practised now by some centres in B.C. While this may be the only alternative in some health units, it must be recognized that it has some limitations. One is a logistical one. For example, the Adult Day Care staff in Focus Group III reported that frequently the only day some alert clients can attend is the day reserved for confused clients. Another limitation relates to the environmental design needs of dementia victims which are different from (and may be irritating to) other Adult Day Care centre clients. For example, doors need to be disguised, barriers put in place or locking mechanisms installed to prevent unauthorized exiting by wanderers.

Simplification of the physical environment is also necessary in order to prevent sensory and cognitive overload. The need to adapt activities and services to the capabilities of dementia victims, touched on in the literature review, is another consideration. So too is the need for staff with expertise in working with this client group. (See Gutman, 1989 and Gutman and Killam, 1989 for a detailed discussion of the environmental design, staffing and programming needs of persons with dementia).

7.2. Summary of Differences by Centre Size

In British Columbia, the Adult Day Care Program is a province-wide program, with access based on referral, by Long Term Care Program staff, following a standard assessment of need. As Strain and Chappell (1983) have pointed out for Manitoba where a similar procedure applies, if the eligibility criteria are applied uniformly across the province, there should be few differences between clients living in urban vs. rural settings. Similarly, there should be few differences between clients attending small, mid-sized and large centres.

As indicated in Section 5.0, few differences were in fact found when the characteristics of clients of small, mid-sized and large centres were compared. There were relatively few differences in the activities and services offered by centres in the three size groupings. Where size differences were most apparent was in the centres' affiliation arrangements, in their operating characteristics, and in their staffing. These differences are reviewed below. Also reviewed are the small number of differences found with respect to activities and services and client characteristics.

7.2.1 Affiliation Arrangements

As indicated in Section 4.2, 15.4% of the small centres, 23.8% of the mid-sized centres, and 40.0% of the large centres were found to be free-standing -- that is, not a part of or affiliated with any other organization. The most noticeable difference between the three centre size groupings, however, was in the much greater proportion of small (76.9%) than mid-sized (38.1%) or large centres (26.7%) that were

affiliated with a care facility. Even more interesting, when looked at in another way, (see Table 2) is that in this province, Adult Day Care centres affiliated with a care facility tend to be small or mid-sized rather than large. Those affiliated with a hospital-based Extended Care Unit are exclusively mid-sized. Those affiliated with a community centre or senior centre or with an acute hospital, on the other hand, tend to be mid-sized or large. A key question is why this is so. While it is possible that the answer lies primarily in the size of the physical space available for centre activities, future studies should explore such other possible contributing factors as differences in objectives and in philosophy of care.

7.2.2 Operating Characteristics

As indicated in Section 4.4 the following differences in operating characteristics were found between centres in the three size groupings:

- the proportion of centres open five days a week increases as centre size increases (from 23.1% among the small centres to 66.7% among the mid-sized centres to 86.7% among the large centres);

- a substantially higher proportion of large than of mid-sized or small centres arrange HandyDART or other publicly supported transportation for clients. Large centres were only slightly more likely than mid-sized or small centres however to own a vehicle or have access to one owned by an affiliated organization;

- the proportion of centres serving private clients increases as centre size increases (from 15.4% among the small centres to 57.1% among the mid-sized centres to 66.6% among the large centres); and

- just over half (57.1%) of the mid-sized centres compared with over two-thirds of the small and large have a wait-list. Average wait-list time tends to decrease, however, as centre

size increases (from 4.1 months for small centres to 3.2 months for mid-sized centres to 1.6 months for large centres).

Of these differences, the only one that needs to be explained is the difference in wait list time. Is it because new spaces have recently been added to the centres classified as mid-sized and large enabling them to serve a greater number of clients? Is it because clients of large centres tend, on average, to attend Adult Day Care centres for a shorter period of time? If the latter, future studies should attempt to ascertain why this might be so. A place to start would be to examine reasons for discharge from the Adult Day Care Program and discharge destination. As previously noted, neither of these variables were examined in the present study.

7.2.3. Staffing

As indicated in Section 4.5, while most centres have a designated administrator/coordinator, only two-thirds of the small centres compared with over 86% of the mid-sized and large centres have one or more program workers (as previously noted, in some centres called a "care aide" or "bath aide"). Just under half of the small centres compared with approximately two-thirds of the mid-sized and large centres employ a nurse. Where small and mid-sized centres are similar to one another and differ most from large centres is in the proportion having a secretary/bookkeeper, a cook and a transport worker. That these latter positions should be more highly represented in large centres is not particularly surprising. What is surprising, at least to the present researchers, is that even among large centres, professional therapeutic staff are rare (e.g. even among the large centres only 20.0% employ a music therapist).

7.2.4. Activities and Services

Differences in the activities and services offered by small, mid-sized and large centres are more a matter of proportion than of type. For example, in the area of health care, the most noticeable differences between centres in the three size groupings (see Table 11) were in the

proportion administering medications (more that three-quarters of the mid-sized and large centres compared with just over half of the small centres); the proportion offering dental care and hearing screening (approximately half of the large centres, a quarter of the mid-sized centres and only 7.7% of the small centres), and in the proportion providing/arranging for Medic Alert bracelets, necklaces, etc. (60% of the large centres, 47.6% of the mid-sized centres and 30.8% of the small centres). The difference in the proportion administering medication is consistent with the greater proportion of large and mid-sized centres having a nurse on staff. The difference in the proportion offering hearing screening is consistent with differences in the proportion having access, on a consultative basis, to an audiologist. Differences in the proportion providing/arranging for Medic Alert equipment may be related to cost factors: presumably large centres are able to take advantage of economies of scale.

In the area of personal care, the most noticeable difference was in the greater proportion of large centres mending/altering patients' clothes (46.7% compared with fewer than 15% of mid-sized and small centres).

In terms of transportation other than to and from the centre, the major difference was that all of the small centres compared with only approximately two-thirds of the mid-sized and large centres transport clients to social and recreational events.

There were virtually no differences between the three centre size groupings in the areas of therapeutic activities, recreational and social activities, social services and educational programs.

More large than mid-sized or small centres, on the other hand, were found to offer clients an opportunity to participate in the running of the centre. They also were found to be more likely to provide take-home meals and quiet time activities other than watching T.V.

The greater availability of take-home meals in large than in mid-sized or small centres is likely due to more large centres having a cook on

staff. A number of the other differences described above may reflect the greater availability and use that large centres make of volunteers.

7.2.5. Client Characteristics

As noted at the outset of this section, differences in the characteristics of clients served by the three centre size groupings are very few. One of these few is that a greater proportion of clients in small centres have diseases of the musculo-skeletal system and connective tissue (58% compared with 42.7% and 43.5% respectively in mid-sized and large centres). This difference was not reflected, however, in any greater use of wheelchairs in small (11.3%) as compared to mid-sized (10.0%) and large centres (10.1%). The only other noticeable difference relates to mental health status.

A higher proportion of clients in small centres (50.9%) than in mid-sized (34.0%) or large centres (37.3%) have diagnoses falling within the ICD category "mental illness." Consistent with this, in all five of the mental status categories of the LTC-I (see Table 28), the proportion of clients showing impairment is higher in small than in mid-sized or large centres. The greater tendency of small rather than mid-sized or large centres to serve clients with mental impairments, suggested by these data, is further supported by the level of care data. As shown in Table 22 these data indicate that 15.4% of the clients of small centres were assessed at the Intermediate Care III level compared with 10.7% of clients of mid-sized centres and 4.3% of clients of large centres. It is small centres, in other words, that are likely "carrying the load", as far as persons with dementia are concerned. Considering what is known about the needs of these individuals (see Gutman, 1989 and Gutman and Killam, 1989), a small scale environment is most appropriate for their care. The extra demands placed on the staff of these small centres must, however, be recognized. Support must be provided to them if services to clients with dementia are to be the best possible and if staff burn-out is to be prevented. Such support should include the development of various types and levels of educational material and programming that communicate the latest information concerning: the natural course of

the most common dementias and their manifestations; effective client management techniques and environmental adaptations; effective ways of working with and assisting families of dementia victims; and teaching staff how to manage their particular type of 'on the job' stress. Toward this end, the establishment of a Dementia Care Resource Centre which would serve both as a source of instructors, and a developer and repository of print and audio-visual materials should be considered. Standing alone, or better yet, being part of a Long Term Care Resource Centre, such a centre could be of considerable value to Adult Day Care centres as well as to home support agencies and care facilities, all of which in future, will be faced with increasing numbers of clients with dementia.

7.3. Phase III Findings

The following portion of this chapter, discusses findings from Phase III of the study. It begins on a note of optimism (Section 7.3.1.) as concerns the reasons for referral data. Some qualifications to the findings are then pointed out. This is followed by some concrete suggestions for improving the flow of information between Long Term Care and Adult Day Care. Next to be considered (Section 7.3.2.) are the reasons for non-attendance data which signal some differences in perceptions among and between the two types of staff respondents and clients. The chapter and the report conclude with discussion of findings from Focus Groups II and III which were explicitly concerned with the referral process and the interface between Long Term Care and Adult Day Care.

7.3.1. Reasons for Referral to Adult Day Care

The data reported in Section 6.1 are encouraging in showing that the reasons for referral which, in the opinion of case managers, are most important, and those they feel Adult Day Care is most likely to have an impact on, are the same ones they report most often having referred people to Adult Day Care for.

A problem with the data, of course, is that they are only opinions. For example, it cannot be established from the data that were collected

that Adult Day Care has the positive impact on client's emotional/mental health status that the case managers think it has. To establish this it would be necessary to conduct a before-after study. That is, to collect staff ratings or measurement scale data that show an improvement in clients' mood state or mental health status relative to what it was before admission to Adult Day Care. Ideally, parallel ratings or measures should be obtained for a matched sample of controls (i.e. for similar clients not referred to Adult Day Care), or there should be random assignment to Adult Day Care and to a wait list and\or "no treatment" condition. Similarly, to ascertain the imputed positive impact of Adult Day Care on caregivers, measures would need to be administered to them and to appropriate controls before and after clients are admitted to Adult Day Care.

The problem of being based solely on opinions also exists with the frequency data. The veracity of these data can, however, be more easily ascertained. All that would be required is for the Continuing Care Division to ask case managers, for an agreed upon period of time, to check off on the form used in this study (or otherwise to systematically record) the reasons for every referral they make. However, a more strongly recommended procedure, given the problem that was identified in Focus Group III (see 6.3.2.), of Adult Day Care staff in some health units having difficulty obtaining information from case managers, would be to incorporate on the LTC-I form, perhaps in the existing Section G, a space explicitly for recording the reason(s) for referral.

Consideration should also be given to revising the LTC-I form (or to developing an accompanying form) so as to include space for the other information Adult Day Care staff in Focus Group III indicated they require (i.e. information describing the client's needs relative to the services Adult Day Care can provide, suggesting approaches that might be tried, and identifying any special concerns the case manager has about the client or any problems he/she feels the centre might anticipate experiencing).

It is also strongly recommended that procedures be put into place to facilitate routine and timely transmission of the LTC-I form, to ensure that all relevant portions of it are sent (i.e., pages 1-4 inclusive) and that Adult Day Care staff receive reason(s) for referral and other needed information from Long Term Care case managers.

A final point that should be made in regard to the reasons for referral data concerns their relationship to the objectives and models of Adult Day Care identified in the literature review.

It is clear from the rank ordering of the reasons for referral that assisting the client and/or the family with the transition from home to nursing home is not perceived by case managers as a particularly important function of Adult Day Care, nor taken by itself, is need for an ambulation/walking program, need for podiatry, recent bereavement or an inability to get along with homemakers. Rather, what appear to be, from their perspective, key reasons for referral and key functions of Adult Day Care are providing clients with opportunities for social interaction, improving their emotional/mental health status and providing caregiver respite.

Given the high proportion (see Tables 11 and 15) of centres providing health maintenance, health monitoring and therapeutic programs and services (e.g. physiotherapy) designed to improve/ restore physical functioning, it is surprising that this was not more prominently reflected in the list of reasons for referral generated by Focus Group I or in the subsequent ranking of the list. It is hoped that this does not belie a perception, on the part of numbers of case managers, that Adult Day Care in B.C. is primarily a socialization/respite program. Clearly it is not. Neither, however, should it be construed as a "medical model" program. Rather, it appears to be a blend of what O'Brien (1982) calls "Health Maintenance Programs" and "Adult Day Care Centers", and what Szekais (1985) calls "a Maintenance Health Care Model" and "a Respite Care Model."

The extent to which a particular centre leans more towards one than to the other pole of the socialization/respite - health maintenance continuum is likely, at least in part, a function of the professional training of its staff. It is important to note, however, as was stated at a session on Adult Day Care held at the recent Annual Meeting of the Canadian Association on Gerontology (CAG) held in Victoria, that: "because an Adult Day Care Centre has a nurse doesn't mean it's a medical model. The nurse may be doing mainly counselling." There is a need to exercise caution, in other words, in making assumptions about the type of activities and services offered and about the orientation of a centre based solely on information about the professional training of its staff. Equally important, is the need for those responsible for hiring centre staff to be careful not to over-react against the medical model, and in their zeal, exclude potentially capable and valuable individuals because of their particular professional training. For example, as the speaker at the CAG session noted, "a sometimes overlooked advantage of having a nurse as part of the staff is that she can respond to medical emergencies. This gives clients, families and other staff a sense of security."

