

IDENTIFYING CLIENT AND SIGNIFICANT OTHER CHARACTERISTICS
FOR DETERMINING TYPE OF CONTINUING CARE SERVICES:
A TOOL FOR HEALTH CARE PRACTITIONERS

by

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INTRODUCTION

There is a need to develop and provide more effective tools for assessing continuing care needs for discharge health care. An increasing elderly population, scarce resources and limited reimbursement for health care, necessitate the development of a method to accurately identify those who will require discharge assistance for continuing care. It is becoming more important that clients be afforded the proper and appropriate type of care so as to utilize scarce and costly resources effectively. Among the scarce resources is the health care provider whose scope and extent of responsibilities will change as the agency's ability to provide services changes. These changes are expected to occur as the Prospective Reimbursement System is initiated in the United States after October 1, 1983. This paper will address these and other issues and provide a literature search and professional practice experience in the development of a tool identifying client and "significant other" characteristics for determining the type of needed continuing care services in the community.

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DEFINITIONS OF TERMS USED

Wholistic Health Care

Care that is provided in a manner related to the total needs of the client i.e., social, physical, emotional, psysiological, environmental (including the client's significant others).

Health Care Practitioners

A health care professional who is certified or licensed to practice in the care of clients. For example nurse, social worker, dietitian, therapist, physician and counselor. In some instances the clergy is included.

Family

Family is viewed as those significant others in the life of the client and may not necessarily be in the same residence.

Significant Other (S/O)

Those persons whose relationship to the client is nurturing and supportive.

Continuity of Care

A series of planned, connected and coordinated patient/client care events or activities which occur within the institution, in the home, and in several health care institutions. (Assessment, care, planning, implementation, and evaluation, of response to care.)

Discharge Planning

The utilization of the patient care process to assist the patient/client to achieve and maintain as high a level of wellness as possible. Discharge planning promotes continuity of care between units within the institution and from institution to another care facility, or from institution to the home. The patient's health care includes health care instruction and discharge planning as well as diagnostic, therapeutic, preventative and restorative measures. The planning should also involve the patient's nonmedical as well as his or her medical needs.

STATEMENT OF THE PROBLEM

Prospective reimbursement under the Tax Equity and Fiscal Responsibility Act (TEFRA), will necessitate innovative discharge management techniques. Cost containment which will be enforced by administrators under this method of reimbursement can be aided by the use of innovative and efficient tools that can readily identify clients early in the institutional stay. Early identification of clients requiring assistance in continuing their care will initiate the discharge planning process, thereby decreasing the length of stay and health care costs.

A study of the literature and examination of professional health care practices is required to determine what characteristics are significant in determining continuing care needs. This is needed in order to develop an innovative tool to assist health care practitioners to provide continuing care services in an efficient and effective manner.

Insight is needed into characteristics common to individuals within institutions for long term care. Also important is the determination of the factors negating or precipitating institutionalization.

The tool is needed in the process of the client's care during the admission and continuing care assessment, planning and implementation process. The tool is to include (a) the client characteristics that describe the intensity of care needs for continuing care, (b) the client and significant other's characteristics to provide that care and (c) the type of care related to the client's needs, including

the client and significant other's ability, willingness and preference for type of care.

BACKGROUND OF THE PROBLEM

Providing continuity of care for clients being discharged from health care institutions has been a growing concern and challenge for health care practitioners. Providing this service is a requirement by licensing and accreditation bodies, e.g. Joint Commission for Accreditation of Hospitals,¹⁰ and fiscal intermediaries for Medicare, Medicaid, and Blue Cross/Blue Shield as a condition for participation in reimbursement of services. The American Hospital Association¹ has described continuity of care as a client's right and placed its provisions in a statement called a Patient's Bill of Rights. Health care institutions have initiated some form of continuity of care by attempting to provide discharge planning, the vehicle that provides continuity of care. Some facilities employ discharge planners and/or social workers, while others place the responsibility solely with the Utilization Review Coordinator.

Hospitals have stepped up their efforts to provide client services for continuity of care. The Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid, maintains that discharge planning will help to lessen health care cost due to fewer days in the hospital. To enforce decreased length of stay and to assure discharge planning, HCFA appointed Professional Standards Review Organizations (PSRO's), which were mandated by P.L. 92-603. The PSRO reviewed and monitored medical records in hospitals. During the early days of PSRO, the length of stay decreased, but began to plateau in 1979

and gradually increased in 1980. This was thought to be related to various factors such as increasing proportion of elderly and persons with chronic diseases whose length of stay is longer. There was also an increasing number of outpatient services available which decreased the admissions of short stay clients. The number of short stay clients lessened; but those who were hospitalized were longer "length of stay" clients, and therefore increased the overall population's length of stay.

Hospitals found themselves with empty beds as the shorter stay patient was provided other alternatives for diagnostic workup and treatment. Hospital administrators attempted to find ways to fill the gap of inpatient services by developing innovative programs such as out-patient surgery, wellness clinics, hospital-based physician programs, walk-in clinics, and community health education programs. Simultaneously, insurance companies accelerated outpatient coverages for home health care and outpatient surgery. Among these were Medicare with expansion in both hospital insurance (Part A) and medical insurance (Part B), Medicaid, and Blue Cross/Blue Shield as well as numerous private insurance companies. There is also an attempt by management to decrease health care costs, by selecting from competitors in the health care industry those who are lower in cost for services. This trend is seen with Preferred Providers Organizations and Health Maintenance Organization. These forces to decrease health care costs and provide services at less costly levels of care along with the mandates for licensure and accreditation created a new word for health care providers - discharge planning. Discharge planning was expected to be initiated on the day of a client's admission to the institution

by inquiring about environment, social characteristics, health history, and rate of compliance to necessary health care measures. Throughout the client's stay, health care practitioners were to determine which clients would require (a) home care services, (b) transfer to institutions such as nursing homes and rehabilitation centers, or (c) placement for basic care and custodial services in foster care homes.

Nursing home growth was controlled by the local Health Systems Agencies and many areas found a scarcity of beds for nursing home placement. The client awaiting a nursing home bed in the hospital increased the average length of hospital stay. Once admitted to the nursing home, and their level of care indicated a discharge was possible, basic care services in the community were absent. This resulted in clients remaining in the nursing home unnecessarily and further backlogging clients from the hospital thereby increasing the length of stay.

Home care agencies began to proliferate in the early 1980's, reflecting expanded insurance coverages and the mandates for continuity of care. Marketing of their services and the promotion of the advantages of home care services over nursing home replacement was commonly heard. Discharge planners began a closer working relationship with home care agencies and in combination with patient-family teaching, many clients were sent home. All the aforementioned forces created pressure on the client's nurse and other practitioners to provide continuing care services. Nursing staff expanded their scope of client-family assessment and focused attention on their client's living and work environment and compliance to health care practices. A new thrust was placed on developing assessment skills by all health care

professionals, to include a wholistic appraisal of the client-family needs as it related to the medical plan for care, the health state upon discharge and the client-family's ability and willingness to learn and provide for that care.

