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Betty Knapp

COST-EFFECTIVENESS OF ACTIVITIES IN EXTENDED-CARE FACILITIES

Nancy Marie Knapp, B.A.

An Abstract for a Thesis Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Human Service Agency Management
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ABSTRACT

The purpose of this project is to evaluate the cost-effectiveness of activities in extended-care facilities. The life expectancy of older adults and housing options is presented in the introduction to this project. A literature review highlights the need for activities to maintain and restore the health of older adults in extended-care facilties. The literature shows that activities help to meet the physical, emotional, and spiritual needs of older adults. Meeting these needs leads to life satisfaction for the residents in extended-care facilities. The importance of evaluation in determining the cost-effectiveness of activities in extended-care facilities is also presented in the literature review.

In order to determine the cost-effectiveness of activities in extended-care facilities, the Activity Directors and Administrators of fifty St. Louis area facilities were sent surveys. Only eleven surveys were returned, and this provided a very small sample to study. Even though it was difficult to evaluate the information for cost-effectiveness, activities were shown to be beneficial. Activities helped residents to maintain their mobility. Activities also provided a means for socialization and personal attention. It continues to be important to find ways to determine the cost-effectiveness of activities in extended-care facilities.

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CHAPTER 1

INTRODUCTION

The purpose of this paper is to evaluate the cost-effectiveness of activities in extended-care facilities. Before reviewing the literature, it is necessary to identify the aging population, in the United States of America. The long term care housing choices, of the elderly, with emphasis on extended-care, will also be discussed.

The percentage of the American population over the age of 65 has increased over the years. In 1988 a man in the United States could expect to live to an average age of 72 and a woman could expect to live to an average age of 78 (Linkletter 254). By 1992, a 65 year old male could expect to live to be 80, and a female to 84 (O'Reilly 109). By the year 2020, 20 to 25 percent of the American population, or more than 50 million people, will be over the age of 65 (Butler xii; Nelson 64).

Carol Bernstein Lewis states, "Although the vast majority of the elderly in this country live in homes or apartments, approximately 5 percent of people over the age of sixty-five live in nursing homes or other long-term care institutions" (352-3). According to Robert C. Atchley, author of Social Forces and Aging, ". . .the percentage of older people living in long-term care facilities and homes for the aged increases with age, from 2 percent at age 65 to 74, to 8 percent at 75 to 84, to 25 percent at 85 or older" (42-3). Joseph Matthews reports, "More than half of all women over 65 and about a third of all men will enter a nursing facility at some point in

their lives; half of these will stay more than six months and about 20% stay more than three years" (10/3). Edward F. Ansello reports, "The average resident of a nursing home in the United States is a female, age 83, who has been in the facility for ten years" (94).

Atchley quotes Kenneth G. Manton and Beth J. Soldo who "projected that the the older population living in long-term care facilities would increase from 1.2 million in 1985 to 2.2 million by the year 2000, mainly due to the aging of the older population" (43). Robert N. Butler, Myrna Lewis, and Trey Sunderland report similar statistics: "The nursing home population, 1.6 million in 1989, is expected to continue to grow rapidly - to 2 million by the year 2000 - and more than double (to 4.6 million) by 2040" (359).

Older adults represent a wide spectrum of opinions, ideas, income levels, health needs, and lifestyles. Such a divergent population requires varied housing options (Gold 2). Jo Horne and Leo Baldwin, authors of Home-sharing and Other Lifestyle Options, say, "The idea that a person's home is his or her castle does not go away simply because a person retires or ages" (1). The elderly have many decisions to make about their housing (Horne and Baldwin 3). In the past, housing for the elderly was limited. Living alone, moving in with family, or entering a nursing home were the only alternatives available (Walser 11). When the elderly need to move from their homes, they now have other options besides moving into a nursing home (Retirees 3). According to Janet Lilley and Letitia Jackson, ". . . alternatives to institutionalization such as home health

care, adult day care settings, group homes, etc., . . . is certainly a legitimate and worthwhile goal" (6).

Congregate living is a popular option to replace nursing home care. This type is best for residents who need minimal personal assistance. In this style of housing, residents have their own apartment and take one meal a day in the main dining room ("Exploring The Options" 27). The retirement community is no longer merely a "spiffed-up" nursing home, and such a community can fulfill many of the needs of the elderly. Some of the needs met include basic health care, meals, and social activities (Retirees 3). Margaret Gold states, "One of the strongest advantages offered by group housing is the opportunity for companionship, recreation, and social interchange" (69). According to Gold, community housing has a variety of shared areas such as dining, laundry, and activity rooms which provide an opportunity for social interaction. Trips and recreational activities are offered by the staff or are planned by a small group of residents (70).

A continuing-care retirement community (CCRC) is a special type of congregate living which provides three levels of care. The three levels of care are: "independent living, assisted living, and skilled nursing care on the premises or transferred to an affiliated nursing home" ("How To - Information On Assisted Living" 67). These facilities charge a large fee up front, followed by ongoing monthly fees. In exchange, the resident will be given lifelong care - no matter what level of care is needed (Linkletter 78).

Assisted living is one of the fastest growing alternatives to nursing home care. The Assisted Living Facilities Association of America (ALFAA) estimated that there are now 30 to 40 thousand residences in existence, housing over a million people. Personal services provided include bathing, dressing, and getting in and out of bed. Residents are encouraged to remain independent and exercise as much control over their lives as possible ("Exploring The Options" 27).

Sometimes the elderly need to move into a nursing home facility. R. Baker Bausell, Ph.D., Michael Rooney, M.P.A., and Charles B. Inlander define a nursing home as ". . . a home for people who have difficulty caring for themselves where rehabilitation on all levels is undertaken (2). Three basic types of services are provided by a nursing home: "1. Nursing / Medical care - for example, medical and rehabilitation procedures 2. Personal care - for example, assistance with daily living tasks. 3. Residential services - for example, providing room and board and activities" (Bausell, Rooney, and Inlander 2).

Nursing homes are classified by the basic levels of care given in nursing homes: "skilled-nursing facilities (SCFs); intermediate-care facilities (ICFs); or residential-care facilities (RCFs)" (Goldsmith 2). It is sometimes confusing when determining the difference between skilled nursing and intermediate nursing. The difference is in the amount of medical attention needed. In SCFs care is delivered by registered and licensed practical nurses on the

order of the attending physician. The ICFs provide less intensive care than the skilled facility (Bausell, Rooney, and Inlander 2; Goldsmith 2). "RCFs . . . provide or arrange to provide in addition to the minimum basic care and services required . . . a supervised supportive and protective living environment and support services for elderly ambulatory residents . . ." (Goldsmith 4). For the purpose of this paper, extended-care refers to nursing homes that offer skilled or intermediate care.

Nursing homes fall into three classes: proprietary or commercial nursing homes, voluntary nonprofit nursing homes (frequently called homes for the aging), and government facilities (Butler, Lewis, and Sunderland 369). The majority of the nursing homes in the United States, approximately 15,000, are privately owned and operated as for-profit businesses" (Goldsmith 5). Government run facilities account for about 1,000 of the nursing homes, while an estimated 4,000 nursing homes are operated as not for profit (Butler, Lewis, and Sunderland 368; Goldsmith 5-6).

Nursing homes have a responsibility to the residents. Nursing homes first provide for the basic physical needs of the residents. Once these needs are met, "It becomes the responsibility of the Activity Department to satisfy the remaining psychological, emotional, and social needs with a meaningful delivery of Therapeutic Recreation services" (Greenblatt 11-12).

Nursing home care can be very expensive for the resident. Medicare and Medicaid are two programs that the government has

set up to help with these expenses. Medicare will only pay for skilled-nursing care which is: (1) ordered by a physician; (2) so complex that the services must be provided by a health professional; (3) be required on a daily basis; and (4) be furnished for a condition that arose as a result of a recent hospitalization (Goldsmith 2). Medicaid, funded by the federal government and administered by the states, pays for the medical care of the financially needy people. Medicaid will cover the cost of home care and almost all levels of nursing home care (Matthews 6/2).

Activities are an important part of the services provided in an extended-care facility. The literature review that follows will emphasize the importance of these activity programs. Since a wide variety of activities are used in the extended-care facilities, the rationale for some of the activities will be discussed. The literature will show that activity programs do become cost-effective in extended-care facilities. The rationale for a wide variety of activities used in extended-care facilities will also be discussed.

CHAPTER 2

LITERATURE REVIEW

Justification for Activities

To evaluate the cost-effectiveness of an activity program, it is important to understand that the activity program offers a unique vehicle for meeting the basic needs of nursing home residents, such as the need for independence and control (Lilley and Jackson 6). According to Joan M. Moran, author of Leisure Activities for the Mature Adult, "Chronic or crippling disabilities are common in nursing-home patients" (55). Handicapped elderly which are either in their own beds, a hospital, or nursing home need activity to help prevent them from always dreaming about the past and retreating into their own little worlds (Lucas, Recreation In Gerontology 77). According to Carol Lucas, "The healthy can go to recreation; the infirm and handicapped must have recreation brought to them. Because of this, it is the responsibility of the institution to provide an all-embracing recreation program for its less healthy residents" (Recreation In Gerontology 77).

An activity program should meet the physical and mental needs of the residents. Gold states, "A well-run recreational and social program can add significantly to the quality of an elderly person's life" (131). Older persons who become active after being inactive can once again enjoy doing things for themselves and leading a more productive life (Lucas, Recreation in Gerontology 6-7). Joan C. Rogers suggests that the goal of the activity program is to

"restore, maintain, or enhance" the health of the residents and "remove, alleviate, or prevent" unhealthy conditions among them (2).

The American Health Care Association states, ". . . the overall needs of the resident should be considered" (Lilley and Jackson 9). These needs include physical, emotional and spiritual needs. Nursing homes and hospitals are providing activities that help the residents be able to do more things for themselves and provide emotional support (Merrill 20). Extended-care facilities offer a variety of activities to meet the varying needs of the residents.

A good activity program is ". . . anything and everything which offers participation and self-activation to a group of elderly people and the staff around them" (Fish 19). "Programming is more than bringing together a potential participant and an arranged activity at an appropriate time and place. It is, rather the sum total of procedures employed . . ." (Shivers and Fait 117). An activity program should motivate older adults to use whatever time, energy, and attention they are able to apply, for their own pleasure and benefit (Fish 19).

Older adults in extended-care facilities present special problems "because of their emotional status as well as their being physically ill" (Merrill 12). Since care of older adults is expensive and time consuming, "good leadership in an activity aide can result in better care for residents at a financial saving for them and for the administrator of the home and hospital" (Merrill 12). Current

literature indicates that varied activities can be beneficial and cost-effective in treating residents in extended-care facilities.

Ansello has researched the factors that lead to life satisfaction for the institutionalized elderly and retirees (88). Both groups share the top four factors contributing to life satisfaction which were: 1) the presence or absence of an intimate interpersonal relationship, 2) social interpersonal relationships, 3) activities, and 4) money (88). Health was not one of the top four factors that contributed to life satisfaction. Ansello states, "A growing body of research suggests strongly that self-perceived health may be a more important factor than clinically measured health as a predictor of how long and how well a person will live" (88).

When a resident comes to a nursing home, more often than not, the first two factors of life satisfaction are taken away. This makes factor three, activities, all the more important to life satisfaction (Ansello 95). Ansello suggests that a rich social environment could improve the health status and cognitive skills of residents. This rich social environment could also help develop positive self-esteem for the residents (95). Dr. William Menninger stated, "People who stay young despite their years, do so because of an active interest that provides satisfaction through participation" (qtd. in Lucas Recreational Gerontology 5).