7.3.2. Reasons for Non-attendance

As indicated in the introduction to this section of the report, the reasons for non-attendance data indicate some differences between the perceptions of case managers and Adult Day Care staff, and between the two types of staff and clients.

Dealing with the latter first, it should be noted (see Table 30) that among staff, the most frequently chosen reason for non-attendance was "client does not believe he/she is like others who attend Adult Day Care." The second and third most commonly chosen reasons among case managers were, respectively, "client does not enjoy groups" and "too much effort required." Corresponding choices among Adult Day Care staff were "too much effort required" and "when space becomes available client is no longer interested." Staffs' perceptions, in other words, were that clients chose not to attend mainly for psycho-social reasons or because they feared Adult Day Care might be too physically and/or

mentally taxing. The clients' responses, on the other hand, suggest that their primary concerns were practical ones --about being able to see or hear well enough to participate, and about logistics and costs.

This difference in perception is an important one, with obvious practical implications in terms of what case managers should focus on when initially approaching clients about attending Adult Day Care and, especially, when attempting to encourage someone to reconsider refusing a referral. The findings also have implication for the charges that are levied for meals and special activities and for the arrangements that are made in regard to transportation. Additionally, they underscore the need to locate Adult Day Care centres in space that is clearly barrier-free and accessible.

Turning now to the differences between case managers and Adult Day Care staff, there are five very noticeable ones in the reasons for non-attendance data:

- a much higher proportion of case managers than Adult Day Care staff (48.3% vs. 16.6%) chose, as one of the three most important reasons for non-attendance, "client does not enjoy groups";

- a much higher proportion of case managers than Adult Day Care staff (25.9% vs. 2.8%) chose "day too long"; and

- much lower proportions of case managers than of Adult Day Care staff chose reasons that indicate they believe that frequently, when a space becomes available, the client is too ill to attend (6.9% vs. 30.5%), is in a long term care facility (3.4% vs. 19.4%), or is no longer interested in Adult Day Care (15.5% vs. 25.0%).

What these data suggest is that whereas case managers place the focus of non-attendance problem primarily on the client, Adult Day Care staff place more emphasis than they do on problems with the system -- in

particular, that too often it requires clients to endure lengthy waits before being able to attend an Adult Day Care centre.

To ascertain which groups' perception is the more correct one, as well as to reconcile the difference between staff respondents' and clients' perceptions, reasons for non-attendance need to be systematically recorded over a period of time. It is possible that the Adult Day Care staff in Focus Group III over-estimated the proportion of clients who deteriorate physically and/or mentally, enter long term care facilities or die before their name reaches the top of the wait list. It is also possible that the clients and family members who responded to the reasons for non-attendance questionnaire are unrepresentative of the non-attendant population. It will be recalled (see Section 3.3) that they did, in fact, constitute only 26.1% of those sent questionnaires. It should be noted however, that it is difficult to know what is the appropriate denominator here since at least some of those who did not respond and about whom we have no information were probably deceased or too incapacitated to respond. It is important, in other words, not to dismiss out of hand, on the basis of a low response rate, the views reflected by those clients who did respond to the reasons for non-attendance questionnaire.

7.3.3. A Summary of Some Final Comments on the Referral Process and the Interface Between the Long Term Care and Adult Day Care Data.

The information gathered in Focus Groups II and III highlights some important points about the referral process and the interface between Long Term Care and Adult Day Care. These include drawing attention to:

- the problems that are created by extensive wait lists and lengthy wait times. Obviously, every effort should be made to reduce both. It is important, however, that in encouraging case managers to "move the wait list," it is made clear by the Continuing Care Division that this must not be at the expense of current clients who could continue to

remain in the community if able to continue to attend Adult Day Care;

- the fact that case managers are limited in who they can refer to what centres, and in those health units with only one or few centres, whether they can refer a client to Adult Day Care at all. As the case managers in Focus Group II indicated in response to questions 5 and 6 (see Section 6.3.1.) not all centres are able to provide/arrange the transportation a particular client may require; not all centres provide the full range of services identified in Phase I of the study; not all centres will accept or feel they can serve clients at all care levels. A further impediment to referral is the physical space that some centres occupy. As the case managers indicated, in some, the number of wheelchair-bound clients that can be accomodated is severely limited by space constraints. If the Continuing Care Division desires that all centres serve all types of clients, it is necessary to ensure that all centres have the transportation, facilities and equipment, physical space, and especially, the appropriately trained staff to do so. An alternative, of course, is to encourage specialization. For example, this would not have to mean that all persons with dementia would be cared for in Special Purpose centres. Such a policy would be neither desirable nor feasible. Being able to attend a specialized Adult Day Care centre would, however, be the option of choice for some dementia victims, from the perspective of all parties concerned including; the client, his/her family; the staff of the existing centre he/she might otherwise be referred to; and other, non-cognitively impaired centre clients.

- the fact that not all case managers are as familiar as they should be with the activities and services, facilities and staff of the centres to which they refer clients. It is strongly recommended that the Continuing Care Division make

every effort to ensure that full familiarity is achieved by all case managers; and

- the fact that in some health units there are some fairly serious problems in the area of information sharing. For example, the Adult Day Care staff in Focus Group III indicated that in some health units important information from the case manager, about reasons for referral, the clients' specific service needs, potential behaviour problems etc., <u>and</u> key documents such as the LTC-I, are transmitted to Adult Day Care centres, if at all, only after much pressure from the centres and/or after many months have elapsed. In some units, forms are routinely sent but they are incomplete. In some units, centres are given only minimal information about the outcome of STAT centre evaluations and are explicitly told not to contact STAT centres (and physicians) directly. It is important that information flow smoothly both from Long Term Care to Adult Day Care and vice-versa. Towards that end it is recommended that the Continuing Care Division instruct/remind case managers and designated Adult Day Care liaisons a) not to over-play their "gate-keeper" role as regards transmission of information and b) to consult with Adult Day Care centre staff when clients are being reviewed or reassessed, prior to making major changes to a care plan, and when transfer to an institution is being considered. Further, the Continuing Care Division needs to give serious consideration to formalizing and standardizing communication channels and reporting procedures and intervals. For example, respondents in Focus Group III indicated that in some health units centres communicate with Long Term Care only through the designated liaison person; in some, usually through the liaison, but with case managers if difficulties arise; while others communicate directly with case managers in all cases. In some health units meetings with the liaison are regularly scheduled, at weekly or monthly intervals, to go over the wait list and update it,

look at new referrals and review any difficulties. In other units there is no established vehicle for face to face communication. Written reports from centres to Long Term Care also very considerably in content, form, and in the frequency with which they are submitted. For example, in some health units centres provide an initial report within a set period following admission. In some health units, centres submit written reports monthly, in some quarterly, and in some annually. In some health units, case managers attend client care conferences held at the centre. If the case manager is unable to attend, he/she is sent a report of the proceedings. In addition to facilitating effective and efficient information transmission between Long Term Care and Adult Day Care, formalizing and standardizing the above practices and procedures would serve several other purposes. One is that it would eliminate the changes that respondents report frequently occur when there is a change of administration in a local health unit. Another is that it would facilitate Adult Day Care program monitoring both at the local and at the provincial level.

A final point from the Phase III data that has a bearing on the interface between Long Term Care and Adult Day Care, and that should be discussed, concerns clients who could benefit from Adult Day Care but who are not now being referred. When asked who these might be, the case managers in Focus Group II singled out younger disabled adults and persons with dementia. They also mentioned Extended Care level clients and clients unable to cope with being at an Adult Day Care centre for a full day. Before acting on their recommendations and allocating additional spaces, the Continuing Care Division needs to determine the extent of unmet need among these groups (e.g. how many younger disabled adults would actually attend an Adult Day Care centre if the opportunity was presented to them?). In regard to Extended Care level clients and dementia victims, the Division needs to take into consideration the concerns voiced by the Adult Day Care staff in Focus Group III about becoming mainly purveyors of socialization and respite

and serving as "holding places" until facility placement is possible. There is also a need, through an examination of billing and other data, to "check out" the perception of Adult Day Care staff that there has been a marked increase in recent years in the proportion of heavy care clients and dementia victims admitted to their centres.

Finally, the Continuing Care Division needs to clarify its position regarding how far it feels it is appropriate for Adult Day Care to go as regards providing restorative and active rehabilitative health care services.

REFERENCES

Aaronson, L. (1983). Adult day care: a developing concept. Journal of Gerontological Social Work, 5(3), 35-47.

American Occupational Therapy Association (1986). Roles and functions of occupational therapy in adult day care. American Journal of Occupational Therapy, 40(12), 817-821.

Anand, K.B., Thomas, J.H., Osborne, K.L. & Osmolski, R. (1982). Cost and effectiveness of a geriatric day hospital. Journal of the Royal College of Physicians of London, 16(1)., 53-56.

Arie, T. (1979). Day care in geriatric psychiatry, 1978. Age and Ageing, 8(supplement), 87-91.

Arling, G., Harkins, E. D., & Romaniuk, M. (1984). Adult day care and the nursing home: the appropriateness of care in alternative settings. Research on Aging, 6(2), 225-242.

Asbury, C. & Merrill, J. (1989). Dementia long term care services: the emerging role of day centres. Pride Institute Journal of Long Term Home Health Care, 8(4), 28-34.

Brockelhurst, J. C. (1979). The development and present status of day hospitals. Age and Ageing, 8(supplement), 76-79.

Brockelhurst, J. C. (1970). The Geriatric Day Hospital. London: Kind Edward Hospital Fund.

Butrin, J. (1986). Day care - a new idea? not really. Journal of Gerontological Nursing, 11(4), 19-22.

Chappell, N. L. (1983). Who benefits from adult day care: changes in functional ability and mental functioning during attendance. Canadian Journal on Aging, 2(1), 9-26.

Cherry, D. L., & Rafkin, M. J. (1988). Adapting day care to the needs of adults with dementia. The Gerontologist, 28(1), 116-120.

Chodosh, H.L. Zeffert, B. & Muro, E.S. (1986). Treatment of dementia in a medical day care program. Journal of the American Geriatrics Society, 34(12), 881-886.

Conrad, K,. J., Hanrahan, P., & Hughes, S. L. (1990). Survey of adult day care in the United States; national and regional findings. Research on Aging, 12(1), 36-56.

REFERENCES (cont'd)

Dilworth-Anderson, P., & Hildreth, G. J. (1982). Administrators' perspectives on involving the family in providing day care services for the elderly. Family Relations, 31(3), 343-348.

Dix, G. Implementation. In: C. L. O'Brien (ed.) Adult Day Care: A Practical Guide. Monterey, California: Wadsworth Health Services Division (Chapter 12).

Doherty, N. J. G. & Hicks, B. C. (1975). The use of cost-effectiveness analysis in geriatric day care. Gerontologist, 15(5), 412-417.

Feingold, J. (1977). Nursing homes versus day care: the cost effectiveness battle. Nursing Homes, 26, 10-11.

Fisher, R.H. Nadon, G.W. Dawson, P. and Curries-Mills, C. (1981). A geriatric day hospital: the Sunnybrook experience. Canadian Medical Association Journal, 125, 447-450.

Frenkel, E. R., Sherman, S. R., Newman, E. S., & Derico, A. (1984). The continuum of care within psychogeriatric day programming: a study of program evolution. Journal of Gerontological Social Work, 7(4), 17-27.

Gaertner, S. L., Sterling, B. S., & Markisohn, G. (1982). Adult day care - a viable alternative: a comparison of adult day-care participants and nursing home residents. International Journal of Partial Hospitalization, 1(2), 151-158.

Gibbons, K. (1971). A new era of day care programs for the elderly. Hospital Progress, 52, 47-49.

Goldstein, R. (1982). Adult day care: expanding options for service. Journal of Gerontological Social Work, 5(1/2), 157-168.

Goldstein, S., Sevriuk, J. & Grauer, H. (1968). The establishment of a psycho-geriatric day hospital. Canadian Medical Association Journal, 98, 955-959.

Greene, J. G. & Timbury, G. C. (1979). A geriatric psychiatry day hospital service: a five year review. Age and Ageing, 8, 49-53.

Greiff, S. A. & McDonald, R. D. (1973). Roles of staff in a psychogeriatric day care center. Gerontologist, 13, 39-44.

Grimaldi, P. L. (1979). The costs of adult day care and nursing homes: a dissenting view. Inquiry, 16, 162.

REFERENCES (cont'd)

Gutman, G.M. (1989). Dementia Patients in Institutions: a Review of Recommendations and Research Concerning their Environmental Design, Staffing and Programming Needs. Vancouver: Simon Fraser University Gerontology Research Centre, March.