In September 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA).²³ One of its provisions changed the manner and process of hospital reimbursement. Previously, hospitals were reimbursed for days of care and even though discharge planning was mandated, the incentive was limited as hospitals were reimbursed for all days determined to be acute or skilled care. Physicians also determined when the patient was to be discharged. With TEFRA, the reimbursement basis changed to provide an amount per diagnosis related group. Therefore, if a client's discharge was delayed and cost went over the amount per diagnosis related group, the difference would not be reimbursed by Medicare. It is expected that other health insurance companies will follow similar methods for reimbursement within the next five years.

With the newly created mandates of TEFRA for prospective reimbursement, health care practitioners must increase their efficiency as well as effectiveness in determining a client's continuing care needs on a more timely basis. Delay in this process would cost the hospital industry money, and needed services may have to be cut to minimize losses in revenue. Another reason for increasing efficiency is to increase the assurance that all clients will receive the necessary care at an adequate level of quality. Inefficient discharge planning programs may spur a discontinuation of a client's service due to lack of additional hospital reimbursement for that care or in some instances

the specific service may be discontinued due to its costliness to provide it. Optimum care, the best or most favorable, may be seen as a service of the past, and in its place, is anticipated at least adequate care at a cost the client can afford to pay. Cost containment programs such as prospective reimbursement will also force health care providers to choose between optimum care and adequate care. Adequate care can be defined as provision of care that is sufficient and accessible in enabling the client and significant others to continue acquisition of services at another less costly level of care. Institutions must provide sufficient health care instruction and resources to enable the client and significant other to move to a lower level of care for completion of health care needs.

PURPOSE OF THE RESEARCH

By exploring the literature and utilizing discharge planning experiences, this paper deals with the problem of predicting "continuing care" service needs for clients. The principle focus is on the characteristics of the client, and of significant other's ability, willingness and preferences for type of service, as it relates to the level of client care need. It is suggested that assessment based on these characteristics, will provide information valuable to the health care practitioner in determining what type of care will be needed. From these identified characteristics a tool will be developed that will aid the health care practitioner in assessment and determination of the type of care for the continuing care services.

Conceptual Framework

Health care practitioners must attempt to meet a client's total health care needs. This is in contrast to providing treatment limited to only the complaint the client presented. This author supports evaluation and treatment of all causative factors that are agreed upon by the client for treatment. The factors that cannot be alleviated in the home without continued intervention must be identified in order to increase compliance with necessary health care practices. These factors include finances for health care, transportation, nutrition, employment or education and protection from abuse or neglect. Health care in its wholistic form must assess these factors in an attempt

to minimize the severity of disease or the disease's residual effects. For example, a client's plan for care is to take a prescribed medication for treatment of an infection. A factor that may circumvent the client's treatment is an inadequate income to purchase medication. The health care providers must determine this and assist the client to acquire medication at an affordable cost. Ignoring this factor will increase the severity of disease and possibly cause long lasting injury as the result of the infection.

It is also believed that the degree of involvement that the client has in developing a plan for care will affect compliance with appropriate health care. Health care practitioners must allow clients and their significant others to participate in the assessment, planning and intervention phases of providing continuing care in order to increase compliance.

The tool not only seeks to determine those who will need assistance in their discharge from the hospital, but also increases participation of the client and/or significant others by planning around their ability to perform health care, willingness and ability to learn the care and their desire for a selected type of care or service. If needs can be identified as completely as possible, it is also believed that health care compliance will increase. It is anticipated that health care costs will decrease with increased health care compliance. Increasing health care compliance should stabilize or may affect the disease or the health state except in terminal cases. Therefore, a change in level of care or type of care may be required. A longitudinal study will be needed to determine accurately the effects on costs by increasing compliance. Short range studies can also be useful in

determining the model's accuracy in aiding practitioners in determining the type of care needed. Inappropriate determinations may increase costs for care. A testing of the tool's reliability is also needed over the use by varied health care professionals.

The following literature review illustrates the findings from various studies that aided in the development of the tool. It is to be noted that the literature indicated "what is" the person's characteristics while institutionalized. The findings do not indicate "what could have been" if e.g., significant other's were educated in the client's care, other type of care was accessible and affordable and knowledge of options were present.

REVIEW OF THE LITERATURE

A variety of approaches were found on reviewing the literature for client characteristics influencing continuing care placement. The analysis of the approaches for those requiring continuing care can be classified as (a) the characteristics and subsequent needs of the client, (b) the characteristics of the client's significant others (S/O) and (c) the communities characteristics in providing services for the client's needs.

The first type of factor for determining continuing care needs is the characteristics of the client. It was the most reported predictor for continuing care. Characteristics were related to the ability to perform activities of daily living or what was commonly known as activities of daily living (ADL).^{8,7,6,11,13,19,20} This included performing health care treatments. Others are financial, educational and style of life factors,^{4,5,8,14,17} severity of medical/physical condition,^{8,19} need for peer group relationships,¹⁸ mental health or morale status,^{8,17,19} race,¹⁴ sex¹⁴ and client or significant other's preferences and or attitude toward placement.^{8,17,19} The following is a literature review of the above activities of daily living (ADL) characteristics pertaining to the client.

Ability to perform activities of daily living commonly known as ADL status was described in various ways. S. Katz, et. al. (1963), developed ADL indices in assisting health care providers in determining the level of independence/dependence in performing ADLs. They

included: bathing, dressing, toileting, transferring, continence, and feeding (11:p. 95). The greater the need for assistance in one or more activities of daily living (ADL) indices the greater the need for continuing care service. Of theoretical significance was their finding of a characteristic order to the level of ADL performance. They found that "the order of recovery of function in the disabled adult is remarkably similar to the progression of function in the developing child." They hypothesized "just as there is an orderly pattern of development, there is an orderly regression as part of the natural process of aging" (11:p. 915). This finding may assist evaluators in also predicting the extent of care according to the level of ADL status. Also in 1963, P. Townsend, described a means to measure an older persons ability to care for themselves at home. In his article he discusses a number of studies and outlines a method taken from questionnaires compiled during a survey of 530 residents in England and Wales who had recently been admitted to long term care institutions. He also cites Katz et. al., (1958), who dealt with the problem of measuring the degree of capacity to perform a given task (12:p.27). From the study, Townsend, indicates a method of measuring incapacity for self care assuming no assistance is received. He groups the person's capabilities into four categories of performance. He admits that the questions were restricted to activities minimally necessary to maintain life in the present day society. What Townsend et.al., claims is that "those scoring an overall score of 10 would be significantly different in their capacity for self care from those scoring 7 or 8" (20: p.280). We would expect there to be marked and significant differences between each group. Similar to Townsend and Katz, J. Greenbert and A. Ginn,

