The Challenge of Nursing Home Care

Nancy B. Ellis

Elders, social scientists, policy makers, and service providers are making significant efforts to combat negative stereotypes and attitudes toward the aged by emphasizing the vitality, the active involvement, and the contributions that the aged make to society. These efforts help all of us, particularly those of us in the health care professions, to understand that the aged are as heterogeneous and diverse a population in terms of their interests, life-styles, and health status as are the young. We also are becoming aware that elders vary widely in their expectations, needs, and use of health care and social services.

Why be concerned with the challenge of nursing home care when the trend seems to be to emphasize the more positive aspects of aging and the alternatives to institutionalization, that is, health promotion, extension of productive work years, and community-based support systems? As health care providers occupational therapists can lend full support to this new emphasis without neglecting the issues involved in providing institutionally based long-term care. The needs of the aged who cannot sustain themselves, or be sustained, in the community must not be forgotten or neglected in the face of the current emphasis on those aged people who are healthy and live independently. Nor should the needs of nursing home residents be minimized, even while community-based services such as in-home and day-care programs for elders increase. The comprehensive services and the protective environment provided by long-term care institutions are likely to remain a necessary part of the continuum of care.

Predictions are that the need for residential long-term care for the older population will increase by 50% in the year 2000 and by 130% in 2030 (1). Currently, over 1.5 million elders, 5% of our aged population, reside in nursing homes. Sixty percent of the elderly in this group are between 75 and 84 years of age, and 20% are 85 and older.

Residency in a nursing home is usually attributable to two factors: a) chronic disease accompanied by impaired function and b) the lack of an informal support system in the community. The probability of nursing home placement increases markedly when these two factors occur, as they frequently do, in combination. In the community, approximately 4% of those in the younger age group (65 to 74 years of age) are dependent in one or more self-care skills, whereas 35% of those over 85 years of age need assistance with at least one aspect of self-care. For nursing home residents these percentages are closer to 50% and 95%, respectively.

Furthermore, in the United States, the population over 65 years of age increases by 1,600 persons each day, with the portion of the population over 75 years of age increasing four times as rapidly. The net result is that by the middle of the next century fully 45% of our adult population will be over 75 years old, with one out of every 20 persons in this group being over 85 years old.

As age increases, impairment increasingly becomes a fact of life. At 82 years of age, Florida Scott-Maxwell expressed this well: “When a new disability arrives, I look about to see if death has come, and I call quietly, ‘Death, is that you? Are you there?’ So far disability has answered, ‘Don’t be silly, it’s me’” (2).

If we add to these demographic factors the prediction that the mean life span, currently 71 to 77 years, may increase significantly in the next decades because of technological advances in medicine and surgery, genetic engineering,
and an increased awareness of the effects of environmental hazards, then the need to be concerned about the quality of institutionally based long-term care in the future is readily apparent.

Occupational therapists would do well to examine several aspects of the challenge of providing long-term care to the aged who cannot be sustained in the community. We need to examine the nature of the task (what interventions are necessary), define strategies for accomplishing our task, and determine methods and techniques for marshalling the necessary resources to provide this care.

The Task

Long-term care facilities do not enjoy a high reputation as caregiving institutions. All concerned individuals—family members, health care providers, and social service providers—use placement in a nursing home as a last resort. This is as it should be because, undoubtedly, the long-term care residential facility is the most restrictive environment among all other options in the spectrum of long-term care services. Still, these institutions should not be considered waiting rooms for the end of life. Programs in long-term care facilities can be structured to meet the health care and the human needs of aged people. The health care needs are familiar to most providers. At minimum these include personal safety, healthy nutrition, environmental comfort and security, and curative and/or palliative treatment. Those programs in long-term care facilities that go beyond this minimum address the universal human needs for dignity, meaning, and enjoyment. More of these programs are needed (3).

Gerontologists suggest that the ability to meet these human needs depends on four factors as follows: engagement in an intimate relationship characterized by mutual commitment and mutual support; participation in social relationships that involve the exchange of ideas and experiences; involvement in activities that call on available knowledge and skills; and the use of resources that provide access to the other three factors.

For the healthy elderly who live independently in the community, these needs are generally met by interactions with family members, friends, and the community’s commercial and social institutions. As individuals age, it becomes more and more difficult to meet these needs as the spouse dies, friends are lost, and offsprings have family responsibilities of their own. Elders whose disabilities (be they physical, cognitive, social, economic, or a combination of these) necessitate a more protected environment characteristically have difficulty meeting their human needs in a long-term care facility. Nursing homes almost invariably emphasize the health care treatment aspects of elder care and give less attention to the interpersonal dimensions of living, belonging, and contributing to the life of the community.