A nursing home can have certain social advantages over other types of living arrangements (Gold 131). Some activities help institutionalized older adults to maintain a social life which can be

beneficial to their well being. In Penn State Studies on Recreation and the Aging a summary of research on the effect of group experiences by Zena Bella Malek states:

> The data collected showed significant improvement in such emotional and self-evaluative changes as pleasant effect, self-esteem, and increased ability to form strong affectional relationships. Malek concluded that a lack of physical activity has implications for leading to a vegetative state in the elderly. (Lundegren 91)

Elmer Cordroy has studied the importance of recreation as a means of promoting social activity in senior citizens. Cordroy concludes that the recreation professional must help the senior citizen to realize that "an organism which is kept in continual use is more likely to remain in a healthy state than one which is at rest too much of the time" (qtd. in Lundegren: 92).

Socializing can help residents to maintain good mental health. An activity program can help combat depression which occurs in residents who do not have enough stimulation. When older adults become depressed, they often have physical symptoms which include backaches, stomach aches, headaches, or even insomnia ("Fighting Depression in Senior Citizens" 3). According to Joan C. Rogers, psychological problems such as "dependency, disorientation, decreased motivation, and confusion" are caused in part by inactivity. Activity can help prevent or reverse the effects of these problems (2).

Older adults often experience anxiety when the status quo is altered. "Survey data indicate that symptoms of anxiety are more prevalent in the elderly population than in any other age group, occurring at more than twice the rate in the aged as in young adults" (Sallis and Lichstein 197). Anxiety leads to other serious illnesses such as cardiovascular disease. "The use of tranquilizing drugs, especially benzodiazephines . . ., is the most common treatment for anxiety symptoms" (Sallis and Lichstein 201). James F. Sallis and Kenneth L. Lichstein point to structured activity programs as a viable alternative to prescription drugs which are extremely costly and have strong side effects. Thus these programs become cost-effective (204). "Structured activities benefit the elderly in a three-fold manner i.e., by decreasing the physical symptoms of anxiety, decreasing vigilance by distraction, and most importantly, by improving the ability of the organism to tolerate and adapt to stress" (Sallis and Lichstein 204).

Recreation can have psychological benefits for residents of nursing homes. According to Paul Haun, author of Recreation: A Medical Viewpoint,:

> In essence, recreation services help to create in the patient a desirable psychological state by contributing to his self-confidence, his optimism, and his ability to accept the inevitable discomfort of his illness. It combats the fears, the isolation, and the resistance that threaten recovery. It may, particularly in chronic

> illnesses, contribute importantly to motivation. In a physical sense, it promotes the return of function, helps the patient compensate for transient as well as permanent defects, assists in the restoration of normal metabolic processes, acts as an effective physiological tonic, and in general, shortens convalescence. (5)

As health is decreased, it is necessary to make adjustments to the activity program to keep the resident as active as possible. Health and activity are interdependent phenomena (Rogers 2). Moran states, "While not a curative in itself, recreation helps create the milieu for successful patient treatment" (83). According to Moran, recreation can direct a patient's attention away from the illness toward something pleasant. By doing this the patient is more likely to become ambulatory sooner and the healing process is accelerated (83).

Types of Activities Provided

Rogers explains five approaches to therapeutic activity for older adults. In the holistic approach, activity is seen as an end in itself to promote a sense of overall well being. Activity negates the harmful effects of inactivity (2). "The activity specialist's major role is to provide opportunities for action and achievement" (3).

The next approach discussed by Rogers is the impairment approach to therapeutic activity. This approach contrasts sharply with the holistic orientation. Activity is used to remediate or prevent specific impairments through the activities provided (4).

The third therapeutic approach Rogers discusses is the abilities, or assets, therapeutic approach. This approach emphasizes patient assets rather than deficits for activity selection (5).

The fourth therapeutic approach discussed by Rogers is the activity balance approach. "This approach is based on the premise that a healthy daily life is normally filled with things to do" (6). Activities are grouped into four areas: "self-care, productive, leisure, and rest" (6). The resident needs to have a balance of activities relating to each of these areas (6).

The final therapeutic approach explained by Rogers is stress regulation. Activity is therapeutic if stress is kept within manageable limits. Activities must be adapted so that residents can accomplish desired tasks without becoming frustrated (7).

"Health status is a major determinant of the preferred activity approach or approaches" (Rogers 10). The activity professional must be able to assess a resident's abilities and limitations in order to choose the correct approach. "The exercise of choice is particularly important in institutional settings in which opportunities for control are often minimal" (Rogers 10). The residents, whenever possible, should chose the activity they wish to do (Rogers 10). "Inherent in the concept of control is the notion of responsibility. When nursing home residents are given more control, those individuals then have the opportunity to choose to become more responsible for themselves and in so doing help retain their dignity" (Lilley and Jackson 16).

Rogers explains that in all of the therapeutic approaches, it's

the caring attitude of the activity professional that makes the approach successful. When a patient has a good rapport with the practioner, the patient will put forth more effort to accomplish the goal (11). Rogers states it this way, "By 'pausing to care', the activity specialist can win the confidence of the patient and can mobilize and release the human forces that promote the health-activity linkage" (11).

According to Moran, ". . . recreational activities . . . can be therapeutic, recreational, or both. The skilled recreation therapist can incorporate both aspects into the programming (84). Activity programs can have a positive "spill over effect" in the lives of nursing home residents (Lilley and Jackson 9). As Butler says, "Doctors could probably write prescriptions for recreation and enjoyment just as they do for drugs - with fewer side effects" (157).

Relaxation activities can be beneficial for many residents. R. Clayton Shealy states, ". . . relaxation training, because of its time and cost-effectiveness, is often used as a direct or adjunctive treatment for insomnia. When one considers abundant usage of costly prescriptions for insomnia in nursing homes today, the implications of this type of relaxation program for its cost-effective benefits are clear" (17).

Another example of the use of relaxation is as an "independence-promoting intervention" (Viney, Benjamin, and Preston 13). Linda L. Viney, Ph.D., Yvonne Benjamin, M.A., and Carol A. Preston, Ph.D., stress the financial as well as emotional

costs of constraints on independence which is typical of many nursing homes. When they tested the effects of independence promoting intervention in elderly clients, clients reported feeling less dependent on others as well as fewer physical symptoms (4-5).

Mental activities are important to help residents maintain a high level of cognitive ability. People who are actively involved in academic activities lose less brain function than those who sit around and don't challenge their minds (White 43). Kathy Keeton, author of Longevity The Science of Staying Young, states, ". . . our brain can remain vigorous, capable, and creative no matter how old we are. The key apparently is to keep our brain in shape. . . by using it" (170). Residents who are confined to a less stimulating environment such as a hospital or nursing home can show a decrease in mental capacity (White 44). According to Spirduso, exercise improves the cognitive process (209). M. P. Lawton states, "Arts and crafts make older people more aware of what is happening around them and forces them to use their minds and hands" (41).

Butler, Lewis, and Sunderland suggest that reality orientation can be used to help cognitively impaired residents (197). Institutions can have a beneficial impact on the social and psychological functioning of residents by using reality orientation (Teaff 168). "Reality orientation is designed to alleviate the confusion and disorientation of older persons . . ." (Teaff 168). For the severely disoriented resident, straightforward conversation explaining step-by-step explanations of what is happening at the moment is

recommended. For residents who are functioning at a higher level, basic personal and current information "beginning with the patient's name, where he or she is, and the date" is given. When the resident learns these facts, then other information is given such as: "age, home town, and former occupation" (Butler, Lewis, and Sunderland 197). Reality orientation has given nursing home care givers "hope and a defined approach to patients who might otherwise be experienced as unreachable and hopeless" (Butler, Lewis, and Sunderland 197).

Exercise is an important element in an activity program. Exercise ". . . can improve circulation by enriching the blood with oxygen, strengthen the heart and lungs, prevent bone deterioration, restore muscle tone, improve flexibility, and increase range of motion (Leitner and Leitner 140). L. J. Frankel and B. B. Richard suggest that "exercise stimulated digestion, metabolism, respiration, blood circulation, and glands of secretion" (34). Exercise can help residents perform activities of daily living (ADL) by maintaining or improving flexibility and strength (Frankel and Richard 36; Flatten 71).

Joseph D. Teaff, author of Leisure Services With The Elderly, states that studies have shown that older adults can increase their cardiovascular fitness through exercise (Teaff 174). Teaff uses a study reported in the 1972 Journal of Gerontology by B. Stamford to substantiate that exercise programs can improve cardiovascular fitness in institutionalized geriatric patients. The carefully controlled

3-month exercise program that met 5 days per week found significant gains in cardiovascular functioning (174).

Exercise can help increase bone and muscle strength. In Leisure Services With The Elderly, Joseph D. Teaff reports that a study by J. Aloia on exercise and skeletal health concludes that "bone mass may be increased as a result of physical exercise" (174).

Arts and crafts are another important component of an activity program. Art programs give older adults the opportunity to share their life experiences with others (Teaff 193). According to Moran, many opportunities should be provided for residents to participate in a wide variety of activities such as "painting, drawing, photography, sculpture, music, dance, drama, intellectual endeavors, and crafts of all types" (110).

The use of entertainment is important in an activity program. "Entertainment has many values: residents enjoy seeing new faces and making new friends. Programs by local groups can be easily arranged, are inexpensive or cost nothing, and usually mean good public relations" (Merrill 19). "It [music] has been used as a therapy with great success in hospitals because, even for the very sick, just listening can provide a certain amount of participation" (Lucas, Recreational Activity Development 24). In Recreational Services for the Aged, the benefits of music are described:

> The effect that music has upon an individual, as either a performer or spectator, illustrates its unique attraction. Whether music is listened to for the pure sensual

> pleasure of the sound, whether the effect is aesthetic, whether it is the rhythm produced, or whether it is the creativity that is released when an individual plays or sings, the value of empathy and emotional release is apparently generated to the extent that it provides universal magnetism. (Shivers and Fait 115)

Pain is one of the chief complaints of the elderly which keeps them from participating in activities (Adams and McGuire 168). The most widely used treatment for pain is medication. With all the medicine that older adults take complications with drug interactions can occur (Adams and McGuire 159). An alternative to medication is the use of humor. In order to determine the effects of humor on pain, Elizabeth Adams and Francis A. McGuire conducted a study using two groups of residents in a long-term care facility. One group watched humorous movies while the other group watched nonhumorous movies for a six week period. Residents who viewed humorous movies reported that they felt less pain at the end of the program (160-1). Many nurses at long-term care facilities have confirmed that laughter makes people feel better (Adams and McGuire 157).

Dance and movement therapy can be used with residents in extended-care facilities (Sandel 41). Some activities require the use of fine motor skills. Movement therapy is an alternative to art and craft activities for residents who because of impairments cannot participate or become frustrated in activities using fine motor skills

(Sandel 42). The purpose of movement therapy is to promote socialization, but physical benefits also result (Sandel 42). Susan L. Sandel used movement therapy with residents at Soundview Specialized Care Center:

> The movement therapy sessions were helpful for patients by providing a structured opportunity for contact, for the sharing of life experiences and memories, and for the appropriate expression for aggression. In addition to the value of the sessions themselves, the increase in patients' socialization stimulated staff's interest in expanding the program of creative, process-oriented group activities (47).

Lewis states, "A clinician has found that rhythmic movements performed by wheelchair patients stimulate cardiovascular function and induce a pleasant relaxation state" (274).