in 1979, provided research to conclude that the preceding characteristics also were related to long term placement but added the ability to take medication (8:p. 86). On bivariate analysis they found that persons in a nursing home were more dependent on others for activities for daily living with the exception of being able to transfer (8:p. 86). N. Dake, in 1981, included ability to take medication and added ability to provide health treatment (6:0. 27). F. Gilkow's, 1980 theoretical model, utilized similar activities of daily living (ADL) assessment and included as the result of that ADL assessment the needs for services. Her model continued to elaborate the specific community service available (7:p. 234). K. McKeenan, in 1979, developed a discharge planning program using nursing diagnosis by describing a functional approach related to ADL that complements the biologic systems approach that medical diagnoses follows (13:p. 522). Like Gikow, the aim was to provide a plan for continuing care once the assessment of ADL was performed. She also rated the ability by three measures of independence and added ability to shave, brush teeth and effective use of health care aids (13:p. 521). The Stein Gerontological Institute at Douglas Gardens, in 1980, performed a Florida statewide hospital discharge study to assess the factors that influenced discharge placement of elderly persons. They also measured ADL status by utilizing the Older American Resource and Service Multidimensional Functional Assessment Questionnaire Rating Scale produced by Duke University from the Center for the Study of Aging and Human Development at Durham, North Carolina. The Stein Institute rated ADL performance on a six point scale from excellent capacity to complete impairment. They found along with the mental health status, higher ADL impairment scores were

potentially significant in placement decisions in nursing homes (19:p. 54 and 87).

Another client characteristic was the financial resources of the client. S. Sherwood, J. Morris, and E. Barnhart, in 1975, looked at the style of life as one of the indicators for determining institutionalization. This included the educational level and family occupation (17:p. 335). E. Palmore, in 1976, found that finances were a predictor but he also indicated that finances were more of an access factor to services. He concluded that those with lower finances had less access to institutions. He further states that those with less education (6 years or less), had lower rates of institutionalization (20%), but when he studied the characteristics statistically, he found education made little difference (14:p. 506). J. Barney, in 1977, and S. Brody, in 1978, also found that persons who lack strong economic supports were more likely to be prematurely admitted to nursing homes (3:p. 79 and 4:p. 12). J. Greenberg et. al., also agreed that a client's financial situation was a characteristic related to long term placement (8:p. 79). They stated that "the gerontological literature with regards to finances indicate the nursing home residents tend to be poorer than non-residents" (8:p. 82). However, their study indicated the reverse pattern. "Twice as many in-home clients had incomes under \$3000.00 as did nursing home clients." Greenberg reconciles this contradiction by stating that "most studies dealt with existing nursing home populations, whereas the current study deals with only new clients" (8:p. 76). Greenberg et. al., further supports their finding by quoting Palmore, 1976, "It may be that financial adequacy provides greater access to institutions, but that institutionalization itself

soon depletes financial reserves in that most persons in institutions rapidly become financially disadvantaged" (8:p. 82). Therefore, researchers interviewing nursing home clients find a population with few financial resources.

A third characteristic of the client was the need for peer group relationships. This was looked at by S. Sherwood et. al., in 1975, who concluded that the lack of relationship prompted institutionalization (17:p. 82).

A fourth characteristic of the client was the degree of severity of the medical condition of the client. Using bivariate analysis, this characteristic was found to be "highly significant and showed that the worse off a person is with regard to this index, the more likely he or she is to be placed in nursing home" (8:p. 90). This was contradicted in the Stein research. Physical health was found to slightly affect placement and therefore suggested that "higher level of physical impairment may be addressed in the community by increased family resources" (19:p. 61).

A fifth characteristic of the client was the morale and mental health status. S. Sherwood et.al., 1975, measured morale by an interview and attempted to measure confusion defined as "the inability to remember the day of the week, to recall the name of the street on which one lives, and to estimate the duration of the interview" (17:p. 87).

Only one of the studies examined patient's race as a factor. E. Palmore, 1976, stated, "Blacks were institutionalized less or had less access to institutions than whites because of their race even after need factors and other access factors" (14: p. 506).

In regards to sex as a characteristic of the client admitted to

long term placement, J. Greenberg et.al., found on bivariate comparisons that "those persons who entered nursing homes were more likely to be female than their counterparts who received services in their homes. They also tended to be older and have higher incomes" (8:p. 81). E. Palmore, concluded that women had a risk of 33% compared to men (20%) for long term placement. However, he thinks this is due to more women living alone, never married or separated and having fewer children (14:p. 505). In the Greenberg study, sex as well as age was found not to be significant for placement decisions (8:p. 83).

Preference and attitude was another characteristic of the client predicting continuing care needs. In the Greenberg studies, client preferences were found to be one of the five variables most related to placement (8:p. 83). E. Brody, also found that the client's attitude toward application for placement was significant if placement actually took place (4:p. 191). This was also found with N. Dake's writings. She included the patient's thoughts and feelings about post discharge care as important indicators for continuing care (6:p. 27).

Age was the last characteristic found related to the client. Palmore found that prevalence rates for long term placement increased with age from 2 percent at ages 65-69 to 14 percent for those over age 85 (21:p. 505).

A client's ADL status indicating a degree of dependence on others was found to be a significant factor by many researchers determining a client need for continuing care services. Other factors were inadequate financial status, lack of peer relationships, inadequate morale and mental health status and preferences for continuing care services.

Race, age, sex and diagnosis were found not to be directly related to a need for continuing care services. However, those persons over age 85 were found to require long term care placement.

The second type of factor for determining continuing care needs was the characteristics of the client's relationships with significant others. Research by J. Greenberg cited S. Saul's work in 1968 where it was found that two common factors were absent with nursing home placement patients. "The physical and emotional presence of a caring person and the opportunity for continuation of roles and relationships" (16:p. 78). Also in an observation study given by E. Brody, in 1968, at the 21st annual meeting of the Gerontological Society in Denver, structure and quality of family relationships were found related to long term placement (4:p. 195). E. Palmore's twenty year longitudinal study found a higher rate of institutionalization for those who lived alone, 33 percent, compared to 24 percent for those not living alone. Other findings by Palmore, in regards to marital status found those who never married had 54 percent of a chance for institutionalization and those separated from spouse at 40 percent (14:p. 503). S. Sherwood's findings, also indicated that those who lacked independence and lived alone without support persons, were at greater risk for institutionalization (17:p. 335). Palmore's findings related to children in the home, indicated that those with no living children (38 percent) and those with one or two children (27 percent) had higher rates for institutionalization than those with several children (22 percent) (14:p. 505).