Gutman, G.M. and Killam, J. (1989). Special Care Units for Dementia: Staff and Family Perceptions. Vancouver: Simon Fraser University Gerontology Research Centre, September.

Hackman, H. (1978). Day care for the frail elderly: an alternative. Public Welfare, Fall, 36-44

Hannah, E. L. & O'Donnell, J. F. (1984). Adult day care services in New York State: a comparison with other long-term care providers. Inquiry, 21, 75-83.

Hildick-Smith, M. (1980). Geriatric day hospitals: practice and planning. Age and Ageing, 9(1), 38-46.

Jarrell, A. (1989). Adult Day Care in British Columbia. A report prepared for the Home Support Association of British Columbia.

Jones, I.G. & Munbodh, R. (1982). An evaluation of a day hospital for the demented elderly. Health Bulletin, 40(1), 10-15.

Keyes, B., & Szpak, G. (1983). Day care for Alzheimer's disease: profile of one program. Postgraduate Medicine, 73(4), 245-247, 250.

Kirwin, P. M. (1986). Adult day care: an integrated model. Journal of Gerontological Social Work, 9(2), 59-71.

Knapp, M. & Missiakoulis, S. (1982). Inter-sectoral cost comparisons: day care for the elderly. Journal of Social Policy, 11(3), 335-354.

Kostick, A. (1972). A day care program for the physically and emotionally disabled. Gerontologist, 12(2), 134-138.

Leung, E. M. F., & Ng, Y. Y. (1984). Geriatric day hospital in Hong Kong: a three-year follow-up study. Age and Ageing, 13, 282-284.

Lindeman, D. A., Bogaert-Tullis, M., Teetz, D.A., Fox, P.J. and Benjamin, A. E. (1987). Final Report - State of California Alzheimer's Day Care Resource Center Program. San Francisco: Institute for Health and Aging, University of California

REFERENCES (cont'd)

Macdonald, A. J. D., Mann, A. H., Jenkins, R., Richard, L., Godlove, C., & Rodwesll, G. (1982). An attempt to determine the impact of four types of care upon the elderly in London by the study of matched groups. Psychological Medicine, 12, 193-200.

MacFarlane, J. P. R., Collings, T., Graham, K., & MacIntosh, J. C. (1979). Day hospitals in modern clinical practice - cost benefit. Age and Ageing, 8(Supplement), 80-85.

McCarthy, R. (1984). Day care within a senior center. Physical and Occupational Therapy in Geriatrics, 3(4), 71-74.

Morishita, L., Sui, A. L., Wang, R. T., Oken, C., Cadogan, M. P., & Schwartzman, L. O. (1989). Comprehensive geriatric care in a day hospital: a demonstration of the British model in the United States. Gerontologist, 29(3), 336-340.

National Institute on Adult Daycare (1984). Standards for Adult Daycare. Washington, D.C. National Council on the Aging.

National Institute on Adult Daycare (1985). Why Adult Daycare? Washington, D.C. National Council on the Aging.

National Institute on Adult Daycare (1990). Standards and Guidelines for Adult Day Care. Washington, D.C. National Council on Aging.

Neustadt, L. E. (1985). Adult day care: a model for changing times. Physical and Occupational Therapy in Geriatrics, 4(1), 53-66.

O'Brien, C. L. (1982). Program development. In: C.L. O'Brien (ed.) Adult Day Care: A Practical Guide. Monterey, California: Wadsworth Health Sciences Division. (chapter 10).

Padula, H. (1981). Toward a useful definition of adult day care. Hospital Progress, 42-45.

Panella, J. (1987). Daycare Programs for Alzheimer Disease and Related Disorders. New York: Demos Publications.

Panella, J. J., Lilliston, B. A., Brush, D., & McDowell, F. H. (1984). Day care for dementia patients: an analysis of a four-year program. Journal of the American Geriatrics Society, 32, 883-886.

Rabinowitz, E. (1986). Day care and Alzheimer's disease: a weekend program in New York City. Physical and Occupational Therapy in Geriatrics, 4(3), 95-103.

Rathbone-McCuan, E. (1976). E. (1976). Geriatric day care: a family perspective. Gerontologist, 16(6), 517-521.

Regional Municipality of Niagara. (1977). A Study of Day Care for Senior Citizens. Welland, Ontario: Senior Citizens Department.

Riddings, K. W., & Isdale, I. C. (1978). The day hospital: efficacy and cost effectiveness. New Zealand Medical Journal, 87, 129-133.

Robertson, G. (1985). Cost Effectiveness Analysis of an Adult Day Care Program. Unpublished Master's Thesis, Faculty of Business Administration, Simon Fraser University.

Ross, D. N. (1976). Geriatric day hospitals; counting the costs compared with other methods of support. Age and Ageing, 5, 171-175.

Sands, D., & Suzuki, T. (1983). Adult day care for Alzheimer's patients and their families. Gerontologist, 23(1), 21-23.

Smith, G., Cantley, C. and Ritman, V. (1983). Patient turnover in a new psychogeriatric day hospital: a pluralistic evaluation. Ageing and Society, 3(3), 325-356.

Statistics Canada (September 1982). 1981 Census: Population, Age, Sex and Marital Status: Catalogue 92-901 Table 6. Ottawa, Ontario: Statistics Canada.

Steele, C., Lucas, M. & Tune, L. (1982). An approach to the management of dementia syndromes. The Johns Hopkins Medical Journal, 151, 362-368.

Szekais, B. (1985). Adult day-care centres: geriatric day health services in the community. Journal of Family Practice, 20(2), 157-161.

Taylor, J.R. (1984). Adult Centers in Virginia. Virginia Medical, 111, 148-150.

Tucker, M. A., Davidson, J. C. and Ogle, S. J. (1984). Day hospital rehabilitation - effectiveness and cost in the elderly: a randomized controlled trial. British Medical Journal, 289(3), 1209-1212.

Wan, T. H., Weissert, W. G., & Livieratos, B. B. (1980). Geriatric day care and homemaker services: and experimental study. _Journal of Gerontology_, _35_(2), 256-274.

Weissert, W. G. (1976). Two models of geriatric day care: findings from a comparative study. _Gerontologist_, _16_(5), 420-427.

Weissert, W. G. (1977). Adult day care programs in the United States: Current research projects and a survey of 10 centres. _Public Health Reports_, _92_, 49-56.

Weissert, W. G. (1978). Costs of adult day care: a comparison to nursing homes. _Inquiry_, _15_(1), 10-19.

Weissert, W. G., Elston, J. M., Bolda, E. J., Cready, C. H., Zelman, W. N., Sloane, P. D., Kalsbeek, W. D., Mutran, G., Rice, T. H. & Koch, G. C. (1989). Models of adult day care: findings from a national survey. _Gerontologist_, _29_(5), 640-649.

Zarit, S. H. (1978). Predictors of outcome among day care participants. _Long Term Care and Health Services Administration Quarterly_, _2_(2), 150-162.

APPENDIX 1

Medical Diagnoses Included in ICD Categories

DIAGNOSES - (Medical diagnoses - from ICDA Classification)

Code 3-digit numbers if applicable, otherwise code 2-digits (plus "X") only.
X codes include "other" or "unspecified" problems within a given category. If two conditions have the same number, repeat that number twice in coding.

I INFECTIVE AND PARASITIC DISEASES

00X Intestinal Infectious Diseases
01X Tuberculosis
02X Zoonotic bacterial diseases
03X Other bacterial diseases
04X Poliomyelitis and other enterovirus diseases of central nervous system
044 Late effects of acute poliomyelitis
045 Aseptic meningitis due to enterovirus
05X Viral diseases accompanied by exanthem
06X Arthopod-borne viral diseases
07X Other viral diseases
08X Rickettsioses and other arthropod-borne diseases
09X Syphilis and other venereal diseases
094 Syphilis of central nervous system
10X Other spirochetal diseases
11X Mycoses
12X Helminthiases
13X Other infective and parasitic diseases

V25 II NEOPLASMS

14X Malignant neoplasm of buccal cavity and pharynx (i.e. mouth and throat)
141 Malignant neoplasm of tongue
149 Malignant neoplasm of pharynx, unspecified
15X Malignant neoplasm of digestive organs and peritoneum
150 Malignant neoplasm of esophagus
151 Malignant neoplasm of stomach
152 Malignant neoplasm of small intestine, including duodenum
153 Malignant neoplasm of large intestine, except rectum
154 Malignant neoplasm of rectum and rectosigmoid junction
155 Malignant neoplasm of liver and intrahepatic bile ducts, specified as primary
156 Malignant neoplasm of gallbladder and bile ducts
157 Malignant neoplasm of pancreas
158 Malignant neoplasm of peritoneum and retro-peritoneal tissue
159 Malignant neoplasm of unspecified digestive organs
16X Malignant neoplasm of respiratory system
162 Malignant neoplasm of trachea, bronchus, and lung
17X Malignant neoplasm of bone, connective tissue, skin, and breast
170 Malignant neoplasm of bone
174 Malignant neoplasm of breast
18X Malignant neoplasm of genitourinary organs
180 Maligant neoplasm of cervix uteri
185 Malignant neoplasm of prostate
188 Malignant neoplasm of bladder
19X Malignant neoplasm of other and unspecified sites
191 Malignant neoplasm of brain
20X Neoplasms of lymphatic and hematopoietic tissue
201 Hodgkin's disease
203 Multiple myeloma
204 Lymphatic leukemia
207 Other and unspecified leukemia
21X Benign neoplasms
23X Neoplasm of unspecified nature

III ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES

24X Diseases of thyroid gland
243 Cretinism of congenital origin
25X Diseases of other endocrine glands
250 Diabetes mellitus
255 Diseases of adrenal glands (Addison's Disease)

III ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES

26X Avitaminoses and other nutritional deficiency (malnutrition)
27X Other metabolic diseases
274 Gout
277 Obesity not specified as of endocrine origin

V27 28X (IV) DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

280 Iron deficiency anemias
284 Aplastic anemia
286 Coagulation defects

V V MENTAL DISORDERS

29X Psychoses
290 Senile and presenile dementia
291 Alcoholic psychosis
295 Schizophrenia
297 Paranoid states
30X Neuroses, personality disorders, and other non-psychotic mental disorders
300 Neuroses (anxiety/depression)
303 Alcoholism
304 Drug dependence
31X Mental retardation

V VI DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

32X Inflammatory diseases of central nervous system
33X Hereditary and familial diseases of nervous system
34X Other diseases of central nervous system
340 Multiple sclerosis
341 Other demyelinating diseases of central nervous system
343 Cerebral spastic infantile paralysis
345 Epilepsy
35X Diseases of nerves and peripheral ganglia
354 Polyneuritis and polyradiculitis
36X Inflammatory diseases of the eye
37X Other diseases and conditions of eye
370 Refractive errors (failing vision, poor vision)
374 Cataract
375 Glaucoma
379 Blindness
38X Diseases of the ear and mastoid process
388 Deaf mutism
389 Other deafness (incl. poor hearing)

V30 VII DISEASES OF THE CIRCULATORY SYSTEM

39X Chronic rheumatic heart disease
40X Hypertensive disease (high blood pressure)
41X Ischemic heart disease (CHF, "coronary", "heart attac
410 Acute myocardial infarction
411 Other acute and subacute forms of ischemic heart disease
413 Angina pectoris
42X Other forms of heart disease (coronary insufficiency, "cardiac condition")
43X Cerebrovascular disease
431 Cerebral hemorrhage (stroke, CVA)
44X Diseases of arteries, arterioles, and capillaries
440 Arteriosclerosis
45X Diseases of veins and lymphatics, and other diseases of circulatory system
451 Phlebitis and thrombophlebitis
454 Varicose veins of lower extremities (leg ulcers)
455 Hemorrhoids

V31 VIII DISEASES OF THE RESPIRATORY SYSTEM

46X Acute respiratory infections, except influenza
47X Influenza
48X Pneumonia
49X Bronchitis, emphysema and asthma
490 Bronchitis, unqualified
491 Chronic bronchitis
492 Emphysema
493 Asthma
50X Other diseases of upper respiratory tract
51X Other diseases of respiratory system (lung problems-unspecified)

V32 IX DISEASES OF THE DIGESTIVE SYSTEM

52X Diseases of oral cavity, salivary glands, and jaws
53X Diseases of esophagus, stomach, and duodenum (gastritis)
531 Ulcer of stomach
532 Ulcer of duodenum
533 Peptic ulcer, site unspecified
54X Appendicitis
55X Hernia of abdominal cavity (incl. hiatus hernia)
56X Other diseases of intestine and peritoneum, constipation
57X Diseases of liver, gallbladder, and pancreas
571 Cirrhosis of liver

V33 X DISEASES OF THE GENITOURINARY SYSTEM

58X Nephritis and nephrosis
59X Other diseases of urinary system
595 Cystitis (bladder infection)
60X Diseases of male genital organs (prostate conditions)
61X Diseases of breast, ovary, fallopian tube and parametrium
62X Diseases of uterus and other female genital organs

