THE FUTURE

A person-specific standardized assessment instrument

The next century will demand that long-term institutional care be better integrated into the health care system as a whole. More co-ordination of care among community and institutional resources will be required to facilitate effective and innovative programmes for respite care, night and weekend admissions for a limited period of time, crisis intervention, short-term rehabilitation and special care units for individuals with, for example, Alzheimer's disease and AIDS. The striking country-to-country variation in the way long-term care institutions are utilized, as demonstrated by Frijters et al. [1], will likely be minimized. As noted, some countries have already established assessment teams to evaluate an individual's need for admission to a long-term care facility. Although cultural differences may persist to a degree, as is true of so much that has followed the introduction of worldwide information services in almost all human endeavours, similarities among people and their needs will likely begin to overshadow differences. A nation will continue to utilize its resources according to its own traditions but each will have the capability of scrutinizing their use in a way never before possible.

Although each of the papers published in this volume might stand alone, when they are laid back to back a much greater appreciation of the Resident Assessment Instrument (RAI) methodology and what it can do for all who are ageing and for the countries in which they reside, is made possible. First, as all developed countries struggle to provide care over the long term to the ever enlarging older population, each nation will truly be able to benefit from the experiences of others. The use of a standardized cross-national assessment tool will permit comparable information bits to be transported across borders and utilized, both to develop a constructive cost-efficient health care policy locally and to improve quality of care in, and outside of, institutions far distant from the sites where the data were collected [2]. Outcomes of care will be able to be compared and may be expected to be similar throughout the developed world with markers of quality stable across nations, as presented by Schroll et al. in this supplement [3].

Second, person-specific studies will likely gain in importance over site-specific analyses. The resident assessment instrument as presently used in nursing homes in the USA and in many European nations opens the way for an individually focused approach, for not only does it address the physical and psychiatric status of each person but it contains domains directed to the personal interests, routines and social milieu of those evaluated. By adapting it for both home care and acute hospital care use (presently in progress) with much overlap of questions it becomes increasingly a 'transportable' person-specific instrument. Information will be obtained which will allow for a recognition of individual needs regardless of the location in which the data were collected. This will almost certainly assure both better individual care and more targeted utilization of health care resources.

In Japan, for example, at present few older people reside in purpose-built long-term care institutions and beds originally intended for acute care are being used for elderly individuals for extended periods of time [4]. With the parent support ratio (the number of people 80 years of age and over per 100 people 50–64 years of age) more than tripling from 13 to 45 in just 35 years in Japan, data provided by a transportable comprehensive assessment tool will make it possible to discover where resources might be better utilized so as to care for this rapidly enlarging group of frail elderly people [5]. Such a policy direction is clearly essential as well for those family members who must pay the costs of that care.

Third, the further development of the RAI instrument specifically for use in the home setting will permit comparisons of care plans and patient outcomes for those in need of continuing care—be that a few days or years. By more clearly delineating an individual's needs, home care services can be more effectively applied, perhaps allowing more people to remain at home. Home care services in many countries are often inadequate in scope and poorly configured to meet the needs of those they are designed to serve. They may be designed to respond to reimbursement policies rather than patient needs. In most developed nations home health care services and home-based social support services remain quite separate and distinct entities [6]. At present, there are striking differences in the way these services are provided. In the case of social services, in many European countries the client has the power to order them, assuming that they can afford them, while health care services must be prescribed by a physician. The interdigitization of services so as to be both effective and efficient is too often sorely lacking. A comprehensive screening instrument is essential to progress in this regard.

Fourth, the development of a comprehensive assessment tool with variation according to the acuity of the
situation yet with considerable similarities across sites will assure that health care professionals, especially physicians, begin to give primacy to function and outcome as well as diagnosis and treatment. For elders especially, this mind-set must be adopted by those organizing care plans. It will likely become more 'physician-friendly' and thus become supplemental to the traditional medical process of obtaining data about patients. For example, the concept of activities of daily living is rarely, if ever, mentioned during the period of training of physicians in many countries, and the principles of rehabilitation are seldom highlighted [7–9]. In the USA, 45% of medical schools do not devote a single hour to home care in the course of a 4-year curriculum [10]—yet American physicians are required by law to prescribe and oversee the care of elders receiving care in the home under Medicare, the federal insurance system for those over the age of 65, as well as to manage the care of those who reside in long-term care institutions [11, 12]. Even in the Netherlands a 3-week course on care for elderly people for third-year medical students at the Vrije Universiteit in Amsterdam is an exception to usual practices. Furthermore, as hospital length of stay declines, the use of a RAI-like instrument for the acute setting, traditionally the domain of physicians, will likely improve both in-hospital care and discharge planning.

Fifth, as innovative residential arrangements—such as residential homes, specialized and assisted living arrangements, group dwellings, congregate housing (multi-level geriatric residential facilities) and home adaptation programmes—replace the rigid system of long-term institutional care presently in place in many developed countries the adaptation of the RAI instrument to each setting will be seen to be especially meritorious [13–15]. Even today, long-term care is no longer static in configuration but is evolving to meet newly appreciated needs as surely as intensive care units in acute care facilities. Reliable and valid interventional assessment tools for use in multiple settings will allow us to assess outcomes of interventions across a seamless health care system [16, 17].

Sixth, the further development of the RAI instrument may highlight preventive health measures long overlooked. For example, the administration of influenza vaccine may become more common place as failure to provide it in one setting will be recognized in the next.

Last, adaptation of the RAI instrument to end-of-life and hospice care will likely draw attention to the needs of all people, not just those who might be 'cured'. Most people accumulate diseases over a lifespan and emphasizing the potential cure of one illness in a person, no matter how laudable that may be, may fail to focus sufficient attention on that individual's level of pain and functioning resulting from other diseases superimposed on the changes associated with the ageing process. A recent study in the USA which has received considerable notoriety has revealed physicians to be strikingly inadequately prepared to manage people who are dying, with the result that many individuals suffer from unnecessary periods of pain before death and receive invasive and 'high tech' care which is both inappropriate and costly [18]. Continuing development of the tools based on the RAI will allow caregivers to determine the need for further evaluative procedures and interventions for significant pain and those problems, such as family stress when a family member is dying, long overlooked by many in the health care professions.

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References