Another characteristics of the client's relationship with others is the significant other's ability to capacity to tolerate the stress

of caring for someone's needs. E. Brody's observational study indicated those with poor family structure, low quality relationships, and little tolerance for stress, contributed to long term placement and also contributed to the client's attitude for desiring institutionalization. The Stein study showed a relationship in resources affecting family relationships and the type of placement (9:p. 48). The lack of resources interrelated with the family's ability to tolerate stress. It should be pointed out that less than 5 percent of the elderly are institutionalized (17:p. 7). Nearly 80 percent of patients for whom personal care was prescribed received care without any type of social agency assistance following discharge from a chronic hospital (22:p. 11).

The last characteristic reviewed was the preference of the family for the client's placement. The characteristic was also significant in the decision for institutionalization according to Greenberg et.al., (8:p. 83) and (2:p. 485). The characteristics of the client's significant others were found to be influential in determining the type of continuing care services. Those with no loving persons, children or adequate family structure were found to be institutionalized more often whereas those with the opposite characteristics were found to have a lesser risk of institutionalization. The preference for type of care was also found significant.

It is to be noted at this time that the literature cited did not mention or emphasize the importance of utilizing a "caring person's" strength by teaching or supporting acceptance for supervision or health care services for the client. The importance of teaching and support for caring by health care providers will be addressed further in this

writing and will be a part of the tool developed.

The third type of factor for determining continuing care needs was the community's provisions of services for the client's needs. E. Brody, 1968, cited "the availability of viable options to institutionalization" as being an indicator or predictor for application to nursing home placement (4:p. 195). Greenberg's studies cites the earlier studies by Palmore, 1976,¹⁴ Barney, 1977,³ Brody, 1976,⁴ Townsend, 1963,²⁰ and Sherwood, Morris and Barnhart, 1974,¹⁷ as also indicating availability of alternatives being related to long term placement (8:p. 79). Greenberg, however, did not place this predictor in his conclusion of the five most related to placement. Availability and accessibility to both family and community resources were also found significant in the Stein study (19:p. 12). Environmental factors defined as patient/family preference and lack of suitable service agencies were frequently found in placement decisions by K. Bay et.al. He also found that care providers then chose a less optimal setting when the community service was not available (2:p. 473). N. Dake's writings also emphasized the importance of suitable services when planning for care after discharge (6:p. 27). F. Gikow's theoretical model heavily weighted the plan for discharge care according to resources available. The reader could then easily view the continuum of care required after assessment and planning with the client and family (7:p. 323).

All literature cited indicated that availability and accessibility of community resources were significant in determining type of care services. The literature indicates that there are factors related to client, significant other, and community characteristics that will aid health care practitioners in predicting those clients who will

require and/or benefit from continuing care services.

Of equal importance, however, will be the experience of health care providers in working and relating to clients and their significant others. The significant others will be an important factor in determining continuing care needs by their ability and willingness to receive health care teaching and provide care to the client.

A client's resource of significant others may well be a valuable ingredient worthy of further study to evaluate if health care costs can be lessened by providing specific support, resources, or funds, as they learn and provide care for their loved ones at home.

Reimbursable extended health care services in the home are not provided by certified home care agencies due to the majority of health care insurance contracts specifying skilled intermittent care only. Intermittent service is estimated to be one to two hours a day for eight to eleven visits. A fee for extended service is available but is not reimbursable under Medicare, Medicaid or most Blue Cross programs. Subsequently these services are not affordable by the majority of clients. If health care decision makers could place a value on the significant others as a resource for care and a substitution for institutionalization, possible innovative methods could be developed. These methods may well be lesser in cost overall, as one compares long term institutionalization over home care with its short term intensified services over a greater part of a day, tapering down to lesser hours of care.

APPLICATION OF THE LITERATURE FINDINGS AND PROFESSIONAL
EXPERIENCE IN THE DEVELOPMENT OF THE TOOL

The literature was reviewed and classified by the characteristics of (a) the client, (b) the significant others as caring persons and (c) community service types.

In developing the tool, the same organizational approach was used for structure. First the characteristics of a client's continuing care needs for assessment and a means to measure the intensity of those needs were provided for in the tool. Note the left hand side of the tool in Illustration I. Second, the characteristics of a client's and significant other's ability to provide care was listed for assessment in the tool. Note the right hand side of the tool in Illustration I.

CONTINUING CARE ASSESSMENT

Client	Assistance Required					Continuing Care Plan
	No Assist	Assist	Some	Total Assist	Unable to Assess	
<ul style="list-style-type: none"> ● Activities of Daily Living ● Sensory Deprivation ● Compliance with Health Care ● Other: Psycho/Social/Economical 						<p>Level of care plan related to client and S/O willingness and ability to learn and provide care and preference for type of care.</p> <ul style="list-style-type: none"> ● Client and/or S/O able and willing to learn and provide care and prefers: ● Client and/or S/O willing and able to learn and perform care. Will require and prefers intermittent assistance and referral for: ● Client and/or S/O unable, unwilling, to learn, perform, provide or prefers:

ILLUSTRATION I

The characteristics of the client's continuing care needs are specified under each category below. See Illustration II.

CONTINUING CARE ASSESSMENT

Use a (✓) to specify degree of assistance

<u>DATE OF ASSESSMENT</u>	ASSISTANCE REQUIRED With Physical Aids			
	No Assist	Some Assistance	Total Assistance	Unable to Assess
Activities of Daily Living				
Bathing				
Dressing				
Feeding				
Preparing meals				
Ambulating				
Transferring				
Continency of bowel and bladder				
Independence outside home				
Communication skills				
Ability to remember				
Decision making				
Sensory Deprivation or Ineffective Aids for:				
Vision				
Hearing				
Touch				
Speech				
Compliance with Health Care				
Medication/ability to take				
**Nutrition or inadequacy of				
Other Health Care Needs				
Performance of health treatments				
Specify				
Frequent Readmissions (2 or more in 6 mo) _____				
Other (Use a (✓) to specify needing assistance.				
Insurance				
*Housekeeping/chore services				
Transportation				
*Finance				
*Housing				
*Adult/child protective services				
*Protection from substance abuse				
*Legal assistance				
*Employment/education assist				
*Emotional adjustment assist				
Past living arrangement/environment-Plan				

ILLUSTRATION II

SELECTION OF CLIENT CHARACTERISTICS FOR THE TOOL

The following characteristics were included in the tool search.