This literature review in no way has identified all types of activities that are available or needed to satisfy the needs of extended-care residents. The purpose has been to show that a wide variety of activities are used and needed. The literature has shown that the activities have value to the residents. Each activity is done for a specific goal for the resident.

Evaluation of the Cost-Effectiveness of Activities

When evaluating the cost-effectiveness of an activity program, it is important to understand the purpose of the activity program. The purpose of an activity program is to help the residents retain or

maintain the most healthy state possible. Fish states: "Ability to keep investment and operating costs down, while increasing patient participation and general good will, is the real measure of an Activity Program Director's success" (27). Haun presents some guidelines to determine the success of an activity program. These guidelines stated that the number of residents participating and the degree of participation are important factors to note when evaluating an activity program. It was also important to observe whether the patients were increasing their abilities to perform higher level of tasks (102). (For the list of guidelines, see Appendix A.)

Residents and extended-care facilities both profit from a successful activity program. According to Lilley and Jackson:

> (1) less costly medications are needed (e.g., for insomnia, anxiety and depression, perceived pain) as a result of activity intervention; (2) less nursing home care time is needed as residents become more competent and assume more responsibility in ADL's; (3) residents experience fewer attentional problems (i.e., excessive concern over health problems) and more satisfaction with their living situation as a result of activity intervention; and (4) activities can improve the overall physical and mental health of nursing home residents. (17)

It is important to realize that an activity program for institutionalized elderly does require resources such as "staff, areas

and facilities, equipment and supplies, and funds" (Teaff 168). A good activity program can usually pay for its own supplies and materials through sales and donations. However, it will never be able to pay for the the use of the building, equipment, and staff to run it (Fish 28). "Activity programs are not intended to pay off in money. They are expected to generate good will, happiness, self-realization; all of the things which senior citizens badly need and upon which the institution's attractiveness depends" (Fish 28).

The goal of a good activity program is to minimize expenses and maximize results. Fish states that activity directors need to make wise judgments when developing an activity program. She indicated that it was important to establish an approved budget which included how outside contributions would be incorporated into the budget. Also, funds available should be used in a manner that would do the most good for the most residents. Volunteers and donated materials from the community should be utilized (28-29. (See Appendix B for the list of Guidelines for Getting the Most from Budget Dollars.)

The evaluation process is very important in determining the cost-effectiveness of an activity program.. According to Lilley and Jackson, activity directors need to use standardized assessments and evaluation instruments to show that activity programs can be "cost-effective" (17). It is also important to maintain complete and accurate financial records (Lilley and Jackson 17). Fred S. Greenblatt states, "A high quality program through evaluation will also help rationalize our justification of services to the administration

whose necessary scrutiny over budgets is becoming more prevalent than ever before" (70). Carol Ann Peterson and Scout Lee Gunn state, "Administrators want to know why programs are needed, what exact objectives and procedures will be employed, and how program effectiveness will be determined" (140).

Thus, an important step in planning an activity is evaluation (Austin 60). Goals for the resident and the activity program are established and then compared to determine how well the goals were met (Greenblatt 71). The resident's progress is studied for the purpose of making improvements in the type of activities provided (Austin 83). The whole activity program is evaluated to make decisions about the merit and worth of program offerings (Austin 170). The evaluation method should be established at the beginning stage of planning (Greenblatt 72; Peterson and Gunn 143).

Evaluation can be carried out by using scientific or informal methods. Data collected can be categorized as quantitative or qualitative (Greenblatt 80). Quantitative data comes from "the use of measurement tools utilized to collect specific numbers and data for evaluation purposes" (Greenblatt 80). Facts and figures substantiate that "services and activities are effective and efficient in relation to outcomes achieved and service dollars expended" (Peterson and Gunn 139). "The use of observation, description of programs, questionnaires, sociograms, interviews, surveys or lists comprise qualitative data" (Greenblatt 80).

Qualitative data may give a clearer picture of the benefits of

an activity program. Merrill suggests that a narrative report is a better indicator of what is happening in activities. A written report, as opposed to a statistical report, can describe how the activity program has benefited the residents and determine future needs of the activity program. Figures do not give the accomplishments of the residents who have participated in the activities (Merrill 38). "Evaluating the fact that only 10 people attend a movie as a recreation activity will have little significance if other factors such as the poor quality of the movie or the inappropriate title are not considered" (Greenblatt 80).

Evaluation of an activity program is a "time consuming, complicated task" (Greenblatt 69). "Evaluation takes time. It requires paper work" (Peterson and Gunn 139). To keep the paper work to a minimum Fish suggests: "Maintain only the records you need to keep track of patient contact, staff hours, personnel data, major equipment inventory, expenses and income, and activity schedules" (27)

Summary of the Literature Review

In summary, an activity program in extended-care facilities can be cost- effective. Activities have therapeutic value as well as adding pleasure for the resident. The goal for each activity should be determined, then evaluated. The evaluation method should be established at the beginning stage of planning and then carried out throughout the implementation process, and at the end to see how well the goal was met. Through the evaluation process activity

programs can be justified to the administration. When activities are matched with the needs of the residents, the activities help to alleviate or prevent an unhealthy state. A healthy body requires fewer medications. When a person feels good, they are able to do more things for themselves. When activities are evaluated for these kinds of benefits, activities provided in extended-care facilities are definitely cost-effective.

CHAPTER 3

RATIONALE

From both the literature available and from personal experience, it is the belief of this author that activities can be a cost-effective way to improve the health status and quality of life for residents in extended-care facilities. Rogers suggests that the goal of the activity program is to "restore, maintain or enhance" the health of the residents and "remove, alleviate, or prevent" unhealthy conditions of the residents (2). An activity program should meet the physical and emotional needs of the residents.

Ansello lists activity as one of the top four factors that lead to life satisfaction. Rogers states that "a healthy life is normally filled with things to do" (6). A healthy active life should include a balance between taking care of oneself, doing for others, pleasurable experiences, and rest (Rogers 6). As Merrill states, "because of their emotional status as well as their being physically ill" older adults in extended-care facilities need an activity program designed to help them meet their basic physical and psychological needs (12). Some residents are bedridden or have limited mobility. These residents need activities to be brought to them or adapted for them. (Lucas, Recreation In Gerontology 77).

Activities not only provide life satisfaction, but they also can help maintain or improve the health status of residents. Health and activity are interdependent phenomena (Rogers 2). Activities promote successful patient treatment by directing a resident's

attention away from their illness or pain. The debilitating condition of poor health can sometimes be overcome or lessened through an activity program that gives the resident a healthy outlook and reason to improve (Ansello).

Most residents in extended-care facilities are given many kinds of medication. Activities can be an alternative to some drugs. With the use of humor therapy, the amount of medication that is needed for pain can be reduced (Adams and McGuire 159). Relaxation therapy can replace drugs used for insomnia (Shealy).

Activities help residents to maintain a healthy state. In order to stay healthy, one must stay active. Exercise programs can improve cardiovascular fitness in institutionalized geriatric patients (Teaf 174; Leitner and Leitner 140). Exercise can also help to increase bone and muscle strength (Teaff 174). Exercise helps residents to perform ADLs by maintaining or improving flexibility, strength, and range of motion .

Activities help institutionalized individuals to use their minds. If one does not continue to use one's brain, some brain function is lost. By conversing with a resident, the resident can remain orientated to the here and now. Reality orientation is an approach that can be used with residents who have lost some of their mental functions. As they become orientated again, they can get back a small amount of independence.

Activities are social in nature, but the activities are able to provide physical benefits. Recreational activities provide therapeutic

value as well as improving the life satisfaction of the residents. Activities can be designed to help residents overcome some of their physical limitations. When this happens the emotional needs of the residents are also met. The activities then become beneficial and cost-effective in treating residents in extended-care facilities. Based on this rationale, a project to evaluate the cost-effectiveness of activities programs in extended-care facilities was developed.

CHAPTER 4

PROJECT PROCEDURES

The purpose of the project was to show that activities could be cost-effective in an extended-care facility. A survey was sent to Activity Directors and Administrators of extended-care facilities in the St. Louis metropolitan area. New Lifestyles, a directory of nursing homes for the St. Louis area, was used to obtain the addresses. From this directory, fifty nursing homes were selected. Since the author lived and went to school in St. Charles, the five nursing homes located there were selected. With St. Louis being the largest city in the area, sixteen nursing homes were chosen. The remaining twenty-nine surveys were sent to the other cities in the area. Each survey was sent with a cover letter and a self-addressed, stamped return envelope. (For an example of the actual letter and survey, see Appendix C.)

The survey was divided into two parts. The first part of the survey included twelve fill-in-the-blank questions. The first question required the person to identify their position. The next six fill-in-the-blank questions asked for demographic information: level of care, number of residents, average age of the residents, average length of stay, the number of residents who were bedridden, and the number of patients who had been rehabilitated and discharged to a lower level of care.

The other five fill-in-the-blank questions dealt with the activity program. Two of these questions inquired about the budget. One

question asked about the per patient per day budget allotment. The other question asked how the funds were divided among specific activities: crafts, association fees, transportation, bingo, newsletter, and entertainment. A space to specify the other activities was provided. Another question asked for the ratio of the activity staff to residents. An additional question asked about admissions that could be attributed to the activity program. The final question asked about the average number of volunteers working in the activity program.

The second part of the survey had three short answer questions. The first short answer question asked for examples of one on one, small group, and large group activities. The other two short answer questions asked about the purpose of the activity program and the strengths of the facility.

The position of the person filling out the survey was noted. The type of care was graphed to determine the type of care given by each facility. The other fill in the blank questions were graphed and statistically studied. The range was established. Then the mean, median, and mode were calculated. The the short answer questions were read to find common components and purposes of the activity programs and strengths of the facilities. Once this information was calculated and analyzed, some conclusions about the cost-effectiveness of activity programs in extend-care facilities were made.

CHAPTER 5

RESULTS

A low rate of response resulted from the one-hundred surveys that were sent to fifty extended-care facilities. Only twelve of the surveys were returned. One Administrator returned the survey with a note saying that she did not have time to complete the survey. One Activity Director and Administrator filled out the survey together. In addition, three Administrators and seven Activity Directors completed the survey.

The survey results are based on the eleven completed surveys. Some of the questions are not answered or answered in such a way that data could not be recorded. Thus, some results are based on fewer responses. The fill-in-the-blank responses from the eleven surveys are given in Table 1.