V34 XI COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM

63X Complications of pregnancy: urinary infections and toxemias of pregnancy and the puerperium.
64X Abortion
65X Delivery
67X Complications of the puerperium

V35 XII DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE

68X Infections of skin and subcutaneous tissue
69X Other inflammatory conditions of skin and subcutaneous tissue
70X Other diseases of skin and subcutaneous tissue, edema or fluid retention, leg ulcer (unspecified cause)

V36 XIII DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

71X Arthritis and rheumatism, except rheumatic fever
712 Rheumatoid arthritis and allied conditions
713 Osteoarthritis and allied conditions
715 Arthritis, unspecified
718 Rheumatism, unspecified
72X Ostemyelitis and other diseases of bone and joint, low back pain, osteoporosis
73X Other diseases of musculoskeletal system (bursitis)

V37 74X (XIV) CONGENITAL ANOMALIES

741 Spina bifida
742 Congenital hydrocephalus
759 Congenital syndromes affecting multiple systems

XVI SYMPTOMS AND ILL-DEFINED CONDITIONS

Includes: S.O.B., edema, shakiness, poor bal., fatigue

78X Symptoms referable to systems or organs
79X Senility and ill-defined diseases
794 Senility without mention of psychosis, old age

XVII ACCIDENTS, POISONINGS, AND VIOLENCE (NATURE OF INJURY)

80X Fracture of skull, spine, and trunk
81X Fracture of upper limb
82X Fracture of lower limb shoulder
820 Fracture of neck of femur (i.e. hip)
824 Fracture of ankle
83X Dislocation without fracture
84X Sprains and strains of joints and adjacent muscl
85X Intracranial injury (excluding those with skull fracture)
86X Internal injury of chest, abdomen, and pelvis
87X Laceration and open wound of head, neck, and tru
88X Laceration and open wound of upper limb
89X Laceration and open wound of lower limb
90X Laceration and open wound of multiple location
91X Superficial injury
92X Contusion and crushing with intact skin surface
93X Effects of foreign body, entering through orifi
94X Burn
95X Injury to nerves and spinal cord
96X Adverse effect of medicinal agents
98X Toxic effect of substances chiefly nonmedicinal as to source
99X Other adverse effects

NOTE:

01A - 99A Operations and Nonsurgical Procedures (see ICDA book, page 524-7)

Code new fractures as surgery and old fractures under section XVII above

Operations and Nonsurgical Procedures: Use ICDA 8th Revision number codes (page 524-7) adding:

A = old

B = recent

C = unspecified

APPENDIX 2

Information and Support Letters Sent to all Centres at the Start of the Study

Province of
British Columbia

Ministry of
Health

Continuing Care Division
Parliament Buildings
Victoria
British Columbia
V8V 4V7

August 30, 1989

To all Adult Day Care Service Providers

Dear :

Re: Adult Day Care Study

The Adult Day Care Program has expanded in the past ten years as an important and integral part of the Continuing Care Division, Home Support Program. In order to ensure development of sound, long range planning for maximum utilization of this resource, additional information is required. Although various studies and surveys have been conducted in the past, some vital information is still not available.

A joint steering committee comprised of Ministry of Health personnel and adult day care service providers requested that the Ministry commission a study to specifically obtain an accurate Provincial summary of the range of services provided in all adult day care centres and the characteristics of the client population being served. In response, the Continuing Care Division of the Ministry of Health has contracted with the Gerontology Research Centre at Simon Fraser University for this study, which is being carried out by a team led by Dr. Stephen Milstein and Dr. Gloria Gutman.

. . . 2

This study is supported by the Home Support Association of British Columbia, the British Columbia Long Term Care Association, and the British Columbia Health Association. Your contribution and that of your agency, as well as compliance with the study schedule is essential.

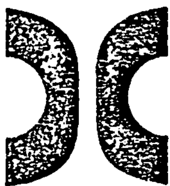
Thank you in advance for your assistance in making this important project successful.

Yours sincerely,

Original Signed By
Andrew Butler

per Paul Pallan
Executive Director
Continuing Care Division

!CICERI/REDGRAVE:drs CCD 3104H



Home Support Association of British Columbia

-4255 Arbutus Street
Arbutus Shopping Centre
Vancouver, B.C. V6J 4R1
Fax (604) 734-8039
Telephone (604) 736-0416

DATE: August 25, 1989

TO: HSABC Adult Day Care Members

FROM: Gloria Lifton

Dear Adult Day Care Member:

I am writing to express my personal support and the support of the Home Support Association of British Columbia for the study of Adult Day Care Programs that is being carried out by the Simon Fraser University Gerontology Research Centre under contract to the Continuing Care Division of the Ministry of Health. Continued healthy development of a Provincial Adult Day Care system demands that accurate information as to the current status of the system be made available. Although a number of surveys have been completed none have been directed toward providing the basic information being sought in this study.

In making this request for your support we appreciate that most agencies and programs have a heavy workload and that you have already participated in several research projects. However, the potential value of this study makes it essential that you participate and also comply with the project timetable. It is my hope that all agencies affiliated with the Home Support Association of British Columbia can adhere to the project timetable.

Sincerely,

HOME SUPPORT ASSOCIATION OF B.C.

Gloria Lifton
Executive Director

GL/jw

APPENDIX 3

Request for Data for Phase I, Part I (all centres)

Please find enclosed a package containing several items. Some of these items are for your interest and to help you understand the importance of the Study. Others are tasks which we are asking you to fulfill during the course of the Study.

While we ask all Adult Day Care Agencies to provide some information in the initial stages of the Study as indicated, not all will be included in the final sample. Rather, the actual agencies selected for sampling will be randomly selected and asked to participate further in the Study. It is expected that 15-20 agencies will be selected to take part in this phase of the Study.

This package should include:

1. a letter from Dr. S. Milstein

2. a brief outline of the study

3. the expected outcome of Study 1

4. the allocation of tasks of all Adult Day Care Agencies with the completion date included

5. the response form

6. addressed envelope in which to return the response form to the research team if necessary

Questionnaires and other information gathering material will be mailed at appropriate times. Complete instructions will be included with this material.

SIMON FRASER UNIVERSITY

GERONTOLOGY DIPLOMA PROGRAM (604) 291-3593
GERONTOLOGY RESEARCH CENTRE (604) 291-3555

BURNABY, BRITISH COLUMBIA
CANADA V5A 1S6

Harbour Centre
515 W. Hastings
Vancouver, B.C.
V6B 5K3

September 7, 1989

Dear :

As you already know the Simon Fraser University Gerontology Research Centre has been asked by the Ministry of Health to carry out a study on Adult Day Care in British Columbia. This study was initiated by the Ministry and a steering committee made up of representatives of Adult Day Care agencies. The study is designed to obtain basic information as to what services are provided by Adult Day Care and who receives these services. In addition, the study will compare the assessed needs for specific services, as viewed by the LTC assessor, with the need following an assessment by the Adult Day Care once the client has been referred.

We are aware that agency personnel are extremely busy and agencies are often short of manpower and resources. Therefore we have designed this study to minimize the work that we are asking you to do. We have enclosed information on the tasks that you are being asked to do and an estimation of the time that each will take. We do realize that you have been asked to cooperate with and participate in a number of other studies and surveys during the last 6 months and regret that we must ask you to do it again. While we have attempted to minimize the demands that this study will make on agency time, we cannot carry out this work without your assistance. YOUR COOPERATION IS ESSENTIAL TO THE SUCCESS OF THIS STUDY.

.../2-

The study is structured and the data will be reported in a way that THE RESULTS CANNOT BE LINKED BACK TO ANY SPECIFIC AGENCY AND THE CONFIDENTIALITY OF YOUR CLIENTS WILL BE PROTECTED.

We are of the opinion that the Ministry of Health is interested in developing a strong continuum of care and that Adult Day Care is seen as an important and essential part of this continuum. Rational planning is not possible without this basic data. The results of this study should increase the value of the other studies, data and information that you have contributed.

It is our hope that the tasks we are asking of you will not provide too much of a burden on your program and that as a result of your participation, the ADULT DAY CARE system will become stronger. Please examine the entire package of material that you have received. If you have any questions or feedback please call me at 684-0846 (in Vancouver). We look forward to your participation and some interesting results.

Sincerely,

Stephen L. Milstein, Ph.D.

SLM/DL/ws

Encl.

ADULT DAY CARE STUDY

BACKGROUND

The idea for this study was first presented in March, 1987 when the Continuing Care Division of the Provincial Ministry of Health asked Dr. S. Milstein and Gutman of the Gerontology Research Centre at Simon Fraser University to attend a meeting of a Ministry steering committee to discuss a study of Adult Day Care in British Columbia. In attendance in addition to Dr. S. Milstein and Gutman were representatives of the Continuing Care Division, of regional health units and of the associations representing Adult Day Care Agencies.

At this and subsequent meetings of this group, it was agreed that there was a need for a study of Adult Day Care and that this work would be carried out by The Gerontology Research Centre. The involvement of key people from a representative group of agencies was extremely important as the cooperation of all of the adult day care agencies is essential to the success of this or any study of these agencies. Several meetings were held at which the type of information needed was discussed and the Gerontology Research Center's approach to collecting this information was presented. The goals, and procedures of this study reflect what was expressed at these meetings.

REASON(S) FOR THIS STUDY

Current thinking within the Ministry of Health, including the Continuing Care Division is that there is a need to strengthen home support services (of which adult day care is an integral part) and to limit the use of residential care to those instances where community supports are not suitable. The Ministry of Health, Continuing Care Division, assumed responsibility for management of the Adult Day Care Program in 1979. Since that time, the Adult Day Care Program has expanded from provision of a primarily social/recreational program to include provision of an organized program of physical, social and preventative health care services and therapeutic activities in 46 centres located throughout British Columbia.

Due to the expansion in size of the Adult Day Care Program and variability in types of programs offered, a comprehensive service review which will yield reliable, quantitative data with respect to identification of services provided, clients served, model(s) of service delivery and the role of adult day care in the overall case management of the client is required. This data will assist the Continuing Care Division with respect to long range planning for this unique resource.

SPECIFIC OBJECTIVES OF THE STUDY

1) To Prepare an inventory and description of all services provided in all adult day care centres.
2) To describe the client population in attendance at adult day care centres.
3) To describe the interface of the Long Term Care Program with adult day care.
4) Using the data collected under objectives 1-3 to determine if there are models of service delivery operating among the surveyed centres and if so to describe the models under which they are operating.

THE THREE (3) PHASES OF THIS STUDY

This study consists of three phases. They are: the description of services provided by adult day cares, the description of clients served by adult day cares, and a description of the relationship between the prescriptions given by the Long Term Care assessors and the service received. Each of these three phases is designed to meet the one of the objectives listed(1-3) in the previous section.

The rest of the material in this package pertains only to Phase 1 and 2. Further information regarding Phase 3 will be sent to you shortly.

THE EXPECTED OUTCOME OF STUDY I

The activity data will be reported as follows:

*A list of every activity and service offered by each of the agencies and the percentage of clients during the year who receive the service and or participate in the activity. This data will also be aggregated by category. The agency specific data will only be provided to the agency supplying it.

*The data from all the agencies will be aggregated by region (lower mainland, northern, interior, island) and the number, and percentage of agencies offering each activity or service will be reported. The percentage of clients during the year who receive the service and or participate in the activity will also be aggregated and reported.

*The data for the whole province from all the agencies will be aggregated, and the number and percentage of agencies offering each activity or service will be reported. The percentage of clients during the year who receive the service and or participate in the activity will also be aggregated and reported.

THE EXPECTED OUTCOME OF STUDY II

* To describe the actual characteristics of the clientele served by Adult Day Care Centres.

* The report on the data will present each demographic variable in a contingency table which will give the number and percentage of individuals at each level of the variable by target group sub-category.

* The data will be aggregated by region and for the whole province.

RESPONSE FORM

I cannot meet the schedule for tasks #1 because of the following reason:

I can complete and return the requested information on the dates listed below.

TASKS #1 FOR THE ADULT DAY CARE AGENCIES
ON BEHALF OF THE ADULT DAY CARE STUDY

As a first step in the Adult Day Care Study, we are asking all the Adult Day Care agencies in the province to provide us with the following information:

1. A copy of the job description for every position within your Agency. This is the responsibility of the Executive Director or head of your Adult Day Care Agency.

2. Any additional information that you have on activities carried out, and programs and services offered by your agency. This information will be used to develop a master list categorizing your duties in operational terms.

3. A blank copy of all forms that contain any client information.

4. The total number of clients your agency has on file. Please note: only those clients who have attended or who have received services within the last 90 days are to be included.

Because we are committed to specific deadlines, it is most important that this information be returned to the research team no later than ten days after the receipt of this package. We expect this to be approximately September 25. If you cannot meet this schedule please complete the response form indicating when you can complete and return the requested information. Thank you for your cooperation.