- Ability to perform ADL in bathing, dressing, toileting, stair climbing, transferring, mobility, continency, feeding self and preparing meals.
- Ability to take medication as prescribed.
- Ability to perform health treatments.
- Ability to make decisions.
- Adequacy of mental health for providing self care.

Characteristics that are also included in the tool based on professional experience are those that indicate the client has difficulty with:

- Independence outside the home for shopping or paying bills in the absence of a caring person.
- The ability to remember affecting compliance with health care needs and safety.
- Sensory deprivation or ineffective aids for vision, hearing and touch which affect communication and safety.
- Compliance with adequate health care for well being, e.g. medication administration, nutrition, and other health related orders.
- Acquiring adequate housing, legal assistance, employment or education needed for employment.
- Acquiring protection from abuse, person and/or substance.
- Obtaining supplies and/or equipment for health care of the ability to have access to them e.g. transportation deficits.

Frequent readmission is also used in the tool as a characteristic of needing continuing care. It is believed that readmission is related to lack of control of the disease process. By providing services

to assist in health care, it is found that compliance is increased in the majority of cases served. It is also experienced that when readmissions do occur after services are provided, the illness state is less acute on admission and the length of stay has been found to be lesser. This deserves further study to determine its exact significance and other contributors to the lesser length of stay.

Age, sex, income, medical problems, and marital status are not direct characteristics and therefore were not included in the tool. They were found to be useful in screening methods prior to direct client and family assessment. For example, those over the age of 80-82 are at greater risk for requiring continuing care in a nursing home. Others are those who live alone such as widows, single, or divorced persons, and persons with inadequate income for health care compliance. This can be identified by noting insurance coverage information on admission. Another characteristic not used in the tool is the client's diagnosis. Because diagnosis is not a direct indicator of the client's ability to perform ADL's and the level of dependence on others or the community, they are not included in the tool.

The tool lists client characteristics requiring continuing care and measures the client's intensity or level of assistance required at the time of the assessment and on discharge. The level or intensity of assistance with or without physical aids are:

- No Assist - completely independent in performance.
- Some Assist - minimal assistance required, is capable of assisting in a limited way.
- Total Assist - requires complete assistance by a caring person.
- Unable to Assist - self explanatory.

The levels of assistance measurements are utilized to aid the health care provider to determine the intensity of care a caring person or community agency will need to fulfill. The measurements are not intended to predict the level of care plan or destination for care. The literature review indicated quantitative measurements for level of client need. It did not provide a suitable quantitative method of measuring the client's needs, in a manner that could predict the level of care plan or destination as it related to the characteristics of the significant other. Literature did indicate that certain activities of daily living need seemed to prompt admission to a nursing home but did not give satisfactory evaluation to determine if significant others were evaluated and offered the option of home care services with support and health care teaching to provide direct care themselves. Experience has shown that home care education and support can enable clients to return to home with significant others where in the past they may have had nursing home placement given to them as the only option for care. More study is needed in the area of quantitative measurements leading to the level of care plan or destination. For the purposes of this tool, the health care provider, client and significant other determine that destination of care together, instead of using a mathematical model for decision making.

Assessment of the Significant Other as a Caring Person

After the client's needs are assessed and measured for the intensity of assistance, the health care provider must assess the client's ability to learn and provide the care needed. If the client can not provide or learn the needed care, his or her preferences for destination for further care will need assessment. Subsequently, the

significant other's willingness and ability to provide care must be assessed. By involving the significant others in developing a plan for continuing care around the client's needs, more appropriate options and community services can be afforded. Knowledge of the intensity of the client's needs aids the health care provider in discussing the client's needs with the significant other. The literature supports the presence of a caring person or significant other as being important in the decision making process for or against institutionalization. However, the literature did not give indications of agency support offered to the significant others such as reimburseable intermittent home care nursing and therapy services, continuing teaching after discharge in the home, or private home care nursing services for a fee. It has been my experience that when significant others are supported to learn complex care while in the hospital, less institutionalization takes place for care after discharge. Community agency supports can begin while hospitalized so as to initiate the bonding to the home care service provider. This has increased the security of the significant other in attempting the care in the home. Emotional support from staff before and after discharge has made a significant difference in the coping and learning about the disease state and health care. Due to the many satisfactory experiences in home care support, the tool will aid in the assessment of the strengths of the relationships and abilities early in continuing care planning. If relationships and ability to provide care are not at a satisfactory level even with support and agency assistance, the health care provider can utilize the tool to select other options for continuing care. The tool's assessment of the significant other's willingness and ability to

provide care is characterized in three ways.

- Client and/or significant other are able and willing to learn and provide care after discharge.
- Client and/or significant other are willing and able to learn, perform and provide care. Will require or prefers intermittent assistance and referral.
- Client and/or significant other are unable, unwilling to learn, perform, provide or prefers.

See A, B, C in the tool, Illustration III.

Determining the Level of Care Plan or Discharge Destination

Community agencies can be classified according to the type or characteristic of services. The tool classifies the agency types according to the client and significant others willingness and ability to learn and provide care and preferences for care. The type of community agency services is specified in the Tool A-C. The assessment of the client aids the health care provider in involving the client and significant other in the determination of the level of care plan or destination for care.

The assessment of the client's continuing care needs and intensity of those needs and the significant other's and client's ability, willingness to learn and provide care and their preferences, determine the continuing care plan by specifying the type of continuing care services. See Illustration III.

CONTINUING CARE PLAN

LEVEL OF CARE PLAN RELATED
TO PATIENT & SIGNIFICANT
OTHER'S (S/O) WILLINGNESS
& ABILITY TO LEARN & PRO-
VIDE CARE.

A. DISCHARGE HOME
 INDEPENDENTLY

Patient or S/O able and
willing to learn & pro-
vide care after dis-
charge.

Date of Plan _____
Signature _____

B. HOME CARE WITH
 SUPPORT

Patient or S/O willing
and able to learn, per-
form and provide care.
Will require or requests
intermittent assistance
and referral for:

1. Skilled Intermit-
 tent Home Nursing Care
 Skilled Therapy-

Agency

2. Basic or Personal In-
 termittent Home Care

Agency

Date of Plan _____
Signature _____

C. DISCHARGE ALTERNATIVES

Patient or S/O unable/un-
willing to learn, perform,
provide or prefers:

1. Continual Skilled or
 Basic Home Care
 2. Skilled Nursing Home
 Placement*
 3. Basic Nursing Home
 Placement*
 4. Foster Care Place-
 ment*
 5. Transfer to other
 acute hospital

Agency

Date of Plan _____

Signature _____

S/O Phone: Home/Work

The level of measurement of the client's needs assists the health care practitioner to provide an awareness to the client and significant others of the intensity of continuing care required. It enables the client and significant other to decide on their ability and willingness to provide care for the anticipated length of time after discharge. At this state of discharge planning, health care education is offered to assist their ability to provide that care. Depending upon the client and significant other's ability to learn and provide care, their preference for type of services can be decided upon.