In the nursing home, it is difficult, and rarely possible, to compensate for the loss of the intimate relationship provided by a marriage partner of 30 years or for the diminution of personal resources. However, it is possible to foster new social interactions and friendships among the elderly and to compensate for the loss of day-to-day activities formerly carried out in the home by replacing them with similar activities in the long-term care facility.

Interventions

The tasks of providing social interaction and activity require sensitivity, imagination, and above all specific knowledge and skills. As we work with older individuals in nursing homes, we often see that work-oriented activities such as washing dishes, sewing on a button, or straightening up a cluttered garage have been replaced by relatively passive, leisure-oriented activities such as watching television or playing bingo. By virtue of our professional training, we occupational therapists understand the importance of engaging in all three spheres of human activity—self-care, work, and leisure. Furthermore, we know how important it is to provide this opportunity for every individual, including those living in an institution. We know that it is possible to identify and employ activities in the nursing home that are equivalent to, and compensatory for, the meaningful and fulfilling activities the elderly once pursued in the community. Furthermore, we know how to foster social interactions as an integral aspect of engagement in activities. This kind of knowledge and training makes occupational therapy personnel uniquely qualified to address the tasks of “social interaction and activity.”

One of the most important contributions we occupational therapists can make to long-term care is to share our knowledge about activities and social interactions with those who are responsible for structuring the day-to-day living
Environment of aged individuals in institutional settings. We should share this information with family members, administrators, directors of nursing, activities staff, and volunteers. We can help nursing homes focus less on what care is to be provided to the residents and more on what the residents are capable of doing. We can help other disciplines in long-term care learn to give priority to what residents want to do and help them define the strategies that are necessary to bridge the gaps between the residents' basic human needs and desires and their current skills.

This type of long-term care requires a collaborative relationship among health care providers where everything possible is done to preserve the elder's control over his or her environment and the activities in which he or she engages to sustain productivity, pleasurable involvement, and a sense of community. This means that all care providers in the nursing home treat elders with respect, making sure that they are being listened to, that they participate in the decision making, and that they are givers and interactors, rather than solely receivers, in day-to-day living.

To accomplish these goals, everyone involved in long-term care must address the issue of expectations—of care givers' and residents' expectations. Occupational therapy personnel working with other providers in nursing homes can help the staff, particularly the nursing aides, to establish the expectation that residents will do for themselves whatever they can, will make decisions about issues important to them, and will express feelings about things that affect them. Occupational therapy practitioners working collaboratively with administrative and nursing staffs can create an environment that encourages residents to act on these expectations. In so doing, they will create a new atmosphere. Passive receptivity and dependency will be replaced by reciprocity; residents will consider themselves capable of contributing to the community, and the staff will support and foster these views.

Developing new expectations leads to new role functions for residents and staff. Here, too, the occupational therapy practitioner has a significant contribution to make by sensitizing activities staff and nursing staff to the variety of roles available for residents and to the importance of ensuring that residents' role responsibilities are geared to their interests as well as their cognitive and physical abilities.

The productive, work-oriented roles that occupational therapists can help the staff identify and use with residents are almost limitless. They range from simple tasks, such as caring for plants, posting and removing bulletin board notices, and guiding visually impaired residents to meetings or activities, to more complex tasks, such as participating in the residents' council, in telephone assurance for home-bound individuals, in academic study, and in sheltered employment. Simple, work-related role functions (laying out napkins for a meal) can be identified for residents with marked cognitive deficits. To be successful both staff and residents must perceive these responsibilities as meaningful and necessary.

Occupational therapy personnel can also contribute to the nursing home staff's skill in the use of leisure-oriented activities. They can help the activities staff develop programs that are sufficiently varied in content, structure, and process to meet the residents' very diverse interests and abilities. In addition, the occupational therapist can be instrumental in developing an effective data gathering process that the staff can use to identify the residents' interests, skills, and values relative to their previous work and leisure activities.

Strategies

If the need for meeting the human needs of elders living in nursing homes is well established and the occupational therapist's skills are unquestionably suited to the task, why are so few therapists providing these services? Three reasons present themselves. First, the supply of occupational therapists is inadequate to meet the need; second, therapists lack interest in the institutionally based long-term care of the aged; and third, reimbursement for the delivery of "human needs" services is lacking.