The answers to the six demographic questions provided information that could be used to compare the facilities. The number of facilities that have different types of beds is graphed in Figure 1, but not statistically analyzed. One survey did not give the number of types of beds, so it is blank on the graph. All levels of care are provided at that facility. All but one of the facilities have SCF beds. That one facility provides mostly intermediate care. Three of the facilities have only SCF beds. Medicare patients are accepted at seven of the eleven facilities. Rehabilitation services are available at four of the facilities. Only two facilities report having ICF beds. Of the eleven facilities, three provide care for Alzheimer's patients

Table 1

Survey Responses

Pos	SK	MED	REHAB	ICF	ALZ	# RES	STAY	BED	AGE	# REHAB	RATIO	ALLOT $	% E	% N	% TR	% A	# B	% CR	% O	VOL
A ACT DIR	Y	Y	Y	Y	Y	150	2	16	75	12	1:25	0.05	75	0	0	0	20	5	0	5+
B ADMIN	124	28	8	0	0	124	.75	0	75	21	1:7	2.05	---	---	---	---	---	---	---	8
C ACT DIR	132	24	0	0	0	123	VARIED	10	84	---	1:61	0.15	25	25	0	10	10	5	25	60
D ACT DIR	130	22	0	0	0	120	2	2	86	---	1:40	0.62	38	7	12	0	0	0	43	60
E ACT DIR	0	20	20	50	16	96	---	10	87	80	1:64	1.50	60	10	5	5	10	10	0	5
F AD./ADM	101	15	0	0	0	71	2.5	10	70	5	1:68	0.50	50	5	10	5	25	5	0	1
G ACT DIR	180	14	0	0	0	204	1	15	80	6	1:41	0.18	50	0	10	0	10	20	10	13
H ACT DIR	120	0	10	0	7	120	1	2	85	22	1:42	UNLIMIT	---	---	---	---	---	---	---	---
I ADMI	132	0	0	0	0	125	2	25	78	22	1:60	0.10	28	34	0	0	15	14	9	35
J ADM	120	0	0	0	0	119	1.5	0	86	25	---	0.103	37.7	4.4	6.9	2.2	15.3	10.3	23.2	12
K ACT DIR	66	0	0	0	0	66	1	2	85	---	1:33	---	---	---	--	---	---	---	---	7

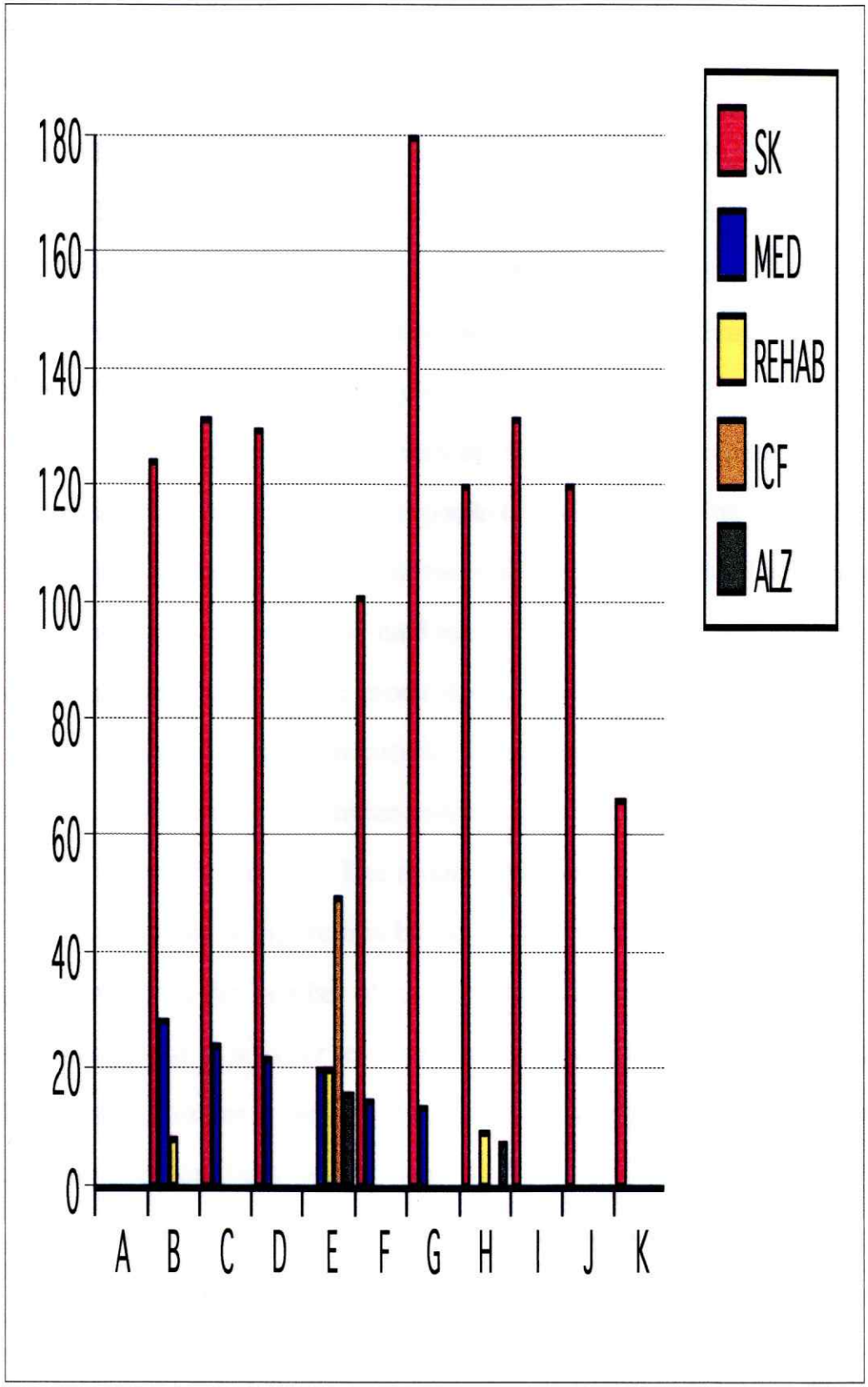
KEY:
EACH LETTER REPRESENTS A SURVEY. --- RESPRESENTS NO RESPONSE GIVEN OR A RESPONSE THAT COULD NOT BE RECORDED

POS: Person filling out the survey (ACT DIR - Actvitiy Director / ADM - Administrator) **SK**: Number of skilled nursing beds **MED**: Number of Medicare beds **REHAB**: Number of rehalbilitation beds **ICF**: Number of Intermediate Bed **ALZ:** Number of alzheimer beds **# RES**: Number of residents currently **STAY**: Average length fo stay in years **BED**: Number of bed ridden residents **AGE**: Average age of residents **# REHAB**: Number of residents dismissed to lower level of care **RATIO**: Number of activity staff to residents **ALLOT**: Budget allotment per paitient per day

%: Percent of budget spent on: **E**-Entertainment **N**-Newsletter **TR**-Trandportation **A**-Association fees **B**-Bingo **CR**-Crafts **O**- Other **VOL**: Number of volunteers

Figure 1

Number of Types of Beds in Each Facility



The current number of residents in each facility is graphed in Figure 2. The smallest facility has sixty-six residents. The largest facility has two-hundred four residents. The mean is one-hundred twenty residents. The median number of residents is one-hundred twenty-three. The mode is one-hundred twenty residents.

The average age of the residents residing in each facility is graphed in Figure 3. The range is seventy to eighty-eight. The mean for the average age is eighty-one. The median average age is eighty-four. The mode is eighty-six.

The amount of time the residents stayed is based on nine responses. The length of stay is graphed in Figure 4. The amount of time ranges from nine months to two-and-one-half years. The mean length of stay is one-and-one-half years. The median is one year and seven months. A tie for the mode exists: one year and two years.

A range of bedridden patients from none to twenty-five is graphed in Figure 5. The mean number of bed ridden patients is eight. The median is ten. The mode is two and ten.

The graph in Figure 6 is based on the eight responses to the questions about the number of residents who have been rehabilitated and discharged to a lower level of care. The smallest number is five. The largest number is eighty. The mean is twenty-four. The median and the mode are both twenty-two.

As with the demographic questions, some of the questions inquiring about the activity program are not answered. The question asking about admissions that were a result of the activity program is