As the needs of the client and significant other change, the tool allows changing of the care plan. Each care plan selection is dated and signed by the health care practitioner. The changes in level of care plan or type of service required are known by the changes in the date entries on the tool.

The tool can be also utilized as transfer information to other agencies. By performing a discharge status client assessment, the discharging agency can provide current client status to the transferring agency. The tool can also fulfill partial requirement for an agency's discharge summary by specifying the discharge status assessment placing a "D" in the assistance requiring columns. The final discharge disposition is indicated in the lower right corner of the tool upon discharge.

Another feature of the tool is the specification of referral to appropriate ancillary staff members. By asterisks or color codes the health care practitioner can specify the need for ancillary referral depending on intensity of level of assistance required. Note illustration IV for nutritional and social work referral indicators.

A need for most health care providers in providing continuing care services is a means to indicate the type of health care supplier, equipment and other resources required for care. The names and phone numbers of these agencies on the tool will aid in providing a ready resource of continuing care information as health care providers change assignment in care of clients.

Providing for continuing care can be more effective when organized tools are provided for assessment and planning. In the era of cost containment, constraints on professional's time will demand less complex and complete tools. More attention will need to be given to the significant others in the lives of clients as caring persons. Health care professionals will need to assist the significant others and the clients to utilize scarce resources wisely by encouraging health education and self care. Each institution will need to modify the tool to fit their method of service delivery and licensing requirements and regulations for documentation.

CONTINUING CARE ASSESSMENT

CONTINUING CARE PLAN

Use a (✓) to specify degree of assistance

Use a "D" for final discharge disposition status

ASSISTANCE REQUIRED With Physical Aids

DATE OF ASSESSMENT	No Assist	Some Assistance	Total Assistance	Assess	Unable to
Activities of Daily Living					
Bathing					
Dressing					
Feeding					
Preparing meals					
Ambulating					
Transferring					
Continuity of bowel and bladder					
Independence outside home					
Communication skills					
Ability to remember					
Decision making					
Sensory Deprivation or Ineffective Aids for:					
Vision					
Hearing					
Touch					
Speech					
Compliance with Health Care					
Medication/ability to take					
**Nutrition or inadequacy of					
Other Health Care Needs					
Performance of health treatments					

Frequent Readmissions (2 or more in 6 mo) _____

Other (Use a (✓) to specify needing assistance. PLAN

- ___ Insurance _____
- ___ *Housekeeping/chore services _____
- ___ Transportation _____
- ___ *Finance _____
- ___ *Housing _____
- ___ *Adult/child protective services _____
- ___ *Protection from substance abuse _____
- ___ *Legal assistance _____
- ___ *Employment/education assist _____
- ___ *Emotional adjustment assist _____

Past living arrangement/environment-Plan _____

Supplies/Equipment Needs (when ordered, place a (✓) alongside)

Agency for Service - _____ phone _____
 _____ phone _____

Final Discharge Disposition
 Specify letter A-C & number of care plan _____
 Discharge via _____
 Discharge Date _____ Time _____
 Signature _____

LEVEL OF CARE PLAN RELATED TO PATIENT & SIGNIFICANT OTHER'S (S/O) WILLINGNESS & ABILITY TO LEARN & PROVIDE CARE.

A. DISCHARGE HOME INDEPENDENTLY

Patient or S/O able and willing to learn & provide care after discharge.

Date of Plan _____
 Signature _____

B. HOME CARE WITH SUPPORT

Patient or S/O willing and able to learn, perform and provide care. Will require or requests intermittent assistance and referral for:

- ___ 1. Skilled Intermittent Home Nursing Care
- ___ Skilled Therapy-

_____ Agency
 ___ 2. Basic or Personal Intermittent Home Care

_____ Agency
 Date of Plan _____
 Signature _____

C. DISCHARGE ALTERNATIVES

Patient or S/O unable/unwilling to learn, perform, provide or prefers:

- ___ 1. Continual Skilled or Basic Home Care
- ___ 2. Skilled Nursing Home Placement*
- ___ 3. Basic Nursing Home Placement*
- ___ 4. Foster Care Placement*
- ___ 5. Transfer to other acute hospital

_____ Agency
 Date of Plan _____

Signature _____

S/O Phone: Home/Work _____

MAY REQUIRE REFERRAL TO THE FOLLOWING:
 *Signifies Social Work Indicator
 **Signifies Nutritional Service Indicator

EVALUATION

According to P. Rossi et.al.¹⁶ (1979), evaluation is "undertaken for management and administrative purposes to assess the appropriateness of program shifts, and to identify ways to improve the delivery of interventions" (15:p. 21).

H. Havens, 1981, comments that "a good program evaluation is one which accomplishes its purposes with reasonable efficiency if it does not affect the real world, if the program is not used, it has failed the test" (9:p. 480). Therefore evaluation must indicate the outcomes of the program. Outcomes of a program to overcome a determined problem, reflect the impact of its intentional and unintentional activities. Outcomes may also expand the scope of the problem and may also determine other underlying problems and causes. It is with this in mind that evaluation of the proposed tool be addressed.

How can the proposed tool be evaluated for use in health care institutions? It is recommended that health care providers determine first, if they have a problem with identifying clients for continuing care in a timely manner? Are length of stays and cost per diagnosis or population too great for the rate of reimbursement? Can the health care institution's method or process be improved upon? One must seriously ask is there a need to change? A method of determining this, is to ask the health care provider and the clients. Interviews and questionnaires are two methods to be considered. Another would be to inquire at the institution's Utilization Review department. It

can give an overall institutional assessment of the discharge planning activities. Data regarding length of stay by population type and diagnosis can specify target problem areas that will be reflected in higher health care cost to the institution. Questions that can be part of an evaluation to determine if the proposed tool can assist in problem resolution are:

1. What are the problems in providing continuing care?
2. What does the institution's administrators want the continuing care program to do?
3. What changes or needs (e.g. administrative, process or procedures) are required to improve continuing care?
4. Who needs improvement and in what way?
5. What population are your improvements targeted for?
6. Who affects that population's continuing care, (staff and departments)?
7. What interventions are currently successful and do they need to be changed? Can they be left intact?
8. How much time (FTE'S) are being expended in current interventions? Can this be improved upon?

Once the need to change and or improve is determined, the objectives for using the tool should be agreed upon and documented. The objectives become a way of measuring and/or evaluating the outcomes of the tool.

On the merits of the proposed tool, objectives and their evaluation can include the following.