The issue of supply and demand in gerontic practice has received public attention. A recent issue of News on Aging highlights a new bill, The Geriatric Education and Training Act of 1985 (GREAT), introduced by Senator Heinz (R-PA) who noted, "Studies show that by 1990, at least a five-fold increase in faculty will be needed to train doctors and dentists in geriatrics. Experts also predict that the current low budget levels for training will create severe manpower shortages down the road for health care professionals who serve the elderly. For one category of specialists—occupational therapists—the demand will increase by 900 percent" (4).
What can we do to meet current and future needs? The recruitment of students who are committed to a career working with the aged is one solution. The enactment of GREAT could do a great deal to focus occupational therapy practice on the elderly. During the 1960s and early 1970s, traineeship support from the Rehabilitation Services Administration provided hundreds of thousands of dollars of support for occupational therapy students who, upon graduation, would commit themselves to working with the severely handicapped. These traineeships are at least in part responsible for the strong group of occupational therapy personnel currently practicing in physical disabilities. GREAT could have the same type of impact on gerontic practice in occupational therapy. We need to track this proposed legislation to ensure that occupational therapy is included as a health care discipline as the bill proceeds through Congress. We will certainly want to work for its passage.

Recruitment of faculty members with clinical experience and research interests in gerontic practice is another important approach to interesting more therapists in providing long-term care. During the past year, three occupational therapy curricula have searched for and employed therapists with expertise in gerontic practice. Faculty groups would be well advised to recruit colleagues with expertise in this field. We need to ensure that at least one faculty member in each of our educational programs is knowledgeable in, and enthusiastic about, gerontic practice. Students tend to have negative attitudes toward aging and the aged. These culture-based attitudes are relatively easy to change if we modify academic content and provide role models who can transmit enthusiasm for working with the aged.

Fieldwork is another aspect of education that we can use to prepare more therapists for practice in aging. Fieldwork plays a crucial role in the development of practice skills and in the selection of a career direction. Yet how many programs currently offer (let alone require) fieldwork experience in long-term care? Furthermore, are there a sufficient number of clinical educators working in these settings to provide a supervised learning experience? Project ROTE (The Role of Occupational Therapy with the Elderly) is an important step toward educating practitioners and students about gerontic practice. This initial step, however, needs to be built on if we are to increase the number of practitioners providing the type of collaborative and consultative services to nursing home staffs that will create an active, socially satisfying living environment for the aged residing in institutions.

The question of how to expand the number of occupational therapists and occupational therapy assistants practicing in geriatrics, particularly in long-term care settings, cannot be addressed solely in terms of strategies within the profession. The question is intricately bound to health care funding.

Clearly, one factor that continues to hamper our ability to deliver services to the aged is our status under Medicare regulations. AOTA's Government and Legal Affairs Division is providing strong leadership in our efforts to achieve parity with other providers. Given the current economic climate of stringent budget cuts, a successful outcome is by no means assured this year. Yet we will eventually overcome this barrier. However, even if Medicare were amended tomorrow and we were covered as primary providers for home health and long-term care treatment, improving the quality of life for nursing home residents would not be a reimbursable service either for occupational therapy or for any other profession.

How to finance long-term care is becoming a critical issue in health care. Today, 25% to 30% of our federal expenditures are dedicated to the aged (Social Security, Medicare, etc.). In view of this, it seems unlikely that Medicare will be expanded to include other chronic care services or that a new federal program addressing the financing of long-term care will be forthcoming in the foreseeable future. However, there are new developments in financing chronic care that we need to be aware of and involved in. For example, the American Association of Retired Persons and the Prudential Insurance Company have plans to test-market a new long-term care insurance policy in six states. Premiums would range from $480 to $1,000 yearly depending on age. Should the insured become chronically ill, the policy would pay for three years of care in a hospital, nursing home, or at home.

Other arrangements that support the costs of long-term care, such as life care communities and social health maintenance organizations, are developing through...
out the country. Our profession needs to ensure that these emerging policies and programs make provisions for occupational therapy services and that in their funding mechanisms they address the issue of the quality of life in addition to the quality of care for elders. We need to work collaboratively with other health professions in this endeavor. We must continue to take an active stand in shaping health financing and in expanding gerontic practice in occupational therapy. One important outcome will be the emergence of long-term residential care as an acceptable, perhaps even a preferred living environment for aged individuals when community living becomes unsafe, socially isolated, or burdensome.

By directing professional energies and resources to gerontic practice now, we can help meet the challenge of the demographic revolution and bring the skills of our profession to bear in reshaping long-term residential care for the aged.

REFERENCES

RELATED READING
Schneider EJ (Editor): The Teaching Nursing Home. New York: Raven Press, 1985