Figure 2

Number of Residents at each Facility

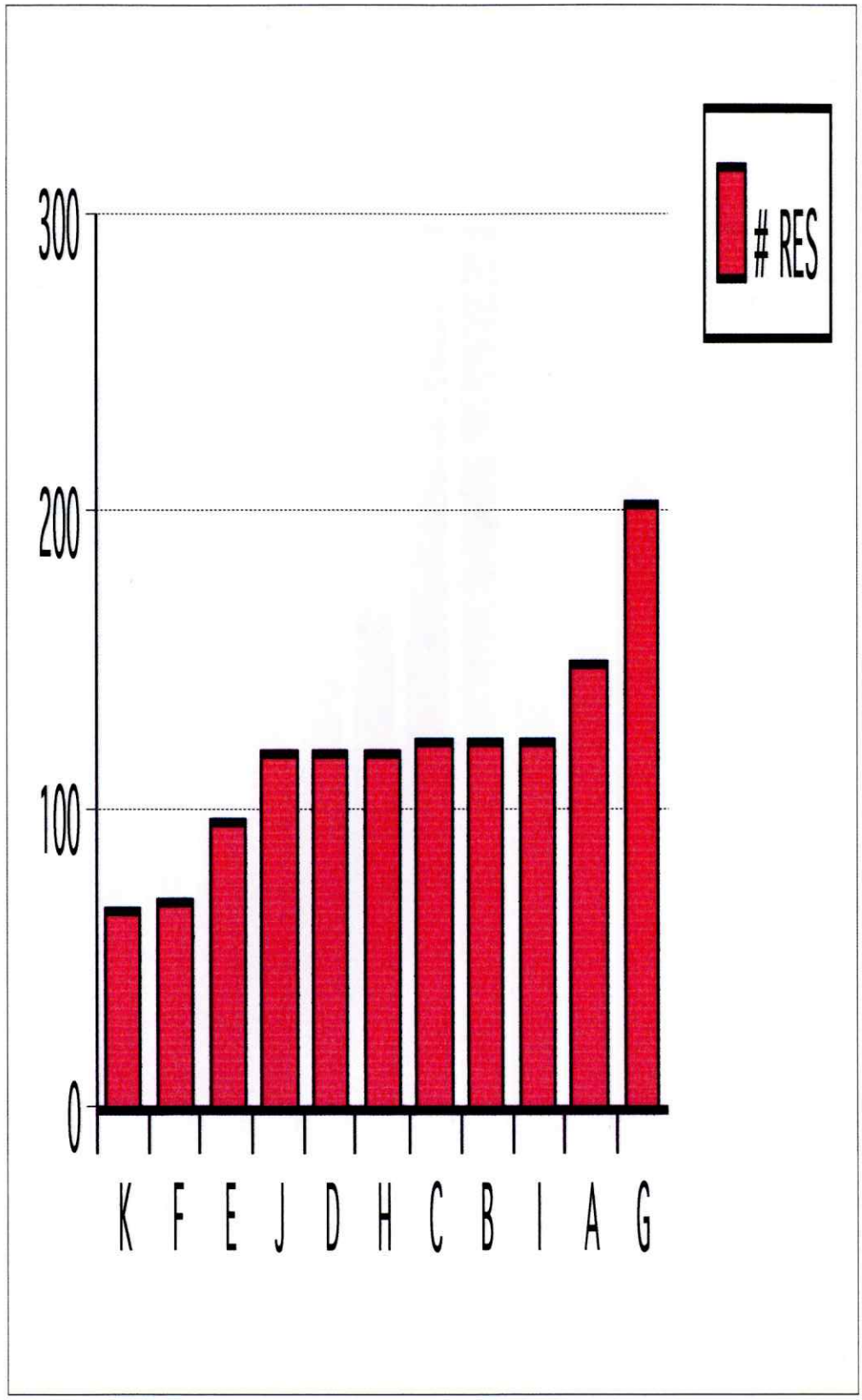


Figure 3

The Average Age at Each Facility

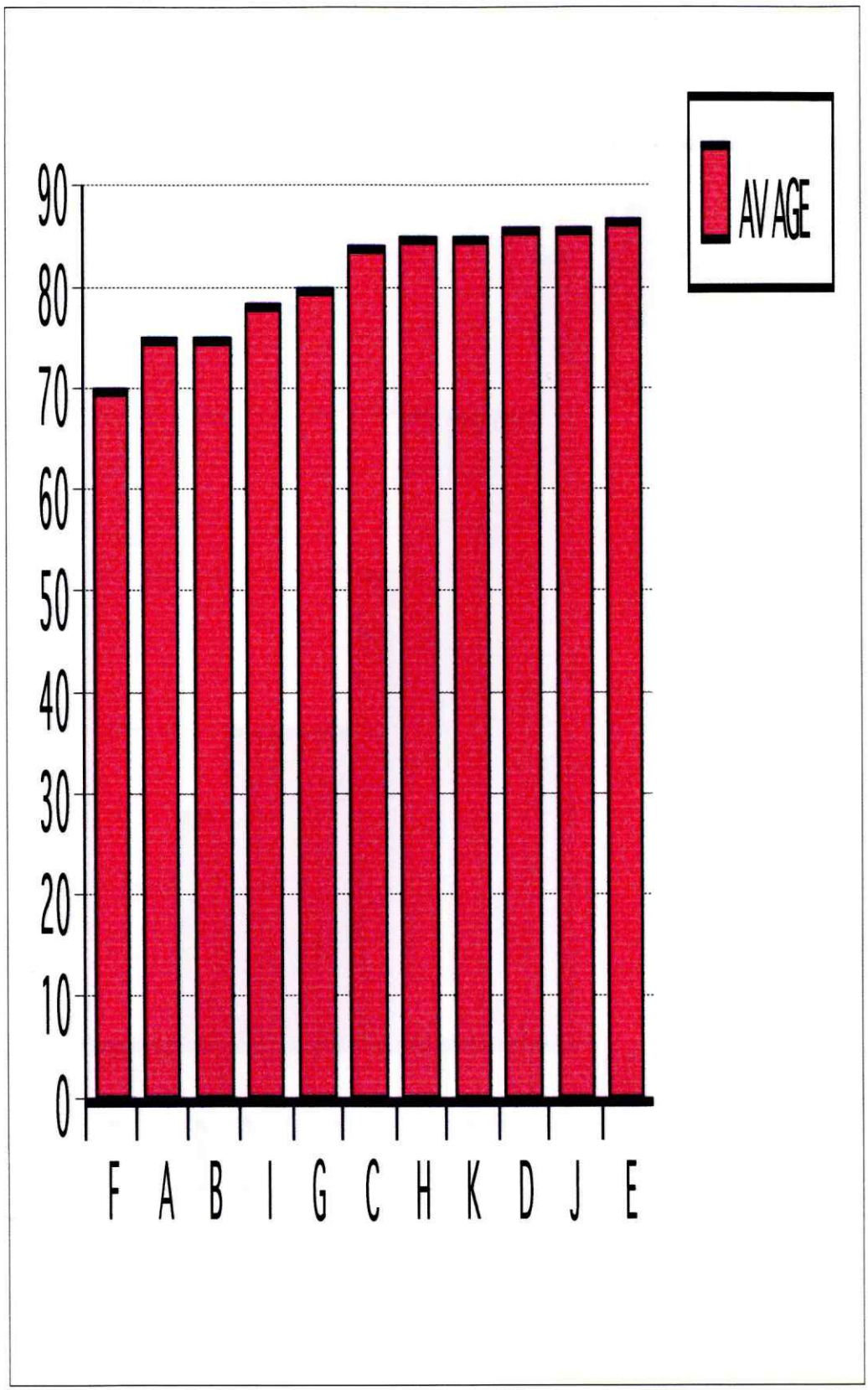


Figure 4

Average Length of Stay of Residents at Each Facility

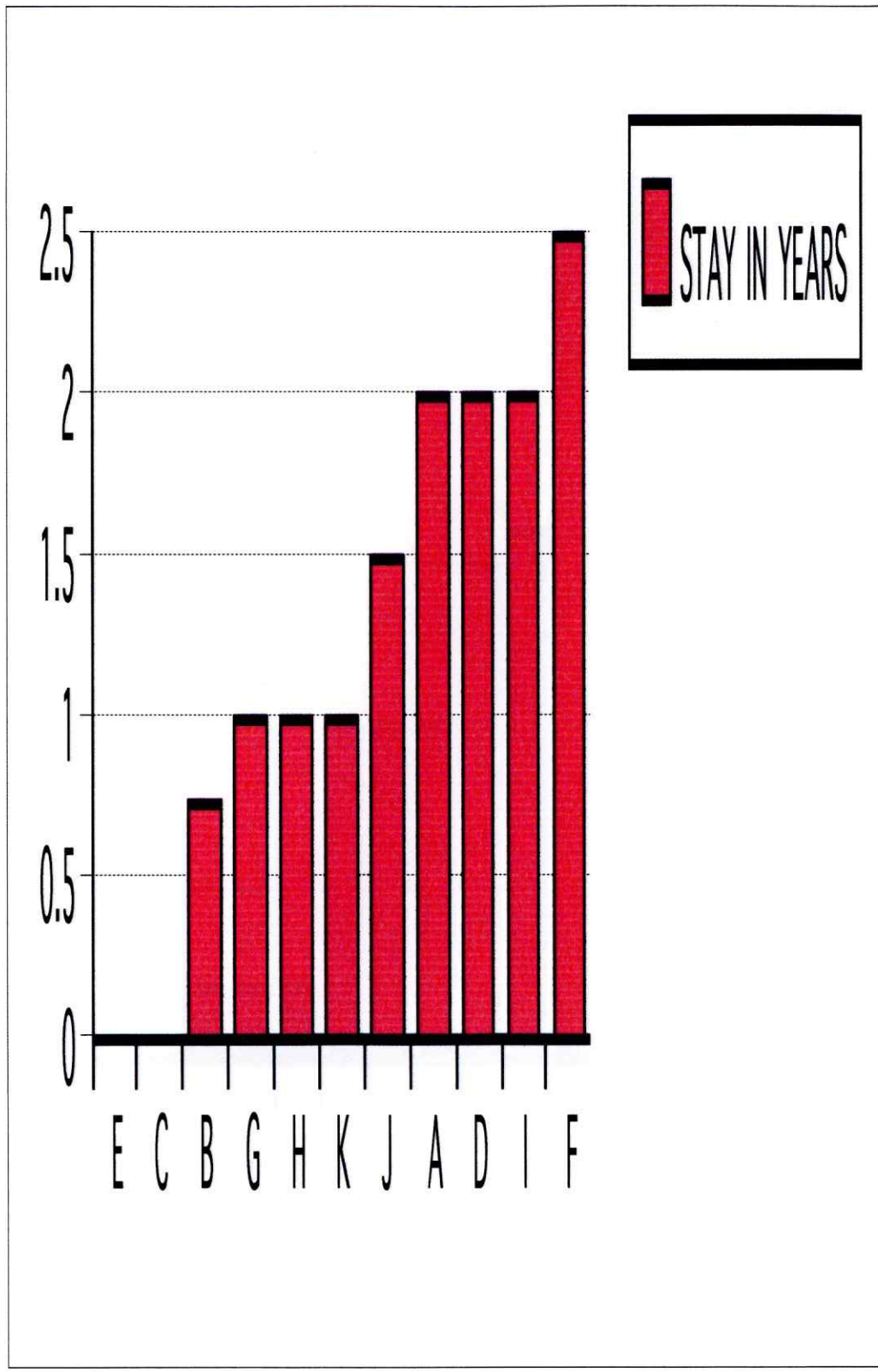


Figure 5

Number of Bedridden Residents at Each Facility

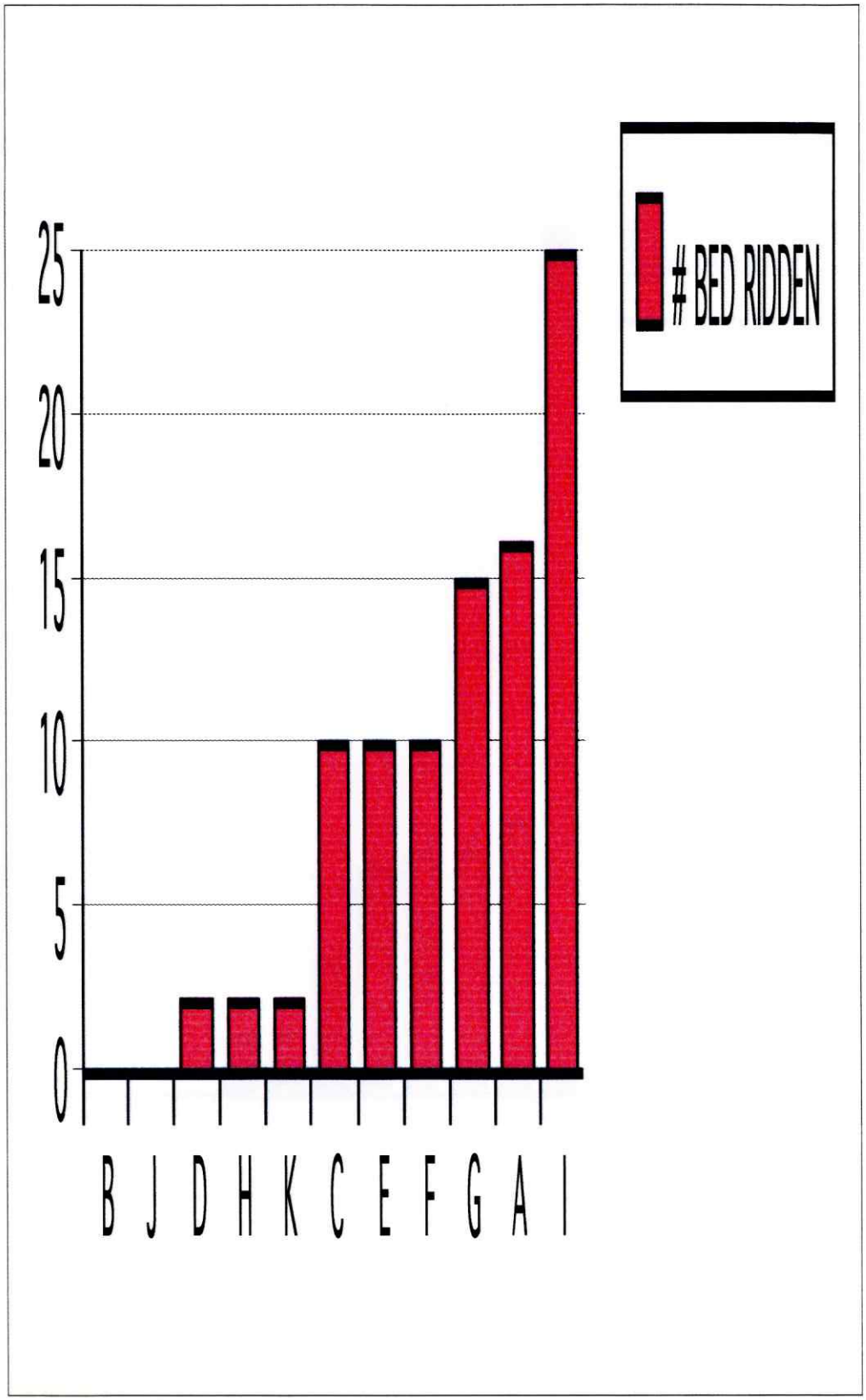
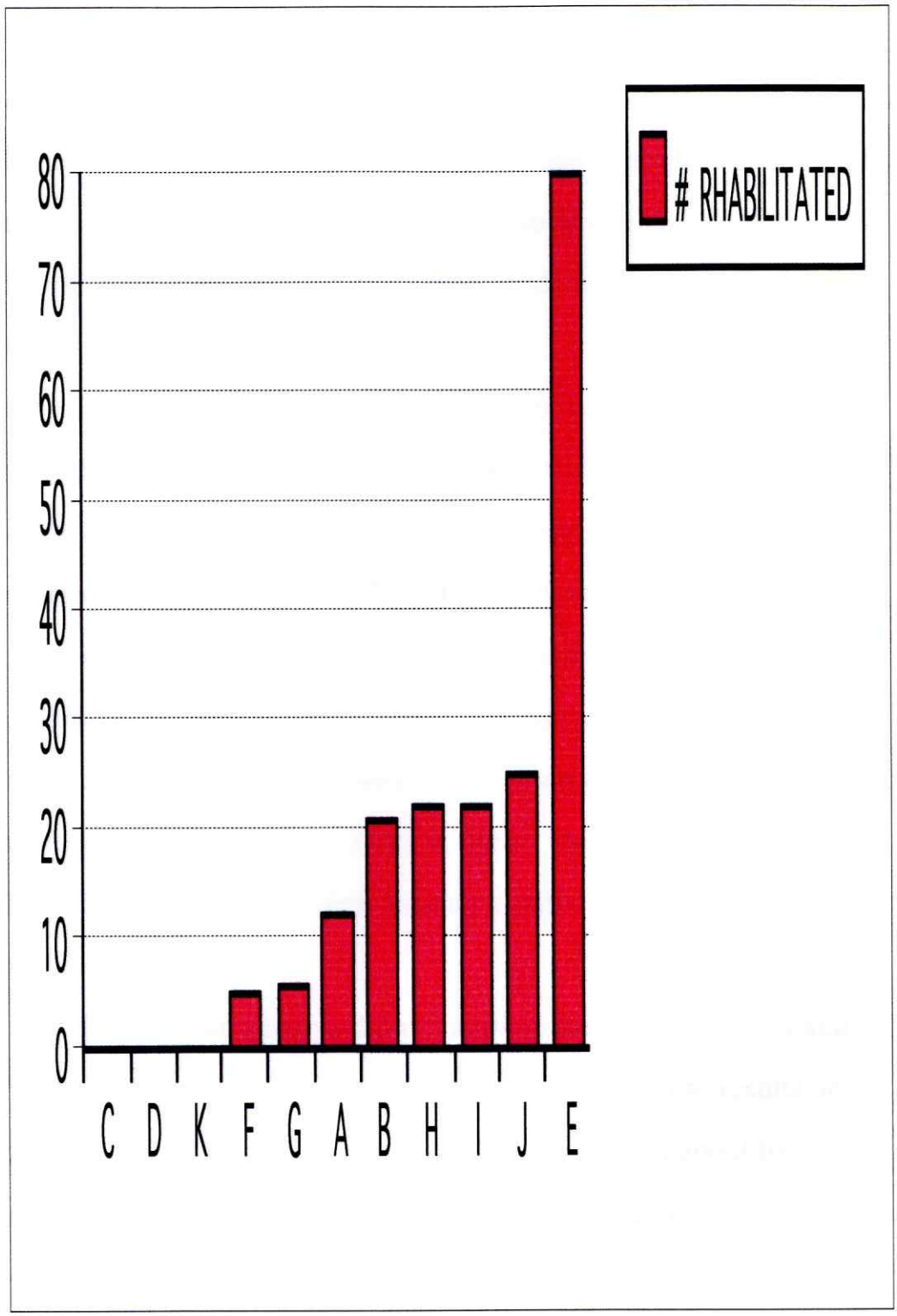