Objectives for the ToolEvaluation

- | | |
|---|--|
| 1. is needed to be used while performing the patient care process. | Did the staff complete the tool?
If not why? |
| 2. must be easily understood. | Were the questions addressed in the tool easily understood? |
| 3. method of documentation on the tool must be used by all staff e.g. definitions for measuring activities of daily living (ADL) needs. | Was the tool filled out as directed? |
| 4. should include all characteristics related to client and significant other needs for continuing care. | Was the tool complete in specifying characteristics of clients and significant other? |
| 5. must assist staff to specify all types of continuing care as it is related to the assessment of client and significant other. | Did the tool specify all types of continuing care related to the assessment of the client and significant other? |
| 6. must be able to assist staff to determine the options for type of continuing care. | Did the tool assist the staff to provide options for continuing care? |
| 7. must assist staff to identify client and significant other characteristics earlier in the stay for discharge planning. | Did the staff initiate earlier discharge planning after using the tool? |
| 8. must assist staff to identify and make appropriate inpatient earlier in the stay. | Did the staff initiate earlier inpatient department and staff referrals? |
| 9. must assist staff to identify and make referrals to community services. | Did the staff make referrals to community services as indicated by the tool. |
| 10. must specify appropriately the type of continuing care options. | Were appropriate options for continuing care services selected in the discharge plan? |
| 11. must not be complicated to follow and or require lengthy documentation. | Was the staff satisfied with the degree of complexity? What was the amount of time to complete the form? |

- | | |
|---|--|
| 12. must aid the process of assessment and planning in the delivery of care in an efficient manner. | Was the staff satisfied with the use of the tool in their daily practice? |
| 13. must aid in decreasing cost of health care. | <p>Did the length of stay decrease? Were more clients provided continuing care. Were clients identified earlier for continuing care; especially those requiring a nursing home bed?</p> <p>Did the rate of readmissions within six month decrease?</p> <p>If readmitted was the length of stay lesser than previous admission?</p> <p>Were the community services identified appropriately for the level of continuing care required?</p> <p>Did the tool decrease the length of time required to perform continuing care?</p> |

Response to Evaluation

All questions for evaluation that are answered "yes," signify a positive response for the use of the proposed tool. It must be mentioned that in order to acquire quantitative comparisons, the method of evaluation should include pre-evaluation to determine differences with and without the tool. Persons involved in the education of tool need to also be committed to its support and be competent in creating environments for problem identification, solution and change. Lastly, if administrators are not concurring to the elements within the evaluation tool, disruptive forces may discontinue the project in order to conceal inefficient departments, practices and personnel. Input, approval, and involvement of all staff in the evaluation is necessary if change is to be constructive and supportive.

POSSIBLE CONSEQUENCES AFTER USE OF THE PROPOSED
TOOL IN 3-5 YEARS

Evaluation and use of the proposed tool can increase efficiency and productivity. The consequences of evaluation can be a reorganization of professional staff roles and the extent of involvement in the patient care process. There is an element of risk in evaluation. Health care administrators may view the evaluation outcomes as a means to specify type of professional staff to provide continuing care services and how and what services will be provided.

The tool could increase the size of population requiring home care services and nursing home placement. It may increase the outpatient cost of health care to a level that will also increase overall health care cost. Possibly in the end we may have more appropriate and timely use of community resources replacing inappropriate e.g., hospital care, but if there is an increase in requests for the community services, we may have only accomplished redistributing costs. A positive outcome would be a sense of greater satisfaction of receiving care in one's own home and decreasing the rate of infection or other related institutional complications that increase health care costs. The proposed tool can be hopefully used at all levels of continuing care, duplicate as a discharge summary and partial requirement of a transfer of information form. It may also increase the quality of discharge care. In an era of cost containment, health care providers will seek out ways to preserve a sense of professional

integrity in providing a quality service to their clients. The health care industry may need to tighten up their belt but ways to preserve professional integrity and quality of care are essential to preserving "professional" services. The proposed tool for identifying client and significant other's characteristics for determining the type of continuing care services may be a step toward doing so in a cost effective and efficient manner.

BIBLIOGRAPHY

1. American Hospital Association, Patient's Bill of Rights, 840 N. Lake Shore, Chicago, Ill., 60611.
2. Bay, K., Leatt, P., Stenson, S., A Patient Classification System for Long Term Care, Medical Care, May 1982, Vol. XX No. 5, p. 468-488.
3. Barney, J., The Prerogative of Choice in Long Term Care, The Gerontologist, 1977, 17, No. 4, pp. 309-34, as described by Joy Greenbery, A Multivariate Analysis of the Predictors of Long-Term Care Placement, Home Health Care Service Quarterly, Vol. 1 (1) No. 1, Spring 1979, Haworth Press Inc.
4. Brody, Elaine, ACSW, Follow Up Study of Applicants and Non-Applicants to Voluntary Homes, The Gerontologist, 1969, 9, No. 3, p. 187-196.
5. Brody, S. J. Poulshach, S. W., and Masciocchi, C. F., The Family Caring Unit: A Major Consideration in Long-Term Support System, The Gerontologist, Vol. 18, p. 556-560, 1978.
6. Dake, Nellie, R. N., Nursing Responsibilities for Discharge Planning in a Community Hospital, Quality Review Bulletin, Oct. 1981, p. 26-31.
7. Gikow, Francine, How to Determine Appropriate Community Services for the Elderly, Nursing and Health Care, June 1981, p. 332-326.
8. Greenberg, Jay, Ginn, Anna, A Multivariate Analysis of the Predictors of Long-Term Care Placement, Home Health Care Services Quarterly, Vol. 1. (1); No. 1. Spring 1979, Haworth Press, Inc., p. 75-99.
9. Havens, Harry, S., Program Evolution and Program Management Public Management Forum, July/August, 1981, p. 480-485.
10. Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals, 1984, Chicago, Illinois, p. 1-229.
11. Katz, Sidney, M.D., Ford Amassa, Makoivitz, Roland, M.D., Jackson, Beverly, B.S., Jaffe, Marjorie, Cleveland, M. A., Studies of Illness in the Aged, Journal of American Medical Assoc., 21, 1963, p. 914-919.