APPENDIX 4

Request for Data for Phase I, Part II (27 centres not selected to provide client demographic data)

INFORMATION SHEET

Enclosed in this package is a letter from Dr. S. Milstein and a questionnaire regarding the activities and services offered by adult day care centres in B.C. We realize that you are coming up to the busiest time of the year. The questionnaire will take 30 minutes or less to answer. Therefore it is our expectation that it can be completed before your Christmas activities commence.

Because we are also working within a tight schedule, if your cannot complete it by the deadline of December 8, 1989, please let us know when we can expect it by completing the following form and returning it to us at the address listed below.

Adult Day Care Centre Study
Gerontology Research Centre
Simon Fraser University at Harbour Centre
515 West Hastings Street
Vancouver, B.C.
V6B 5K3

Attn: Doris Lewis.

I cannot meet the deadline of December 8, 1989 for returning the questionnaire but can complete and return it by

____

Signed______________________

Facility______________________

SIMON FRASER UNIVERSITY
AT HARBOUR CENTRE

Sample letter to those agencies not providing client sample.

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

Nov. 17, 1989

Dear :

Thank you for providing us with the program and client information that was requested of you. We are pleased to report that <u>every</u> Adult Day Care in the province sent in their information. This 100% participation will help us all to obtain an accurate picture of Adult Day Care in British Columbia.

We are now ready for step 2 of this study. Enclosed you will find an exhaustive check list of activities that were generated from the program material sent in by all the programs. Please read the instructions very carefully, complete the checklist and return it to us by December 8.

This is the last task that we are asking you to do for the Study. We greatly appreciate the cooperation that you have given us and look forward to providing you feedback on the array of services being offered in B.C.

Sincerely,

Stephen L. Milstein, Ph.D.
Research Associate

Encl.
SM/DL/ws

APPENDIX 5

Request for Data for Phase I, part II and Phase II
(22 centres selected to provide client demographic data)

INFORMATION SHEET

Enclosed in this package is:

a) a letter from Dr. S. Milstein

b) a questionnaire regarding the activities and services offered by adult day care centres in B.C.

c) a list of instructions regarding the procedure to be followed for providing the required information

d) a sample of the first page of a LTC form as a guide for gathering the required information

e) a faceplate to be used during the information gathering process

f) a worksheet containing identification numbers and names of clients to be used during the information gathering process.

We realize that you are coming up to the busiest time of the year. The questionnaire will take 30 minutes or less to answer. The photocopying of the LTC's of your sample of clients as listed on the enclosed worksheet will take approximately 30 to 40 minutes. Therefore it is our expectation that it can be completed before your Christmas activities commence.

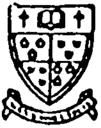
Because we are also working within a tight schedule, if your cannot complete it by the deadline of December 8, 1989, please let us know when we can expect it by completing the following form and returning it to us at the enclosed address.

I cannot meet the deadline of December 8, 1989 for returning the questionnaire but can complete and return it by

____

Signed___________________________

Facility_________________________



SIMON FRASER UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

Nov. 17, 1989

Dear :

Thank you for providing us with the program and client information that was requested of you. We are pleased to report that every Adult Day Care in the province sent in their information. This 100% participation will help us all to obtain an accurate picture of Adult Day Care in British Columbia.

We are now ready for steps 2 and 3 of this study. Enclosed you will find an exhaustive check list of activities that were generated from the program material sent in by all the programs.

In addition to the activity list we require some information from you regarding the clients attending your program. Only 22 of the 49 Adult Day Agencies have been randomly selected to provide client information, therefore it is very important that you follow the instructions regarding the selection of those clients on whom you will provide information. Please note when you are reading the client selection instructions that we do not wish to receive the names of the clients whose information that you send us.

.../2-

Office location: 2175-555 West Hastings Street

This is the last task that we are asking you to do for the Study. We greatly appreciate the cooperation you have given us and look forward to providing your feedback on the array of services being offered and characteristics of the clientele served by Adult Day Care in B.C. Please read the instructions very carefully, complete the checklist, gather the client information and return it to us by December 8, 1989.

Sincerely,

Stephen L. Milstein, Ph.D.
Research Associate

Encl.
SM/DL/ws

TASK #2

A SURVEY OF ACTIVITIES AND SERVICES OFFERED BY ADULT DAY CARE CENTRES IN BRITISH COLUMBIA

Col.#

		1

1. Facility ______________________

2. Location ______________________

Thank you for responding so well to our first request for a list of activities and services offered by your agency. The information you provided has been most helpful in developing this master list of activities and services which we are now asking you to complete.

We have designed this questionnaire with your busy schedule in mind. You will notice we have kept the writing of answers to a minimum. This questionnaire should take no longer than 30 minutes to complete.

Please note that we wish to know what services and activities your agency offers AT THE PRESENT TIME, not what you may hope to offer or have provided in the past. It is important that you answer each question as is indicated. Each question requires an answer; please do not leave any questions unanswered. Fill appropriate blanks with the requested information and CIRCLE "Yes" or "No" where applicable. The numbers in the far right columns are for data entry purposes and should be ignored by you.

SECTION I FACILITY DEMOGRAPHIC INFORMATION

3. How many days per week is your Centre open? ________ | 4

4. How many hours per day are you open? (to the nearest half hour) ________ | 5-8

5. a) Do the clients themselves pay any fee? (1) Yes (2) No | 9

   IF NO, skip to question 6.

   If yes, answer Parts (b) and (c).

   b) Fee charged LTC client per day? (to the nearest dollar) ________ | 10-11

   c) Fee charged private client per day? (to the nearest dollar) ________ | 12-13

6. Do you provide transportation to and from the Adult Day Care Centre to some or all of your clients? (1) Yes (2) No | 14

   IF NO, skip to question 7.

   If yes, type of transportation:

   a) facility owned (1) Yes (2) No | 15

   b) Handi-dart (1) Yes (2) No | 16

   c) other public supported (1) Yes (2) No | 17

   d) private service (1) Yes (2) No | 18

   e) private car (1) Yes (2) No | 19

   f) Other (specify) ________ (1) Yes (2) No | 20

7. On average, how many clients come to the Centre per day ? ________ | 21-22

8. On average, how often does an individual client attend the Centre each week? ________ days | 23

9. How many clients on your active list are categorized as : |

a) personal care? ________ 24-25

b) intermediate care I? ________ 26-27

c) intermediate care II? ________ 28-29

d) intermediate care III? ________ 30-31

e) extended care ? ________ 32-33

f) unclassified? ________ 34-35

10. In total, how many clients have been admitted to your Adult Day Care Centre within the last 12 months? ________ 36-38

11. a) Is your Centre affiliated with any other institution or organization? (1) Yes (2) No 39

IF NO, skip to question 12.

b) If yes, is it affiliated with :

i) a community/seniors' centre? (1) Yes (2) No 40

ii) a personal care facility? (1) Yes (2) No 41

iii) an intermediate care facility? (1) Yes (2) No 42

iv) an extended care hospital? (1) Yes (2) No 43

v) an acute care hospital? (1) Yes (2) No 44

vi) a municipal health department? (1) Yes (2) No. 45

vii) some other institution? (1) Yes (2) No 46
(specify type) ________

c) If yes, do you share :

i) space? (1) Yes (2) No 47

ii) staff? (1) Yes (2) No 48

iii) programs? (1) Yes (2) No 49

iv) Other resources? (1) Yes (2) No 50
(specify) ________

12. a) Do you have a client waiting list? (1) Yes (2) No — 51

IF NO, skip to question 13.

b) If yes, how many people are currently on the list? ____________ — 52-53

c) If yes, what is your average wait time at this moment? (in months) ____________ — 54-55

13. How many people do you presently have on your staff? (include approved but unfilled positions)

a) full-time paid ______ — 56

b) part-time paid ______ — 57

c) casual paid ______ — 58

d) volunteers ______ — 59

14. Please indicate the number of full-time equivalents (FTE's) for each of the following positions in your centre (include approved but unfilled positions).

	No. of FTE'S	
a) Administrator	______	60
b) Co-ordinator/Director	______	61
c) Assistant Director	______	62
d) Program Worker (Attendant)	______	63
e) Transport Worker	______	64
f) Nurse	______	65
g) Cook	______	66
h) Secretary/Bookkeeper	______	67
i) Education Officer	______	68
j) Art Therapist	______	69
k) Music Therapist	______	70
l) Occupational Therapist	______	71

m) Physiotherapist ________ 72

n) Social Worker ________ 73

o) Other (specify) ________________ ________ 74

________________ ________ 75

________________ ________ 76

Col.#

		2

15. Please indicate for each of the following positions/ professions, whether or not you have access to consultative services, either in the community or through an affiliated facility or organization.

a) Art Therapist	(1) Yes	(2) No	4
b) Audiologist	(1) Yes	(2) No	5
c) Dietician/Nutritionist	(1) Yes	(2) No	6
d) Geriatrician	(1) Yes	(2) No	7
e) Music Therapist	(1) Yes	(2) No	8
f) Nurse	(1) Yes	(2) No	9
g) Occupational Therapist	(1) Yes	(2) No	10
h) Pharmacist	(1) Yes	(2) No	11
i) Physiotherapist	(1) Yes	(2) No	12
j) Psychiatrist	(1) Yes	(2) No	13
k) Psychologist	(1) Yes	(2) No	14
l) Recreation Therapist	(1) Yes	(2) No	15
m) Social Worker	(1) Yes	(2) No	16
o) Speech Therapist	(1) Yes	(2) No	17
p) Other (specify) ________________	(1) Yes	(2) No	18

SECTION II

SERVICES

Below is a list of services offered by some Adult Day Centres. Please indicate if your agency presently offers these services by circling "yes" or "no" for each service listed. If you offer any services which are not listed, add them in the spaces provided at the end of each section.

16. Health Care Services

a)	Review clients medications	(1) Yes	(2) No	19
b)	Administer medications	(1) Yes	(2) No	20
c)	Monitor compliance with medication schedule	(1) Yes	(2) No	21
d)	Monitor blood pressure, heart rate blood sugar, weight, etc.	(1) Yes	(2) No	22
e)	Nutrition counselling	(1) Yes	(2) No	23
f)	Podiatry/foot care	(1) Yes	(2) No	24
g)	Dental care	(1) Yes	(2) No	25
h)	Vision screening	(1) Yes	(2) No	26
i)	Hearing screening	(1) Yes	(2) No	27
j)	Change medical dressings	(1) Yes	(2) No	28
k)	Skin care (rubs, etc.)	(1) Yes	(2) No	29
l)	Arrange medical appointments	(1) Yes	(2) No	30
m)	Provide emergency alert services (e.g. Life line)	(1) Yes	(2) No	31
n)	Provide/arrange for Vial of Life	(1) Yes	(2) No	32

o)	Provide/arrange for Medic Alert bracelet, necklace, etc.	(1) Yes	(2) No	33
p)	Obtain equipment for clients (wheelchair, glasses, adaptive clothes, etc.)	(1) Yes	(2) No	34
q)	Maintain client equipment (wheelchair, glasses, adaptive clothing etc.)	(1) Yes	(2) No	35
r)	Other health care services offered (specify)	(1) Yes	(2) No	36
	______________________________			37
	______________________________			38
	______________________________			39

17. Personal Care Services

a)	Bath (ADC clients)	(1) Yes	(2) No	40
b)	Bath (non-ADC clients)	(1) Yes	(2) No	41
c)	Personal grooming (hair dressing etc.)	(1) Yes	(2) No	42
d)	Mend/alter clients' clothes	(1) Yes	(2) No	43
e)	Take clients on shopping trips (for food, clothing etc.)	(1) Yes	(2) No	44
f)	Other (specify) ______________	(1) Yes	(2) No	45
	______________________________			46
	______________________________			47

18. Transportation (other than to or from ADC)

a)	Transportion for medical appointments	(1) Yes	(2) No	48
b)	Transportation for shopping	(1) Yes	(2) No	49
c)	Transportation for social/ recreational events	(1) Yes	(2) No	50
d)	Other (specify)	(1) Yes	(2) No	51
	______________________			52
	______________________			53

19. Social Services

a)	Information and referral to other services	(1) Yes	(2) No	54
b)	Counsel clients, caregivers and/or families	(1) Yes	(2) No	55
c)	Telephone check clients	(1) Yes	(2) No	56
d)	Set up client telephone network	(1) Yes	(2) No	57
e)	Client advocacy	(1) Yes	(2) No	58
f)	Liaise between client and other social agencies	(1) Yes	(2) No	59
g)	Coordinate various agencies involved with client	(1) Yes	(2) No	60
h)	Visit client in his/her home	(1) Yes	(2) No	61
i)	Visit client in hospital	(1) Yes	(2) No	62
j)	Follow-up clients after hospitalization	(1) Yes	(2) No	64
k)	Locate suitable housing	(1) Yes	(2) No	63
l)	Pastoral services	(1) Yes	(2) No	65
m)	Operate special interest groups (stroke, weight control, diabetic)	(1) Yes	(2) No	66
n)	Letter writing for clients	(1) Yes	(2) No	67

o)	Letter reading for clients	(1) Yes	(2). No	68
p)	Other social services (specify)	(1) Yes	(2) No	69
	____________________			70
	____________________			71

