AINO JOURNAL, Vol. 1, 2002, pp. 49－51

Report

Considering elder community-based healthcare in Los Angeles

Eric ASABA *Hospital of the Asaba Medical Research Foundation, Kohnan Hospital*
OTR/L, Occupational Science Program University of Southern California

This report is based on my clinical experiences as a consulting occupational therapist in Los Angeles. During the past year I have worked for the University of Southern California (USC) Occupational Therapy Faculty Practice. During the majority of this time I have rendered services to an Adult Day Healthcare Center (ADHC) in a predominantly Korean-American community of Los Angeles. In this short report I want to provide a brief overview of occupational therapy within the context of a California ADHC setting, and in doing so also briefly revealing some of the historical ideas and features surrounding the ADHC entity.

I believe that it is important to briefly consider why services for the elder population have grown so rapidly in the United States. It is not only because people are living longer and reproducing less. It is also because of a change in social values. Achenbaum (1983) discusses how the concept of family values has changed over the past century in America. The *individual versus family* value in particular, has clearly changed over recent years and certainly since the Great Depression era (1930's). It is astounding to think that only 60 years ago, less than two percent of people over the age of fourteen were divorced in the United States (Achenbaum, 1983). Moreover the overwhelmingly prevailing characteristic of the American family at the time consisted of a working husband and a stay-home wife with anywhere from zero to ten or more children, although it was uncommon to have no children. Needless to say, today the American family has become much more diverse and can no longer be defined by man, woman, and children. The Great Depression era resulted in a rapid decrease in birth rates. The notion of the extended family had already shifted to a more nuclear family. Where elders then were accustomed to have several offspring it is now more common to have two ; and where elders used to be cared for by their offspring, they can no longer expect that today. Younger generations feel much less obligated to care for their elders, as evidenced by increasing geographic and social mobility coupled with elder interest groups and the constant commercializing of care for the elder. It is partly because of this type of shift in social values, that the need for organizations catering to the elder has emerged.

Broadly, ADHC services are part of an expansive spectrum of services included under the umbrella of long-term care (LTC). The concept of ADHC, as it is understood in America, originated out of a government-based incentive to seek an alternative to expensive nursing home care. In 1983, the United States (U. S.) congress passed legislation authorizing the Department of Veterans Affairs to pilot test the idea of ADHC programs to ascertain the effectiveness and cost-benefit of providing such services (Kane & Kane, 1987). The purpose of attending an ADHC is to have access to a community of peers where there are planned group activities as well as social stimulation. Moreover, nurses, occupational therapists, physical therapists, speech therapists, dieticians, psychologists, and social workers are typically on staff to provide individual assessment, treatment, and consultation. Program assistants are available to aide with carrying out treatment plans or assisting with meals. As part of the program, clients generally receive lunch, transportation to and from the center, support groups, and community related education programming.

In California, ADHC services are privately paid

for by the individual or paid for by Medi-Cal if the person is a Medi-Cal beneficiary. Medi-Cal is the acronym used to refer to Medicaid of California, which is a federally funded program of health and social service benefits. However the management of these federal funds is administered on a state level (Torres-Gil, 1992). Medi-Cal is overseen by the Center for Medicaid and Medicare Services (formerly HCFA). Information about this service can be explored in depth at http : //www.hcfa.gov. Medi-Cal beneficiaries need to be pre-approved by the Medi-Cal field office in their area. The fee for ADHC services is usually a set daily rate. At the ADHC where I work, most clients attend 3 days per week, which is in keeping with the national trend. The number of days is decided based on the severity of the person's diagnoses and the individual person's level of function, thus it is possible for some clients to attend 2 days per week while others attend 5 days per week. Participants spend anywhere from 4 to 8 hours each day at the center. Information about ADHC services in California can be found at the California State Website (http : //www.aging.state.ca.us/html/programs/adhc.htm).

I will illustrate what an ADHC is like by describing the setting where I render my services. The center where I work is conveniently located in a central part of the Los Angeles Koreatown area, which is accessible by public transportation. Since many of the clients are unable to drive, being accessible to public transportation is a key asset for an ADHC. The center is located on the first floor of a modern gray cement building that is home to several medical offices. The inside of the ADHC space is divided into a general area, kitchen area, clinic area, and an administrative area. The general area is where the clients remain during the majority of the day and is used for games, karaoke, large group exercise, dancing, various arts and crafts activities, as well as meals. The clinic area is divided into a small treatment room and a gym. The small treatment room is used by the consulting physician, nurses, and therapists and is where physical examinations as well as clinical assessments are conducted. The gym area is mostly utilized under the supervision of the occupational and/or physical therapist. The gym is equipped with mirrors, upper extremity pulley's, cuff weights, various games, parallel bars, practice stairs, a treadmill, and leg bikes. The kitchen area is mostly used to organize the daily lunch boxes and afternoon snacks. The administrative offices and staff area is where charts and most of the office supplies are kept. Every office is equipped with an internet-ready computer terminal for staff use. Although staff is present between 8 am to 5 pm five days per week, clients can only attend between 8 : 30 in the morning to about 2 : 30 in the afternoon at the center where I work.

As an occupational therapist at the center I am responsible for evaluations, semi-annual and quarterly re-assessments, as well as individual and group treatments. I am also responsible for program planning and implementation. For instance, there are a fair number of clients whose lives have been disrupted by arthritis. These limitations range from pain and limitations in range of motion to a lack of knowledge about proper body mechanics and energy conservation techniques. As part of occupational therapy, clients receive a series of interventions including range of motion exercises and fine motor activities, as well as education about proper body mechanics and energy conservation. This new knowledge is then applied and integrated through occupation. For example, one group of clients wanted to incorporate their newly acquired techniques in the occupation of gardening. Hence the intent of occupational treatment is to go beyond biomechanical exercises or passive client education, and instead incorporate exercise and education in a program that addresses function in a personally meaningful way and also in a manner that is closely linked to a natural context.

In summary, in the face of changing social values the ADHC setting is a community-based healthcare setting where chronic conditions and illnesses can be monitored by professional staff while still allowing for the individual to live at home. Moreover, unlike an outpatient clinic, the ADHC setting allows for social peer support and serves as a gateway to community activities. Although many elder men and women spend more days with disabling conditions than their younger counterparts, it is understandable that they prefer to live in their *familiar* home environment rather than

move to an *unfamiliar* nursing home setting (Moody, 2000). The ADHC setting is one attempt at making this possible. Since occupational therapists are concerned with helping people live their lives healthfully, meaningfully, and as independently as possible, the ideology behind the ADHC establishment and the philosophy of occupational therapy are well matched.

References

Achenbaum, A. : Shades of gray : Old age, American values, and federal policies since 1920. Little, Brown & Co : Boston,1983

Kane, R. A., Kane, R. L. : Long term care : Principles, programs and policies. Springer Publishing Co : New York, 1987

Moody, H. R. : Aging : Concepts and controversies (3rdEd). Pine Forge Press : Thousand Oaks, CA., 2000

Torres-Gil, F. M. : The new aging : Politics and change in America. Auburn House : Westport, CT., 1992