12. Katz, S., Chin, A. B., Cordrey, L. J., Ford, A. B., Grotz, R. C., Newberry, W. B., Orfirer, A. P., Kelly, A., Mason, R. E., Ryder, M. B., Bittman, M., Contey, C. C., Hayward, M., Hofferbirth, A. O., Mealing, M. L., Robins, L. M., Sherback, M. A., Frew, M., Priebe, J. H., Takacs, S. J., Warrall, R. J. Multidisciplinary Study of Illness in Aged Persons: Methods and Results. Journal of Chronic Diseases, 1958, 7, p. 332-345. As cited by Peter Townsend, Measuring Incapacity on Self-Care, Process of Aging, Vol. II, Atherton Press, Prentice Hall, Inc., 1963, p. 270-288.
13. McKeehan, Kathleen, R. N., M.S., Nursing Diagnosis in a Discharge Planning Program, Nursing Clinics of North America, Vol. 14, No. 3, Sept. 1979, p. 517-524.
14. Palmore, Erdman, Ph.D., Total Change of Institutionalization Among the Aged, The Gerontologist, Vol. 16, No. 6, 1976, p. 504-507.
15. Rossi, Peter, Freeman, Howard, Wright, Sonia, Evaluation: A Systematic Approach, Sage Pub. Inc., Beverly Hills, 1979.
16. Saul, S. R., A Study of Family Factors Relating to Application to a Home for the Aged, Doctorial Dissertation Abstracts, 1968, 28, No. 7, 237A., UN Microfilms No. 69-00674 as cited by Jay Greenberg and Anna Ginn, A Multivariate Analysis of the Predictors of Long-Term Care Placement, Home Health Care Service Quarterly, Vol. 1, (1) No. 1, Spring 1979, Haworth Press, P. 75-99.
17. Sherwood, Slyvia, Ph.D., Morris, John, Ph.D., Barnhart, Esther, BA, Developing a System for Assigning Individuals into an Appropriate Residential Setting, Journal of Gerontology, Vol. 30, No. 3, 1975, p. 331-342.
18. Steffl, Bernita, Comprehensive Assessment: The Heart of Discharge Planning a Nursing Perspective. Discharge Planning Update, Winter 1981, p. 3-5.
19. Stein Gerontological Institute at Douglas Gardens, Statewide Hospital Discharge Study: An Assessment of Factors Impacting upon the Discharge Placement of Elderly Persons in the State of Florida, Miami Jewish Home and Hospital for the Aged, 1981.
20. Townsend, Peter, Measuring Incapacity for Self Care, Process of Aging, Vol. II, Atherton Press, 1962, p. 270-288.
21. U. S. Census Inmates in Institutions U.S. Govt. Pub. Office, Washington, 1970 and 1970, as cited by Erdmore Palmore, Total Change of Institutionalization Among the Ages, The Gerontologist, Vol. 16, No. 6, 1976, p. 504-507.

22. U. S. Department of HEW, P.H.S., National Institute of Health, and HEW Pub. No. (NIH) 78-1444, For Future Selves a Research Plan Toward Understanding Aging (Report of the Panel on Behavioral and Social Sciences Research, National Advisory Council on Aging).
23. U. S. Government Printing Office Federal Register, Tax Equity and Responsibility Act, Sept. 30, 1982.

RESUME

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EDUCATION

University of Michigan
Graduate of Winter, 1983
Rackam School of Public Administration in Health Care
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University of Detroit
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Nazareth College and St. Joseph School of Nursing, 1960

PROFESSIONAL EXPERIENCE

- 1979-present Liaison for Discharge Planning
McLaren General Hospital, Flint, Michigan
- 1978-1979 Audit & Program Development
Genesee Medical Corp. & Professional Review Org., Flint, MI
- 1976-1978 Operations Manager
Genesee Medical Corporation & Professional Review
Organization, Flint, Michigan
- 1975-1976 Review Coordinator
Genesee Medical Corporation & Professional Review
Organization, Flint, Michigan
- 1973-1975 Director of Nurses
Clara Barton Terrace for Skilled Nursing Care, Flint, MI
- 1973-1975 Instructor in Pre-Nursing
C. S. Mott Community College, Flint, Michigan
- 1970-1973 Instructor for National Association for Practical Nurses
Pharmacology, Flint, Michigan
- 1963-1970 Staff Nurse
St. Joseph Hospital, Flint, Michigan
- 1960-1963 Head Nurse
Oakdale Center, Lapeer, Michigan

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PROFESSIONAL MEMBERSHIPS

Michigan League for Nursing
Michigan League for Nursing, Council for Continuity of
Patient Care
Michigan Gerontology Society
American Society for Public Administration
Continuing Care Council of Genesee, Lapeer, Shiawassee,
and Tuscola Co., President 3 years
Michigan Association for Continuity of Care & Program
Committee, Communications Chairman
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COMMUNITY SERVICES AND OTHER RELATED PROFESSIONAL ACTIVITIES

- 1983 President of Council for Continuing Care of G.L.S.T. Co.
Member of the Michigan League for Nursing
Member of the MLN Committee for Council for Continuity
of Patient Care
Member of Michigan Chapter for Continuing Care Committee
for Education and Programs
Member of Valley Area on Aging Health Advisory Committee
for Long Term Care
Member of Valley Area on Aging Health Planning and Review
Committee
Member of Greater Hospital Oncology Program
Advisory Committee Member to Mott Community College
Program for Gerontology
- 1982 President of Council for Continuing Care of G.L.S.T. Co.
Member of the Michigan League for Nursing
Member of the MLN Committee for Council for Continuity
of Patient Care
Member of Michigan Chapter for Continuing Care Committee
for Education and Programs
Member of Valley Area on Aging Health Advisory Committee
for Long Term Care
Member of Greater Hospital Oncology Program
- 1981 Chairman of Discharge Planning Council, reelected
Member of Community Hospital Oncology Program Advisory
Board
Member of Valley Area on Aging Health Advisory Board
Speaker at Mott Community College Seminar on Gerontology
and Related Service
Provided classes in Gerontology, Team Building, Creative
Problem Solving, Change Agent, Feedback Communication,
Community Resources and Making Referrals
- 1980 Chairman of Discharge Planning Council of G.L.S.T. (Now
known as Continuing Care Council
Instructor for High School Student Development
(L.I.F.T. Program)

Carol A. Hunt

Community Services and Other Related Professional Activities (Con't)

Prior to 1980 Mott Children's Health Center Advisory Board Member
Genesee Co. Area Skill Center Advisory Board Member
Grand Blanc Board of Education Advisory Member
Grand Blanc, Jr. High School Secretary of Parent, Teacher,
Student Organization
Instructor of Elementary, Jr. High School, High School
Religious Education, 9 years
Director of Elementary School Religious Education, 3 years
Speaker for various organization on Reality Orientation,
Professional Review Organization
Instructor and Parental Development, Chairman for Religious
Education
Instructor of Geriatrics and Gerontology
Speaker at Public Schools on Health Related Topics
Instrumental in the development of M.L.N. Council for
Continuity of Patient Care
Instrumental in the development and planning of Michigan
Association for Continuity of Care
Instrumental in the development of Continuing Care Council
of G.L.S.T.