Col.#

		3

20. Therapeutic Activities

a)	Training/retraining in ADL	(1) Yes	(2) No	4
b)	Physiotherapy (rehabilitation, assisting in mobility)	(1) Yes	(2) No	5
c)	Art therapy	(1) Yes	(2) No	6
d)	Music therapy	(1) Yes	(2) No	7
e)	Sensory stimulation	(1) Yes	(2) No	8
f)	Reminiscence therapy	(1) Yes	(2) No	9
g)	Reality orientation	(1) yes	(2) No	10
h)	Management of incontinence/ toileting training	(1) Yes	(2) No	11
i)	Teach meal planning and cooking skills	(1) Yes	(2) No	12
j)	Exercise class (as therapeutic activity)	(1) Yes	(2) No	13
l)	Whirlpool therapy	(1) Yes	(2) No	14
m)	Stress management	(1) Yes	(2) No	15
n)	Swimming (as therapeutic activity)	(1) Yes	(2) No	16
o)	Other therapeutic activities (specify)	(1) Yes	(2) No	17
	____________________			18
	____________________			19
	____________________			20

21. Recreational and Social Activities

a)	Arts and crafts	(1) Yes	(2) No	21
b)	Baking and cooking as a social activity	(1) Yes	(2) No	22
c)	Games (cards,bingo, etc.)	(1) Yes	(2) No	23
d)	Visiting entertainment at the Centre	(1) Yes	(2) No	24
e)	Pet visits to the centre	(1) Yes	(2) No	25
f)	Pet care (of pets at ADC)	(1) Yes	(2) No	26
g)	Physical recreation (bowling, swimming, etc.)	(1) Yes	(2) No	27
h)	Gardening	(1) Yes	(2) No	28
i)	Computer activities (instruction, videogames, etc.)	(1) Yes	(2) No	29
j)	Outdoor activities (walks, picnics, barbeques, etc.)	(1) Yes	(2) No	30
k)	Special meals (such as birthday parties, holidays)	(1) Yes	(2) No	31
l)	Client socials	(1) Yes	(2) No	32
m)	Social activities involving families	(1) Yes	(2) No	33
n)	Day excursions	(1) Yes	(2) No	34
o)	Overnight excursions	(1) Yes	(2) No	35
p)	Activites involving community groups (regular school children visits, etc.)	(1) Yes	(2) No	36
q)	Other recreational and social activities (specify)	(1) Yes	(2) No	37

______________________________ 38

______________________________ 39

______________________________ 40

22. Educational Programs

a)	Current events	(1) Yes	(2) No	41
b)	Information about community resources	(1) Yes	(2) No	42
c)	Preventive health measures	(1) Yes	(2) No	43
d)	Safety in the home	(1) Yes	(2) No	44
e)	Safety outside the home	(1) Yes	(2) No	45
f)	Financial planning	(1) Yes	(2) No	46
g)	Wills	(1) Yes	(2) No	47
h)	Living wills	(1) Yes	(2) No	48
i)	Other (specify)	(1) Yes	(2) No	49
	______________________			50
	______________________			51
	______________________			52

23. Client Volunteer Activities

a)	Doing volunteer work for the community	(1) Yes	(2) No	53
b)	Doing volunteer work for other clients	(1) Yes	(2) No	54
c)	Client participation in running the Centre	(1) Yes	(2) No	55
d)	Other client volunteer activities (specify)	(1) Yes	(2) No	56
	______________________			57
	______________________			58
	______________________			59

24. Quiet Time Activities

a)	Rest	(1) Yes	(2) No	60
b)	Conversation	(1) Yes	(2) No	61
c)	Reading	(1) Yes	(2) No	62
d)	Watching T.V.	(1) Yes	(2) No	63
e)	Other quiet time activities (specify)	(1) Yes	(2) No	64
	______________________			65
	______________________			66
	______________________			67

25. Meals

a)	Hot meals at Day Care	(1) Yes	(2) No	68
b)	Snacks at Day Care	(1) Yes	(2) No	69
c)	Take-home meals	(1) Yes	(2) No	70

CLIENT CHARACTERISTICS

The objective of this phase of the study is to describe the actual characteristics of the clientele served by adult day care centres. In order to obtain a truly representative sample of the total client population of all the adult day care centres, we have randomly selected 22 centres from 4 areas of B.C. These are: Vancouver Island and the Coastal region, Fraser Valley and the Lower Mainland, Interior, and the City of Vancouver. The centres have been chosen so that agencies with both a large and small client population are represented. From these 22 centres, we have obtained a sample of approximately 500 clients.

PROCEDURE TO BE FOLLOWED

1. Enclosed with your package is a Worksheet containing identification numbers and names of some of your clients. This will be your share of the total sample of clients. The set of identification numbers is the unique identification number for each client listed and will be the only identifying information to appear from this point onwards, thus protecting the anonymity of all selected clients.

2. For each client listed please make a photocopy of their completed LTC Assessment forms. The LTC forms are numbered on the right hand corner. There will be 5 of them to photocopy for each client. Obliterate any identifying information and place their identification number on each sheet as indicated in the following steps:

a) Place the enclosed template over the area on Form 1 where the identification information is recorded and secure with paper clips as indicated in the sample page provided.

b) Photocopy this page and the remaining 4 pages ensuring the copies are completely legible and readable.

c) Using a marking pen or a file folder label, obliterate the signature on page 1 <u>and</u> the client's name on the remaining 4 pages.

d) Place the unique identification number assigned to that client, as listed on the work sheet provided with your package, in the upper right corner of <u>each</u> of the 5 pages.

e) Fill in the date of admission to your Adult Day Care Centre for each client in the place specified on the front of the faceplate. We have enclosed a sample.

7. Return the copies of client information and the completed activity list by DECEMBER 8, 1989 to

Adult Day Care Centre Study
Gerontology Research Centre
Simon Fraser University at Harbour Centre
515 West Hastings Street
Vancouver, B.C.
V6B 5K3

Attn: Doris Lewis

WORKSHEET

Note: CONFIDENTIAL INFORMATION.

Please destroy this list once the LTC forms are copied and the ID numbers are transferred to photocopies. DO NOT SEND WITH THE REST OF THE INFORMATION.

Identification Number	Client Name

Province of British Columbia
Ministry of Health

LONG TERM CARE PROGRAM

APPLICATION AND ASSESSMENT FORM

SECTION 1
ADMINISTRATIVE AND SUMMARY

1 ☐ NEW ASSESSMENT
2 ☐ REVIEW
3 ☐ RE-ASSESSMENT
4 ☐ APPEAL
5 ☐ CORRECTION

(Sample only)
(Agency I.D.) (Client I.D.)
27 - 0078

Date of Admission to ADC ______

3 MARITAL STATUS
1 ☐ SINGLE
2 ☐ MARRIED
3 ☐ WIDOWED
4 ☐ DIVORCED
5 ☐ SEPARATED
6 ☐ OTHER

SEX ☐ M ☐ F

BIRTHDATE Y Y M M D D

B A 'CONTACT PERSON' IS ONE WHO ASSISTS THE CLIENT WITH AN APPLICATION AND/OR A PERSON WHO IS WILLING TO MAINTAIN A CONTINUING INTEREST IN THE CLIENT'S WELFARE WITHOUT IMPLYING RESPONSIBILITY.

C GIVE DETAILS OF PERSON OR NEXT-OF-KIN WHO SHOULD BE CONTACTED IN AN EMERGENCY. ENTER 'CONTACT' IF PERSON IS NAMED IN PARA. B.

D GIVE DETAILS OF PHYSICIAN RESPONSIBLE FOR CARE OF CLIENT. IF THERE IS SPECIALIST OR OTHER PHYSICIAN, ENTER IN PARA. F. SUMMARY

E APPLICATION

I HEREBY APPLY FOR BENEFITS FOR WHICH I/CLIENT MAY BE ELIGIBLE UNDER THE LONG TERM CARE PROGRAM AND CERTIFY THAT THE INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND MAY BE RELEASED TO THE LONG-TERM CARE SERVICE PROVIDER.

CLIENT OR AUTHORIZED SIGNATURE

CLIENT'S PREFERENCE (SEE REVERSE) PREFERRED FACILITIES

1 ☐ CARE AT HOME
2 ☐ FACILITY CARE 1. ______
21 ☐ STANDARD
22 ☐ SEMI-PRIVATE
23 ☐ PRIVATE 2. ______

F ASSESSMENT SUMMARY (TERM REVIEW IF CARRIED OUT)

ASSESSMENT DATE
REVIEW DATE
REASSESSMENT DATE
Y Y M M D

ASSESSMENT DONE
1 ☐ CLIENT'S HOME
2 ☐ FACILITY
3 ☐ ACUTE HOSPITAL
4 ☐ OTHER

1 ☐ TEAM REVIEW
2 ☐ FOLLOW-UP

ASSESSOR'S SIGNATURE

G APPROVAL OF CARE LEVEL AND SERVICES (FOR ADMINISTRATOR'S USE ONLY) THE FOLLOWING SERVICES ARE APPROVED:

1 ☐ NOT ELIGIBLE
2 ☐ CARE DECLINED BY CLIENT
3 ☐ CARE AT HOME
4 ☐ CARE AT HOME; MENTAL HEALTH SUPPORT
5 ☐ FACILITY CARE
6 ☐ DAY CARE

1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

PREFERRED FACILITY		ALTERNATE FACILITY	
FACILITY CODE	DATE ON LIST (Y Y M M D D)	FACILITY CODE	DATE ON LIST (Y Y M M D D)

LTC ADMINISTRATOR'S SIGNATURE

DATE SIGNED

HLTH LTC 1.1 JUNE 86 [illegible]

ORIGINAL

APPENDIX 6

Information Sheets and Consent Forms for Phase III Focus Groups and Information Letters and Questionnaires for Staff and Non-Attending Clients

Focus Group I, II, & III

ADULT DAY CARE STUDY

GERONTOLOGY RESEARCH CENTRE

SIMON FRASER UNIVERSITY

The Gerontology Research Centre of Simon Fraser University at the request of the Continuing Care Division of the Provincial Ministry of Health is conducting a study of the Adult Day Care system in British Columbia. Since the Continuing Care Division assumed responsibility for management of the Adult Day Care Program in 1979, the program has expanded from provision of a primarily social/recreational program to include provision of an organized program of physical, social and preventive health care services and therapeutic activities. Due to the expansion in size and scope of the Adult Day Care Program and variability in types of programs offered, a comprehensive service review was deemed advisable. The goal is to obtain quantitative data with respect to identification of services provided, clients served, model(s) of service delivery and the role of adult day care in the overall case management of the client. This data will be used to assist the Continuing Care Division with respect to long range planning for this unique resource.

The study is being conducted in three phases, each with a specific objective. Phases I and II entailed the description of services provided by adult day care centres and of the clients they serve. The objective of Phase III is to describe the interface of the Long Term Care Program with adult day care.

One facet of this phase involves the canvassing of assessors to ascertain the reasons for referring clients to adult day care and the relative priorities attributed to these reasons. In order to devise a relevant questionnaire a focus group will be held with ten assessors from throughout the province to explore as completely as possible potential referral reasons. In addition, the same group of assessors will participate in a second focus group to examine the referral process and, in particular, any difficulties it presents to them. A similar focus group will be held with adult day care personnel.

All information that you provide will be confidential. You will not be named or otherwise identified in reports of the study. You may refuse to answer any questions.

Focus Group IV

ADULT DAY CARE STUDY

GERONTOLOGY RESEARCH CENTRE

SIMON FRASER UNIVERSITY

The Gerontology Research Centre of Simon Fraser University at the request of the Continuing Care Division of the Provincial Ministry of Health is conducting a study of the Adult Day Care system in British Columbia. Since the Continuing Care Division assumed responsibility for management of the Adult Day Care Program in 1979, the program has expanded from provision of a primarily social/recreational program to include provision of an organized program of physical, social and preventive health care services and therapeutic activities. Due to the expansion in size and scope of the Adult Day Care Program and variability in types of programs offered, a comprehensive service review was deemed advisable. The goal is to obtain quantitative data with respect to identification of services provided, clients served, model(s) of service delivery and the role of adult day care in the overall case management of the client. This data will be used to assist the Continuing Care Division with respect to long range planning for this unique resource.

The study is being conducted in three phases, each with a specific objective. Phases I and II entailed the description of services provided by adult day care centres and of the clients they serve. The objective of Phase III is to describe the interface of the Long Term Care Program with adult day care.

One facet of this phase involves ascertaining why clients who are referred to adult day care either do not attend or stop attending after 1 or 2 times. A questionnaire will be completed by a sample of LTC case managers, adult day care personnel and clients or caregivers who did not attend following referral. In order to devise a relevant questionnaire a focus group will be held with five case managers and five adult day care personnel to develop as complete a list of reasons as possible.

Separate focus groups of ten LTC case managers and 10 adult day care personnel will be held to examine the referral process and, in particular, any difficulties it presents to them.

All information that you provide will be confidential. You will not be named or otherwise identified in reports of the study. You may refuse to answer any questions.

INFORMED CONSENT BY SUBJECTS
TO PARTICIPATE IN A RESEARCH
PROJECT

NOTE: The University and those conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of subjects. This form and the information it contains are given to you for your own protection. Your signature on it will signify that you have received a written description of this project, that you have received adequate opportunity to consider the information in that description, and that you voluntarily agree to participate in the project.

Having been asked by Dr. Stephen Milstein of the Gerontology Research Centre at Simon Fraser University to participate in a research project, I have read the description of the Adult Day Care Study.

I understand the procedures to be used in this study.

I understand that I may register any complaint I might have about the project with the chief researcher named above or with Dr. Gloria Gutman, Director of the Gerontology Research Centre, Simon Fraser University.

I agree to participate by sharing my opinions in a discussion group as described in the document referred to above, on June 27, 1990 at Simon Fraser University Harbour Centre, Vancouver, B.C.

DATE ____________________ NAME ____________________________

ADDRESS ____

SIGNATURE ____

SIGNATURE OF WITNESS _______________________________________

When you read the description of the Adult Day Care Study please initial it.

SIMON FRASER
UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

May 10, 1990

Dear

As you are already aware, the Gerontology Research Centre of Simon Fraser University is conducting a study of the Adult Day Care Program in British Columbia on behalf of the Ministry of Health. We are currently in the third phase of this study which is looking at the referral process including the reasons case managers make such referrals. You are one of 75 randomly selected case managers who have been asked to participate in this project.

We are asking you to carry out two tasks. The first is to complete the enclosed questionnaire regarding reasons for a referral to day care. This list was developed from a meeting of case managers. Please read the questions carefully, answer as indicated, and mail the completed questionnaire in the envelope that we have provided no later than <u>May 25</u>. We anticipate it will take about 30 minutes to complete.

The second task involves providing a list of all clients referred to adult day care between May 1, 1989 and April 30, 1990 <u>and</u> a copy of the LTC 1 forms for each such client. We do appreciate the time involved but it is believed that the information is of sufficient value to warrant the time being spent. Continuing Care management has suggested that clerical staff could assist you to do this. We ask that this information be mailed to our office no later than <u>June 1</u>.

Please note we are asking that the questionnaire be returned by an earlier date than the other information. Please do not wait for the client information to be available before mailing the questionnaire.

Office location: 2175-555 West Hastings Street

Confidentiality of clients and yourselves will be maintained throughout the study.

We realize that you are busy people and that additional tasks such as this increase your time pressures. However, we and Continuing Care management believe the information that will result from this study can ultimately assist you and the division in providing a top quality service while minimizing frustration.

Thank you in advance for your assistance. Please help us stay on schedule by responding by the dates given.

Yours sincerely,

Stephen L. Milstein, Ph.D.

Encl.
SM/jk/ws

SIMON FRASER UNIVERSITY

GERONTOLOGY RESEARCH CENTRE

ADULT DAY CARE STUDY

PHASE III

REASONS FOR REFERRAL OF CLIENTS TO ADULT DAY CARE

I.D. Number ______________

Health Unit ______________

1. This questionnaire contains 3 questions regarding referral of clients to Adult Day Care.

2. Please answer all the questions from your own experience and perspective. It is the decision making process that you use which is of interest.

3. The questions are quite similar, therefore please read them very carefully taking particular note of the bold, underlined word or phrase in each one.

4. The decision to refer a client in order that they receive a particular service can involve many factors. However, for the purpose of this questionnaire you are being asked to consider individual factors in isolation. You will be asked to respond to the same list of factors 3 times, but to consider them from a different point of view each time. It is important that you consider each factor alone when answering the questions.

5. Examine the example given for each question prior to answering that question.

Question 1

RESPONSE INSTRUCTIONS

A. Rank order the following list of reasons for referring clients to Adult Day Care in terms of the frequency with which they are a reason for which you make a referral.

B. Assign the number [1] to the most frequent reason and the number [21] to the least frequent.

C. To rank order the list, first examine the full list completely and select number [1]. Then re-examine the list and select number [2] and so on for each rank order through to number [21].

D. Please attempt to rank each item uniquely but if in your opinion two items have an equal rank, assign them equal numbers.

E. If, in your opinion. a particular reason is not relevant i.e. is not a reason to refer, put a zero [0] in the box.

F. We are aware that people are often referred for more than one reason. However, in responding by assigning a rank, treat each reason separately and independently.

G. Carefully examine the example prior to answering the question.

In this example, "need for bathing" was the most frequent reason for referral, "socially isolated" was second, "need for nutrition/meal" was third most frequent progressing down to "need for further assessment/monitoring of client" being the second least frequent reason and "request of client" being the least frequent reason used for referral to adult day care.

Reason	Rank
Lives alone	17
Socially isolated	2
No caregiver	19
Caregiver burden/need for respite	4
Recently bereaved and otherwise eligible	10
Emotional/mental status e.g. depression	18
Request of client	21
Care required too heavy for family or homemaker.	11
Unable to access other community resources	16
Unable to get along with any homemakers	7
Only alternative to facility placement	15
Need for bathing	1
Need for ambulation/walking program	13
Need for physiotherapy	8
Need for podiatry	9
Need for nutrition/meal	3
Need for further assessment/monitoring of client	20
Specific condition matching an available program	6
Age of client	14
To help client prepare for facility placement	5
To assist the family accept facility placement	12

Question 1. For the following possible reasons for referring clients to adult day care, please rank them in order of the frequency with which they would be a reason for you referring them. Rank them by assigning each a number with [1] indicating the most frequent and [21] indicating the least frequent.

Reason	Rank
Lives alone..	
Socially isolated....................................	
No caregiver...	
Caregiver burden/need for respite....................	
Recently bereaved and otherwise eligible.............	
Emotional/mental status e.g. depression..............	
Assigned level of care e.g. P.C., I.C., E.C..........	
Care required too heavy for family or 1 homemaker......	
Unable to access other community resources...........	
Unable to get along with any homemakers..............	
Only alternative to facility placement...............	
Need for bathing.....................................	
Need for ambulation/walking program.	
Need for physiotherapy...............................	
Need for podiatry....................................	
Need for nutrition/meal..............................	
Need for further assessment/monitoring of client.......	
Specific condition matching an available program.......	
Age of client..	
To assist the client prepare for facility placement....	
To assist the family accept facility placement.........	

Question 2

RESPONSE INSTRUCTIONS

A. Rank order the following list of reasons for referring clients to adult day care in terms of the importance of the reason in your decision making process.

B. Assign the number [1] to the most important reason and the number [21] to the least important.

C. To rank order the list, first examine the full list completely and select number [1]. Then re-examine the list and select number [2] and so on for each rank order through to number [21].

D. Please attempt to rank each item uniquely but if in your opinion two items have an equal rank, assign them equal numbers.

E. If in your opinion a particular reason is not relevant i.e. is not a reason to refer, put a zero [0] in the box.

F. We are aware that people are often referred for more than one reason. However, in responding by assigning a rank, treat each reason separately and independently.

G. Carefully examine the example prior to answering the question.

In this example, "caregiver burden/need for respite" was considered to be the most important reason for referral, "to help client prepare for facility placement" was second most important, "need for nutrition/meal" was third progressing down to "lives alone" being the second least important reason and "age of client" being in the answerer's opinion the least important reason for referral to adult day care.

Reason	Rank
Lives alone....................................	20
Socially isolated..............................	5
No caregiver...................................	4
Caregiver burden/need for respite..............	1
Recently bereaved and otherwise eligible........	19
Emotional/mental status e.g. depression.........	7
Request of client..............................	12
Care required too heavy for family or homemaker.	11
Unable to access other community resources......	8
Unable to get along with any homemakers.........	13
Only alternative to facility placement..........	10
Need for bathing...............................	6
Need for ammbulation/walking program............	16
Need for physiotherapy.........................	17
Need for podiatry..............................	15
Need for nutrition/meal........................	3
Need for further assessment/monitoring of client	11
Specific condition matching an available program	9
Age of client..................................	21
To help client prepare for facility placement...	2
To assist the family accept facility placement..	18

Question 2. For the following possible reasons for referring clients to adult day care, please rank them in order of the importance of the reason in your decision making process. Rank them by assigning each a number with [1] indicating the most important and [21] indicating the least important.

Reason	Rank
Lives alone	
Socially isolated	
No caregiver	
Caregiver burden/need for respite	
Recently bereaved and otherwise eligible	
Emotional/mental status e.g. depression	
Assigned level of care e.g. P.C., I.C., E.C	
Care required too heavy for family or 1 homemaker	
Unable to access other community resources	
Unable to get along with any homemakers	
Only alternative to facility placement	
Need for bathing	
Need for ambulation/walking program.	
Need for physiotherapy	
Need for podiatry	
Need for nutrition/meal	
Need for further assessment/monitoring of client	
Specific condition matching an available program	
Age of client	
Sex of client	
To assist the client prepare for facility placement	
To assist the family accept facility placement	

Question 3

RESPONSE INSTRUCTIONS

A. For the following reasons for referring clients to adult day care, please rank them in terms of the likelihood that adult day care can have an impact or effect on the client.

B. Assign the number [1] to the reason for which adult day care is most likely to have an impact or effect and the number [21] to the reason for which adult day care is least likely to have an impact or effect.

C. To rank order the list, first examine the full list completely and select number [1]. Then re-examine the list and select number [2] and so on for each rank order through to number [21].

D. Please attempt to rank each item uniquely but if in your opinion two items have an equal rank, assign them equal numbers.

E. If, in your opinion, a particular reason is not relevant i.e. is not a reason to refer, put a zero [0] in the box

F. We are aware that people are often referred for more than one reason. However, in responding by assigning a rank, treat each reason separately and independently.

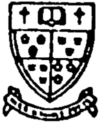
G. Carefully examine the example prior to answering the question.

In this example, adult day care would most likely have the greatest impact or effect on "to help client prepare for facility placement", the second greatest impact or effect on "need for nutrition/meal", the third greatest impact or effect on "emotional/mental status", while it would have the second least impact or effect on the client who was "recently bereaved and otherwise eligible" and the least effect on "to assist the family accept facility placement."

Item	Rank
Lives alone....................................	13
Socially isolated..............................	11
No caregiver...................................	7
Caregiver burden/need for respite..............	5
Recently bereaved and otherwise eligible........	20
Emotional/mental status e.g. depression.........	3
Request of client..............................	14
Care required too heavy for family or homemaker.	6
Unable to access other community resources......	14
Unable to get along with any homemakers.........	8
Only alternative to facility placement..........	9
Need for bathing...............................	4
Need for ambulation/walking program.	19
Need for physiotherapy.........................	15
Need for podiatry..............................	18
Need for nutrition/meal........................	2
Need for further assessment/monitoring of client	12
Specific condition matching an available program	16
Age of client..................................	17
To help client prepare for facility placement...	1
To assist the family accept facility placement..	21

Question 3. For the following reasons for referring clients to adult day care, please rank them in terms of the likelihood that adult day care can have an **impact or effect** on the client. Rank them by assigning each a number with [1] indicating the most impact or effect on the client, and [21] indicating the least impact or effect.

Reason	Rank
Lives alone	
Socially isolated	
No caregiver	
Caregiver burden/need for respite	
Recently bereaved and otherwise eligible	
Emotional/mental status e.g. depression	
Assigned level of care e.g. P.C., I.C., E.C.	
Care required too heavy for family or 1 homemaker	
Unable to access other community resources	
Unable to get along with any homemakers	
Only alternative to facility placement	
Need for bathing	
Need for ambulation/walking program.	
Need for physiotherapy	
Need for podiatry	
Need for nutrition/meal	
Need for further assessment/monitoring of client	
Specific condition matching an available program	
Age of client	
Sex of client	
To assist the client prepare for facility placement	
To assist the family accept facility placement	



SIMON FRASER
UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

October 29, 1990

Dear

As part of the third phase of the Adult Day Care study being conducted by the Gerontology Research Centre for the Continuing Care Division, we are examining why clients who are referred for adult day care services by Long-Term Care choose not to go on to attend when offered a space.

Enclosed is a questionnaire listing reasons for non-attendance which have been encountered. We are asking you to choose from your experience the three most frequently encountered reasons. The staff person most inolved with client intake would be in the best position to complete the questionnaire.

We recognize this is only one of several tasks you have been asked to complete for this study, but it should take no more than 5 minutes to do.

The same questionnaire is being completed by a sample of LTC case managers from around the province, and, in addition, a similar questionnaire is being sent to a sample of clients who chose not to attend adult day care after referral. Thus, you can appreciate the importance of receiving input from adult day care centres in providing a comprehensive view.

If you have any questions, please feel free to call Judy Killam at 291-5047.

Enclosed is a stamped, addressed envelope for your convenience, and, since it is a short questionnaire, we are asking they be returned no later than November 9.

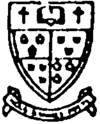
Office location: 2175-555 West Hastings Street

Thank you for your attention to this matter. We appreciate your previous cooperation and the information received thus far has been most valuable. It is anticipated that the information gathered by this study will be of great value in future planning for Long-Term Care services in the province.

Yours sincerely,

Stephen L. Milstein, Ph.D
Research Associate

Encl.
SM/JK/ws



SIMON FRASER
UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

Oct. 30, 1990

Dear

As part of the third phase of the Adult Day Care study being conducted by the Gerontology Research Centre for the Continuing Care Division, we are examining why clients who are referred for adult day care services choose not to go on to attend when offered a space.

Enclosed are several copies of a letter to case managers and a questionnaire listing reasons for non-attendance which have been encountered. In the questionnaire we are asking case managers involved in referring clients to adult day care to choose from their experience the three most frequently encountered reasons.

The same questionnaire is being completed by a Adult Day Care Centre personnel and, in addition, a similar questionnaire is being sent to a sample of clients who chose not to attend adult day care after referral. Thus, you can appreciate the importance of receiving input from your staff in providing a comprehensive view.

Please distribute the letters and questionnaires to Long-Term Care case managers who do refer clients to adult day care. We recognize that several of them will already have been involved in completing a previous questionnaire for the study. However, this information is essential and it should take no more than 5 minutes of their time.

Please attach one of the stamped, addressed envelopes to each questionnaire prior to distribution. Because of the brevity of the questionnaire we are asking them to be returned no later than November 9.

Office location: 2175-555 West Hastings Street

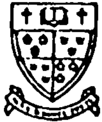
If you have any questions, please feel free to call Judy Killam at 291-5047.

Thank you for your attention to this matter. We appreciate your previous cooperation and the information received thus far is most valuable. It is anticipated that the information gathered by this study will be of great value in future planning for Long-Term Care services in the province.

Your sincerely,

Stephen L. Milstein, Ph.D
Research Associate

Encl.
SM/JK/ws



SIMON FRASER
UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

October 30, 1990

Dear Case Manager,

You are being asked to assist with the ongoing Adult Day Care study being conducted by the Gerontology Research Centre for the Continuing Care Division.

Attached you will find a questionnaire listing reasons why clients referred to adult day care may choose never to attend. It should take no more than 5 minutes. Please read the instructions carefully before completing it.

Please return the completed questionnaire with the front sheet attached no later than November 9.

We do appreciate your co-operation in this study and we recognize that some of you will have already been involved in previous stages. However, it is anticipated that the information gathered by this study will be of great value in future planning for Long-Term Care services in the province.

Yours sincerely,

Stephen L. Milstein, Ph.D
Research Associate

Encl.
SM/JK/ws

Office location: 2175-555 West Hastings Street

November 1990

SIMON FRASER UNIVERSITY

GERONTOLOGY RESEARCH CENTRE

ADULT DAY CARE STUDY

PHASE III

QUESTIONNAIRE FOR PROFESSIONALS

REASONS CLIENTS DO NOT ATTEND

ADULT DAY CARE

I.D. Number ________________________

1. Attached is a list of reasons clients do not proceed to attend adult day care following referral to such a program and being offered a space.

2. You are being asked to choose the three (3) most common reasons you encounter for such clients never attending adult day care.

3. In any given situation, several reasons may be involved. You are being asked here to consider each factor in isolation and to make your decision based on your experience with many clients.

4. Please read the Response Instructions and the Example before completing the questionnaire.

RESPONSE INSTRUCTIONS

1. Please read all the reasons listed below for clients never attending an adult day care program following referral to, and the offer of a place in, such a program.

2. Choose the three (3) most frequently encountered reasons.

3. Circle the number in the box opposite these three reasons.

4. Examine the Example before completing the questionnaire.

5. Return the completed questionnaire with the front page attached in the enclosed stamped addressed envelope by November 9, 1990.

EXAMPLE ONLY:

Reasons Referred Clients Subsequently Never Attend Adult Day Care

Circle the number in the box opposite the 3 most frequent reasons

REASONS	
Transportation is not available	1
The trip is too long	2
Physical barriers (e.g. steps) at home	3
Physical barriers (e.g. steps) at ADC Centre	4
Cost of transportation	(5)
Cost of meals	6
Hearing or vision difficulties	7
Too much effort required	8
Too early to be ready in the morning	9
Day too long	10
Client does not believe he/she is like others who attend ADC	11
Client does not like the term "Adult Day Care"	12
Client is not interested in the activities offered	13
Client does not enjoy groups	14
Family does not want him/her to go to ADC	(15)
Suitable alternate arrangements made	16
Waiting for facility placement so not worth starting	17
Client fears will lead to placement in a facility	18
When a space becomes available the client is no longer interested	19
When a space becomes available the client is too ill to attend	20

When a space becomes available the client is in an acute care hospital....................................	21
When a space becomes available the client is in a LTC residential facility....................................	(22)
When a space becomes available the client is deceased.........	23
Other reason(s): Please specify	
______________________________..	24
______________________________..	25
______________________________..	26

Reasons Referred Clients Subsequently Never Attend Adult Day Care

Circle the number in the box opposite the 3 most frequent reasons

REASONS

Reason	
Transportation is not available	1
The trip is too long	2
Physical barriers (e.g. steps) at home	3
Physical barriers (e.g. steps) at ADC Centre	4
Cost of transportation	5
Cost of meals	6
Hearing or vision difficulties	7
Too much effort required	8
Too early to be ready in the morning	9
Day too long	10
Client does not believe he/she is like others who attend ADC.	11
Client does not like the term "Adult Day Care"	12
Client is not interested in the activities offered	13
Client does not enjoy groups	14
Family does not want him/her to go to ADC	15
Suitable alternate arrangements made	16
Waiting for facility placement so not worth starting	17
Client fears will lead to placement in a facility	18
When a space becomes available the client is no longer interested	19
When a space becomes available the client is too ill to attend	20

When a space becomes available the client is in an acute care hospital..	21
When a space becomes available the client is in a LTC residential facility...	22
When a space becomes available the client is deceased	23
Other reason(s): Please specify	
______________________________________..	24
______________________________________..	25
______________________________________..	26

THANK YOU

Province of
British Columbia

Ministry of
Health

Continuing Care Division
Parliament Buildings
Victoria
British Columbia
V8V 4V7

October 15, 1990

Dear Long Term Care Client:

The Continuing Care Division of the Ministry of Health is conducting a research study of the Adult Day Care Program in British Columbia. Information is being gathered about the role of adult day care in serving the people of British Columbia. We are interested in the experience and opinions of persons and families who have had any contact with the Adult Day Care Program, whether you ultimately used it or did not.

The Gerontology Research Centre at Simon Fraser University has been contracted to carry out this research on behalf of the Continuing Care Division and its staff members are, therefore, considered to be representatives of the Division for the duration of the study.

Your name has been selected and in the near future you will be contacted by mail by a researcher at Simon Fraser University requesting your participation in the study. You will be asked to complete a brief questionnaire and return it in the stamped, addressed envelope provided. Your response will be totally anonymous as there will be no identifying information on the questionnaire to link it with you.

We would like to reassure you that:

1. All identifying information is strictly limited to one or two research staff members who are operating under guidelines set out by the Continuing Care Division.

2. Answers from all participants will be grouped and your name or any other thing that could identify you will not appear in any reports of the study.

3. Your participation is voluntary, you are free to withdraw your participation at any time, and your decision regarding whether to participate will in no way jeopardize your access to health care.

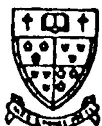
. . . 2

The information obtained will be valuable in planning services for British Columbia residents and it is hoped that you will be willing to help with this study. Please watch for the letter from the Simon Fraser University researchers.

If you have any questions or require additional information, please contact Ms. Judy Killam, Gerontology Research Centre, Simon Fraser University, at 291-5047.

Sincerely,

Paul Pallan
Executive Director
Continuing Care Division



SIMON FRASER
UNIVERSITY
AT HARBOUR CENTRE

Gerontology Research Centre
Gerontology Diploma Program

515 West Hastings Street
Vancouver, British Columbia
Canada V6B 5K3

Centre Tel: 604/291.5062
Program Tel: 604/291.5065
Fax: 604/291.5066

Nov. 1, 1990

Dear Long Term Care Client:

You recently received a letter from the Continuing Care Division of the Ministry of Health telling you to expect the enclosed questionnaire. As described in that letter the Gerontology Research Centre at Simon Fraser University is gathering information for the Ministry of Health.

You have been selected to receive the questionnaire because at some point in your contacts with the Long Term Care system, attending an Adult Day Care Program was suggested to you. However, when offered the opportunity to attend such a Centre, you chose not to or were unable to do so.

We are not questioning this decision nor urging you to attend but we are interested in the reasons for your decision. You are being asked only to mark the reason(s) for not attending that apply to you. The questionnaire is very simple to complete and will take only a few minutes of your time.

You will notice that there is nothing on the questionnaire to link it with you so the information will be totally anonymous and your name can not be mentioned in any reports.

Your completion and return of the questionnaire will be taken as your consent for the information to be used in the study. Your participation is voluntary but we do ask you to help by completing and returning the questionnaire. The information obtained in this study will be of use in planning for future services to the senior citizens of British Columbia.

Please help us by returning the completed questionnaire in the enclosed postage-paid envelope by November 19, 1990.

If you have any questions, please feel free to call Judy Killam at 291-5047.

Your sincerely,

Stephen L. Milstein, Ph.D
Research Associate

Province of
British Columbia

Ministry of
Health

Continuing Care Division
Parliament Buildings
Victoria
British Columbia
V8V 4V7

October 15, 1990

Dear Friend/Relative:

The enclosed letter is addressed to your relative/friend but if, for any reason, they will have difficulty in reading or understanding the contents, we ask you to read it on their behalf. The questionnaire to be sent shortly from Simon Fraser University will be similarly addressed and, at that time, your assistance in completing the questionnaire will be requested and appreciated.

It is important for the development of needed services that we receive replies from all persons who are sent the questionnaire. It will limit the value of the study if we only receive information from those clients who are independently able to complete the questionnaire. Therefore, we are requesting your cooperation so that valuable information is not lost.

All assurances regarding confidentiality outlined in the attached letter apply equally to you.

Thank you for your time in this matter and please watch for the arrival of the questionnaire in the near future.

Sincerely,

Paul Pallan
Executive Director
Continuing Care Division

Attachment

SIMON FRASER UNIVERSITY

GERONTOLOGY RESEARCH CENTRE

ADULT DAY CARE STUDY

PHASE III

QUESTIONNAIRE FOR CLIENTS

REASONS FOR NOT ATTENDING DAY CARE

1. Attached is a list of reasons why people choose not to attend adult day care programs when offered the opportunity.

2. You are being asked to indicate the reason(s) why you chose not to attend adult day care.

3. You may pick up to 3 reasons if they apply to you. If more than 3 reasons apply, please choose the 3 most important reasons.

4. Please read the entire list of reasons before making your choice of reason(s).

5. Circle the number in the box opposite your chosen reason(s) (no more than 3 reasons).

6. Return the completed questionnaire in the enclosed stamped addressed envelope by ____________________.

7. Thank you for your assistance.

Reasons for Choosing not to Attend Day Care

Circle the number in the box opposite up to 3 reasons that apply to you.

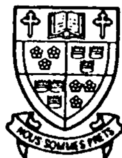
REASONS

REASONS	
Transportation is not available	1
The trip is too long	2
Physical barriers (e.g. steps) at home	3
Physical barriers (e.g. steps) at Adult Day Care Centre	4
Cost of transportation	5
Cost of meals	6
Hearing or vision difficulties	7
Too much effort would be required	8
Too early to be ready in the morning	9
The day would be too long	10
You are not like others who attend Adult Day Care Centre	11
You do not like the term "Adult Day Care"	12
You are not interested in the activities offered at Adult Day Care	13
You do not enjoy groups	14
Your family does not want you to go	15
Other suitable arrangements were made	16
You are waiting for a place in a residential facility ("nursing home) so it is not worth starting	17
You think it might lead to moving to a residential facility ("nursing home")	18

PLEASE TURN PAGE FOR MORE REASONS

When the Adult Day Care offered you the opportunity to attend, you were no longer interestered	19
When the Adult Day Care offered you the opportunity to attend, you were too ill to attend	20
When the Adult Day Care offered you the opportunity to attend, you were in an acute care hospital	21
When the Adult Day Care offered you the opportunity to attend, you were in a LTC residential facility	22
Other reason(s): Please specify	23
______________________________	24
______________________________	25

THANK YOU



GERONTOLOGY RESEARCH CENTRE
SIMON FRASER UNIVERSITY

The Gerontology Research Centre was established in 1982 both to stimulate and to undertake research on topics related to population and aging. The Centre also provides an information and consulting service. The research focus of the Centre relates generally to social gerontology and to the biophysiology of aging. Areas of research concentration include: victimization and exploitation of the elderly; population aging and changing life-styles; health and aging; and aging and the built environment.