Figure 6

Number of Residents Rehabilitated and Discharged to a Lower level of care



answered on only two surveys. Since there were so few responses to this question, it is impossible to provide a statistical analysis. The other four questions were statistically analyzed.

As noted in Figure 7, a wide range exists for the ratio of activity staff to the number of residents. The statistics are based on all eleven responses. The smallest ratio is one to seven. The largest ratio is one to sixty-eight. The mean ratio is one to forty-four. The median ratio is one to forty-two. The mode is all numbers since no ratio is repeated.

Two surveys did not have recordable answers to the question concerning the amount of money spent on the activity budget. One person completing the survey did not answer. The other had an unlimited budget which could not be given a dollar amount. For the remaining nine, the per patient per day allotment for activities and supplies excluding salaries is shown in Figure 8. The smallest amount is $ .05. Since the unlimited amount could not be calculated, the next highest amount of $2.05 is used. The average amount allotted is $ .54. The median amount allotted is $ .18. The mode is $ .10.

Three of the surveys did not answer the question that asked about how the allotted activity money is spent, so these results are based on the eight surveys that did give information about the way budget money is used. The eight pie graphs in Figure 9 represent the responses from those eight surveys. A pie graph is used to better represent and compare how each facility spends its budget dollar.

Figure 7

Ratio of Activity Staff to Number of Residents

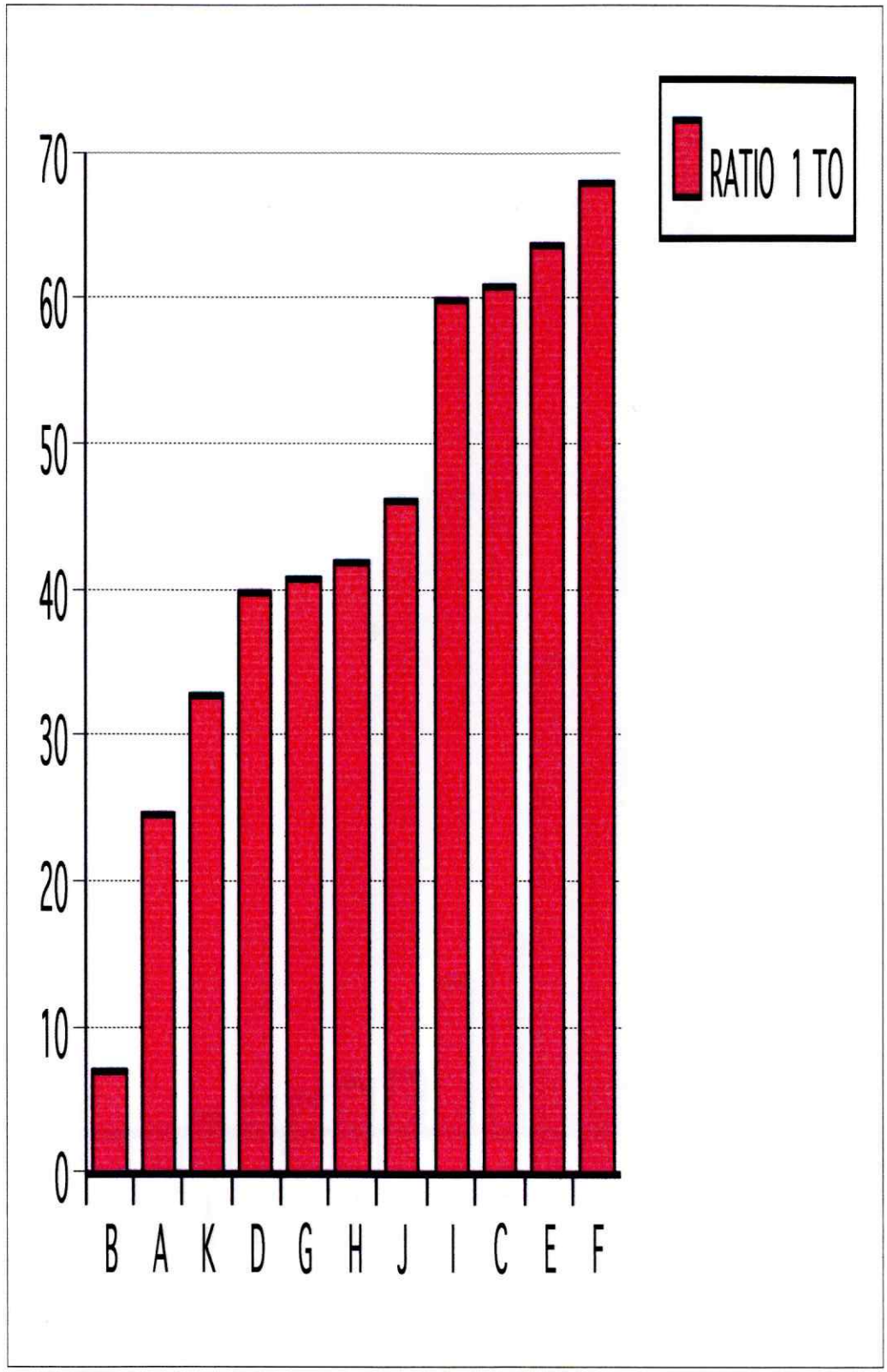


Figure 8

Budget Allotment in Dollars

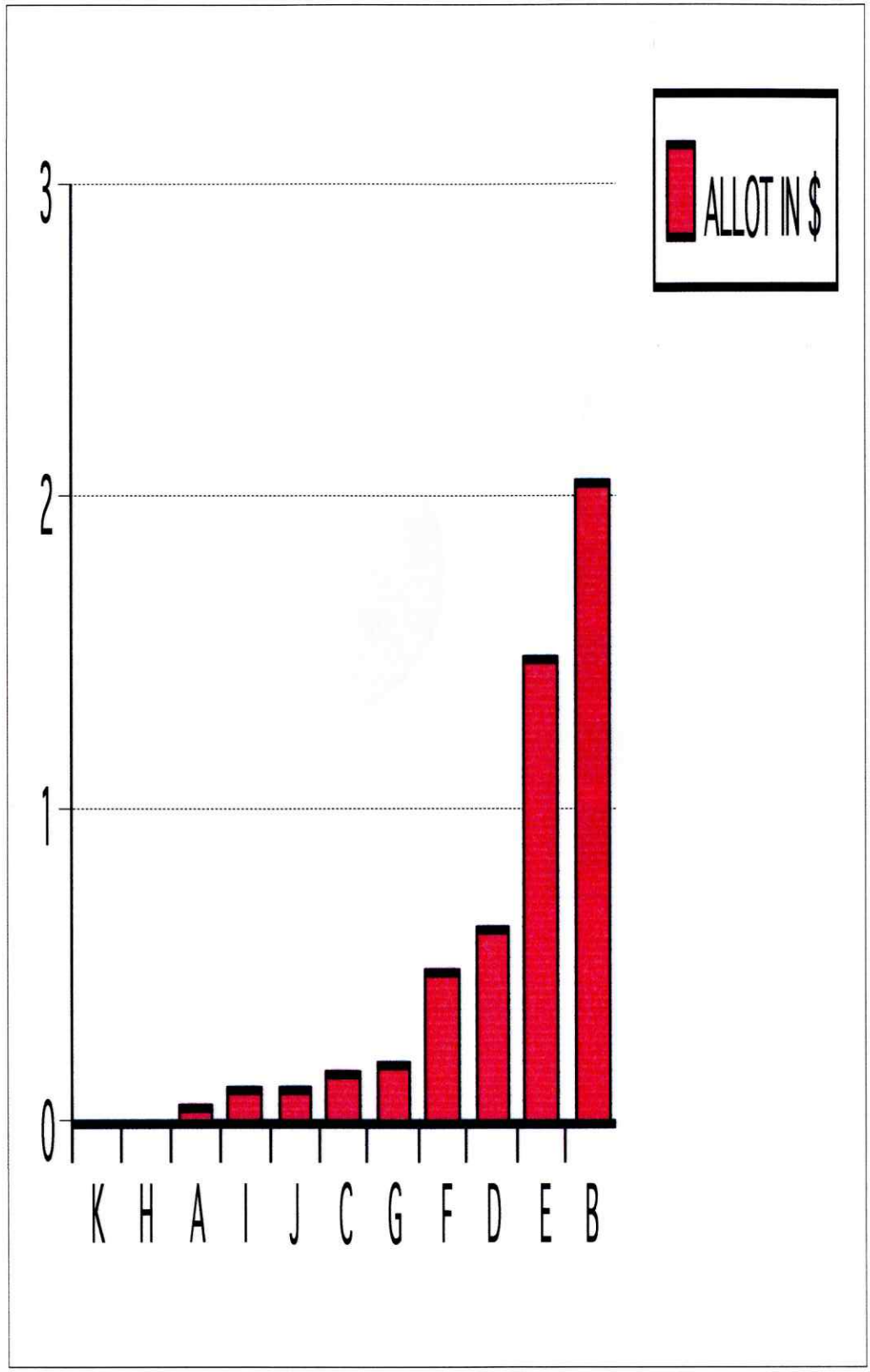


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility A

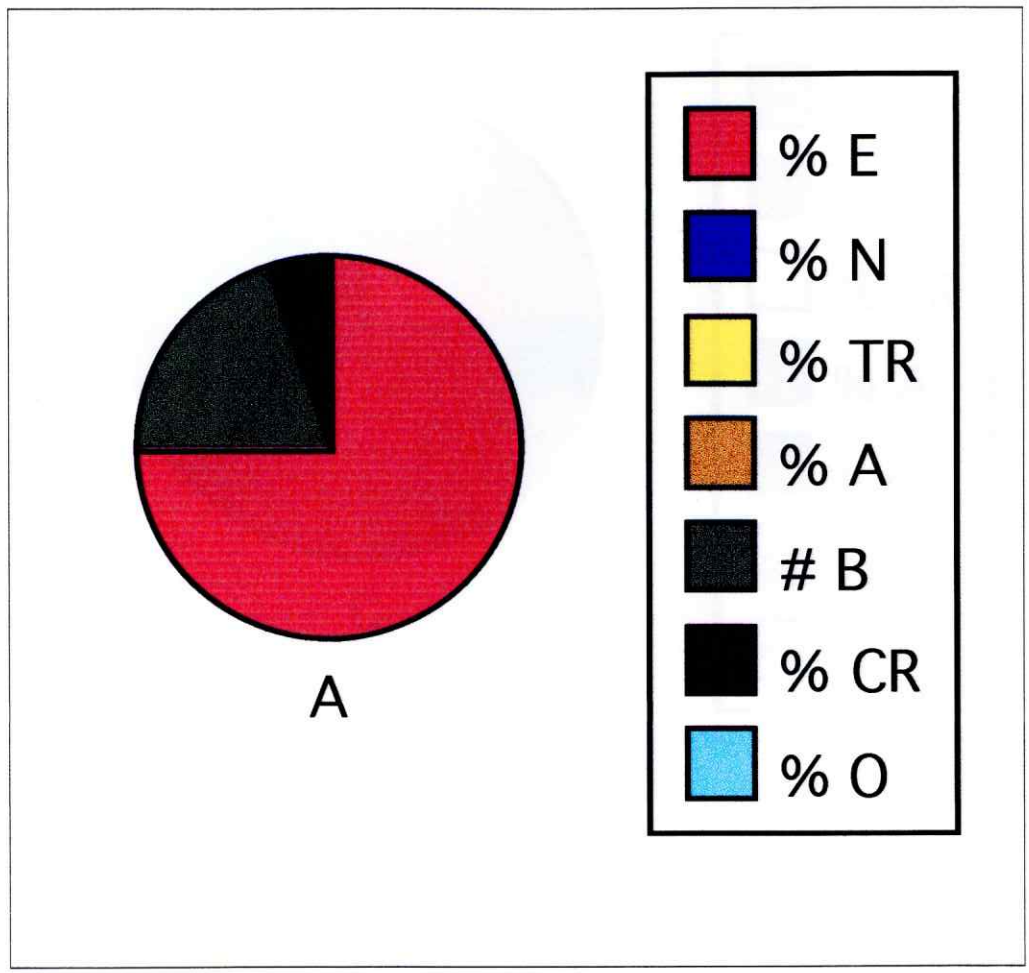


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility C

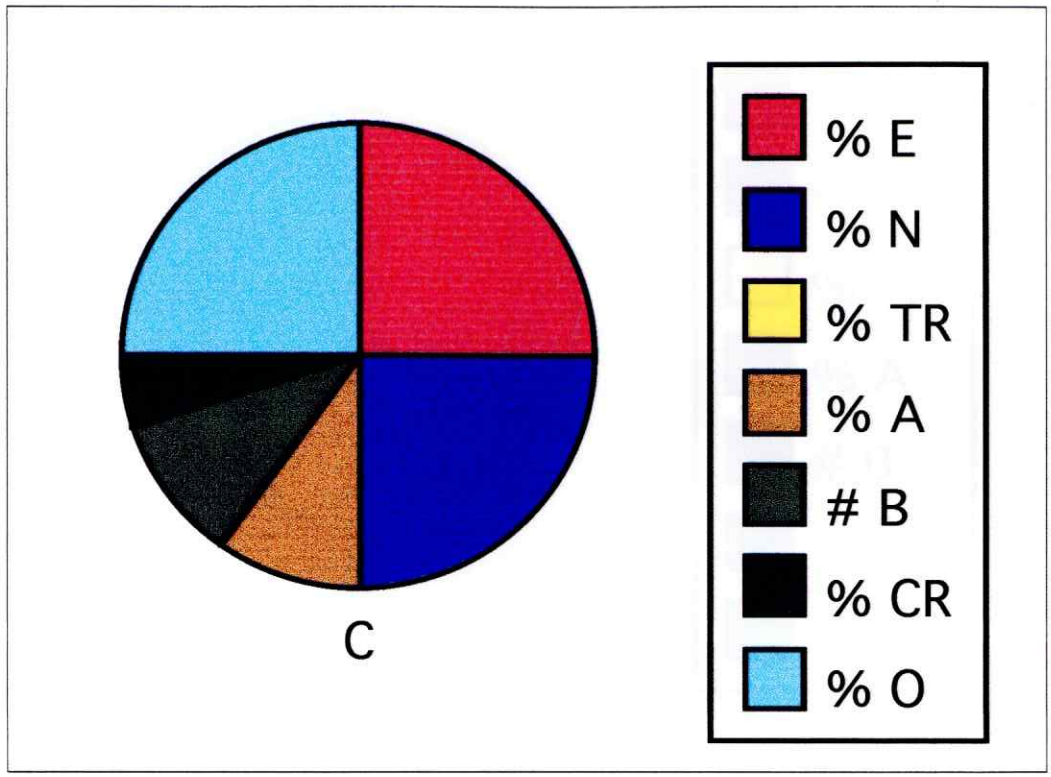


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility D

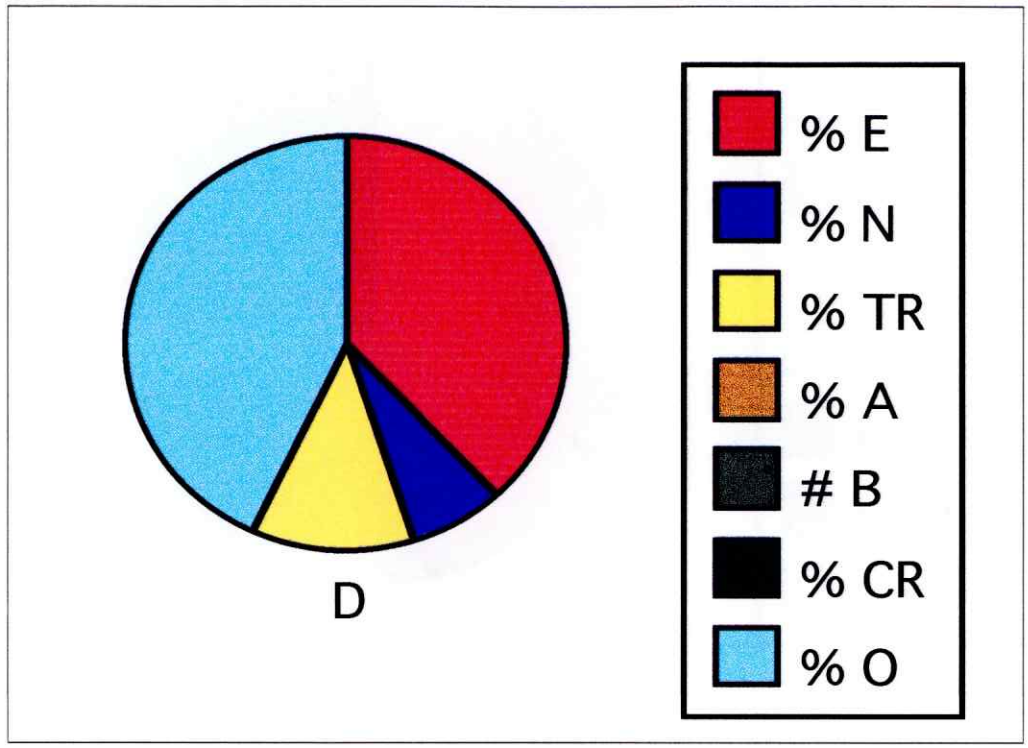


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility E

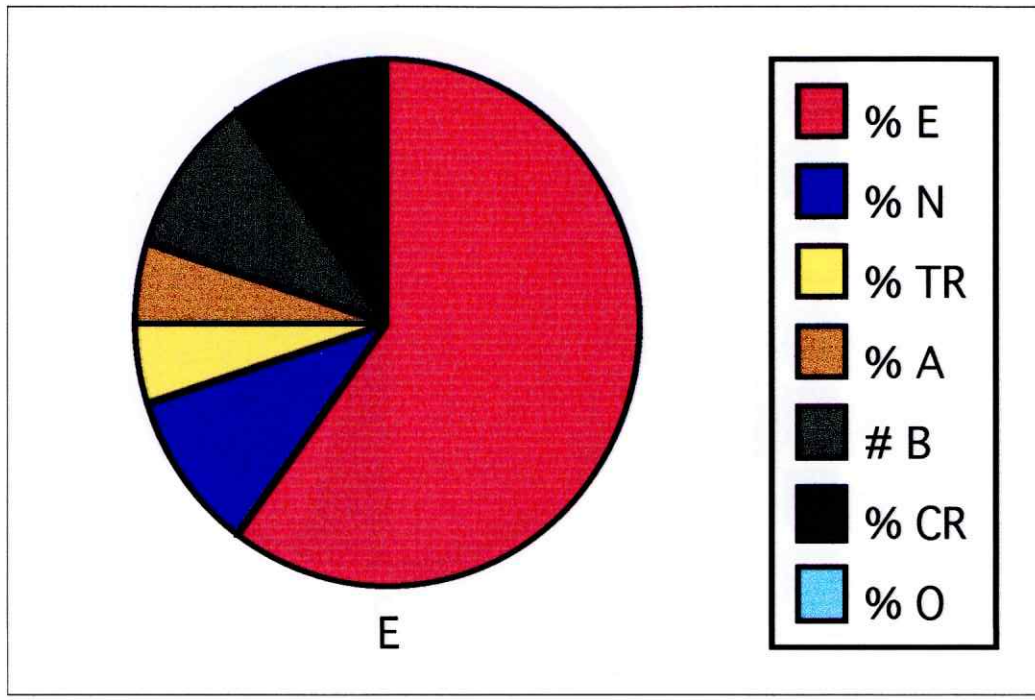


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility F

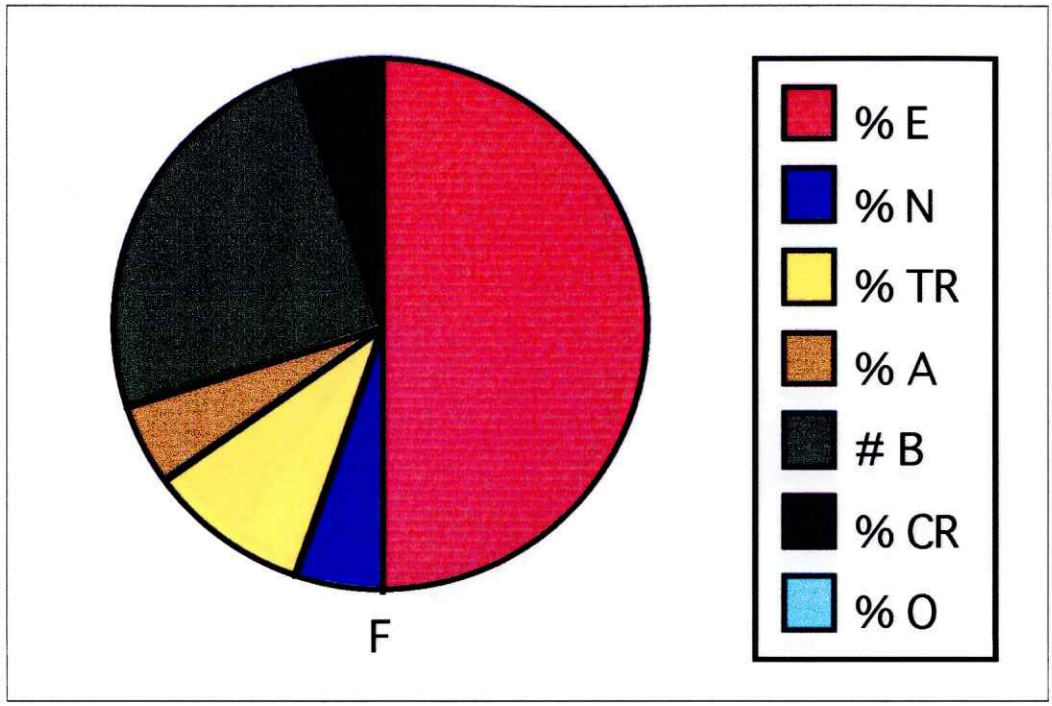


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility G

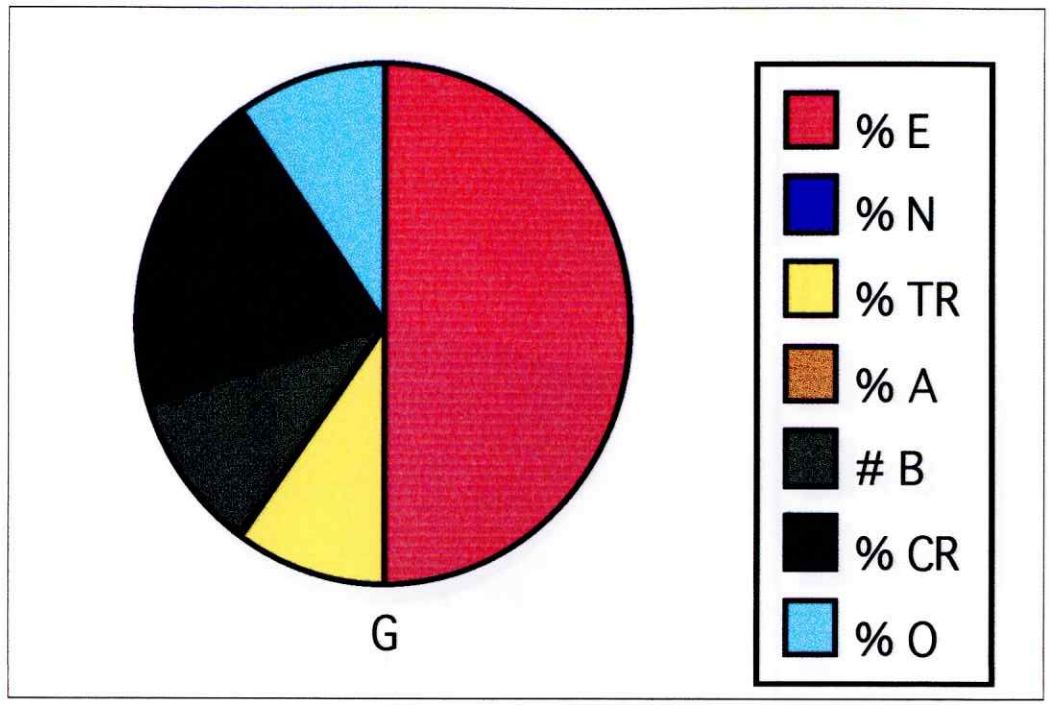


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility I

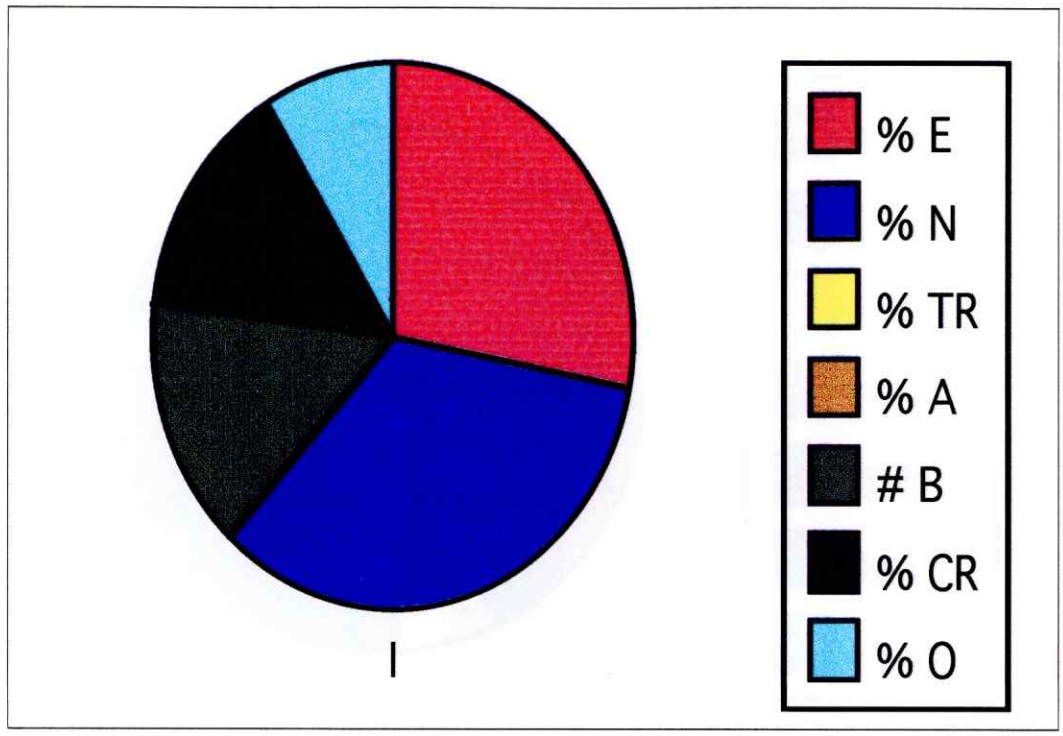
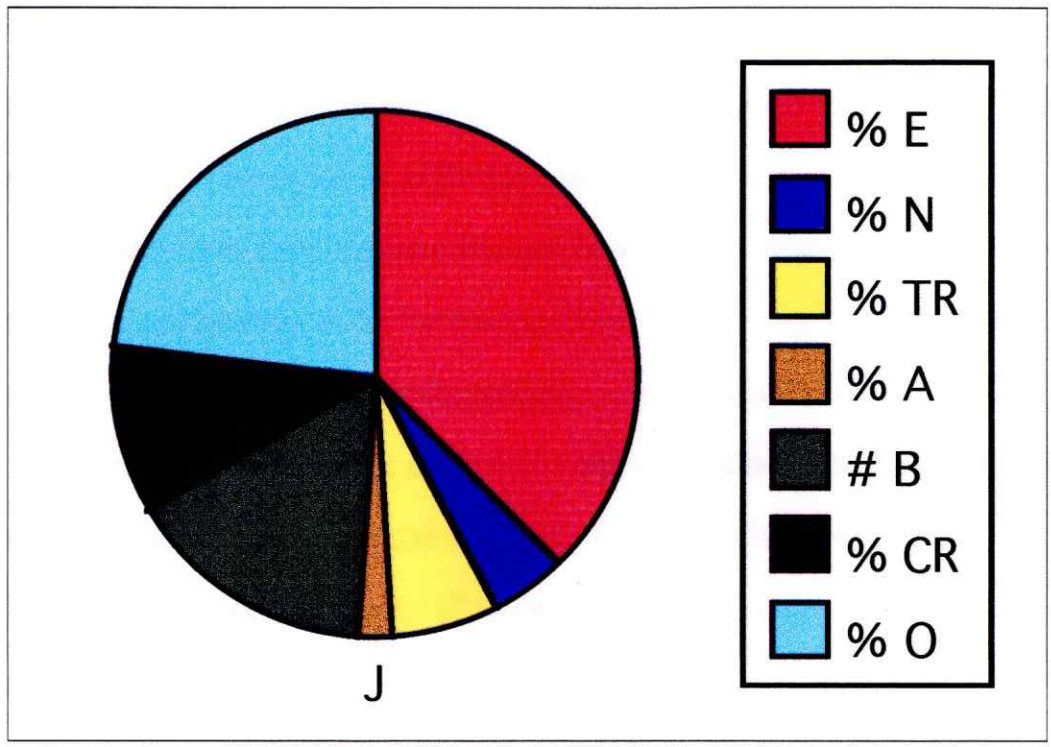


Figure 9

Percentage of the Budget Spent on Specific Activities

Facility J



All of the facilities spent a significant percentage of their budget on entertainment. The range is from twenty-five percent to seventy-five percent. The mean is forty-six percent. The median is forty-four percent. The mode is fifty percent.

The range of the percentage of budget spent on a newsletter is zero to thirty-four. The mean percentage is eleven. The median is six percent. The mode is eight percent.

Only five facilities use budget funds for transportation. The range of percentage used for transportation is zero to twelve. The mean and median are both six percent. The mode is zero.

Four of the budgets do not include association fees. So zero to ten percent is the range used on fees. The mean is three percent. The median is one percent. Since most did not use budget funds for association fees, the mode is zero.

Bingo is included in all budgets. One survey has bingo included in the other category so it is not included with these Bingo results. The range of percentage of the budget used for bingo is ten to twenty-five. The mean, median, and mode are all fifteen percent.

Crafts are included in all eight of the budgets. Like bingo, that one survey includes crafts with the category other. These statistics are therefore based on seven surveys. The range of percentage of the budget used for crafts is five percent to twenty percent. Both the mean and median are ten percent. The mode is five percent.

The percentage of the budget used for other activities is given

on all surveys, but only one specified what those activities were. The range is zero to twenty-five percent. The mean is eleven percent. The median is ten percent. The mode is zero.

The number of volunteers, working in the activity program as shown in Figure 10, is answered on ten of the surveys. The number of volunteers ranges from one to sixty. The mean number of volunteers is twenty-four. The median is fourteen volunteers. Two numbers tied for the mode: five and sixty.

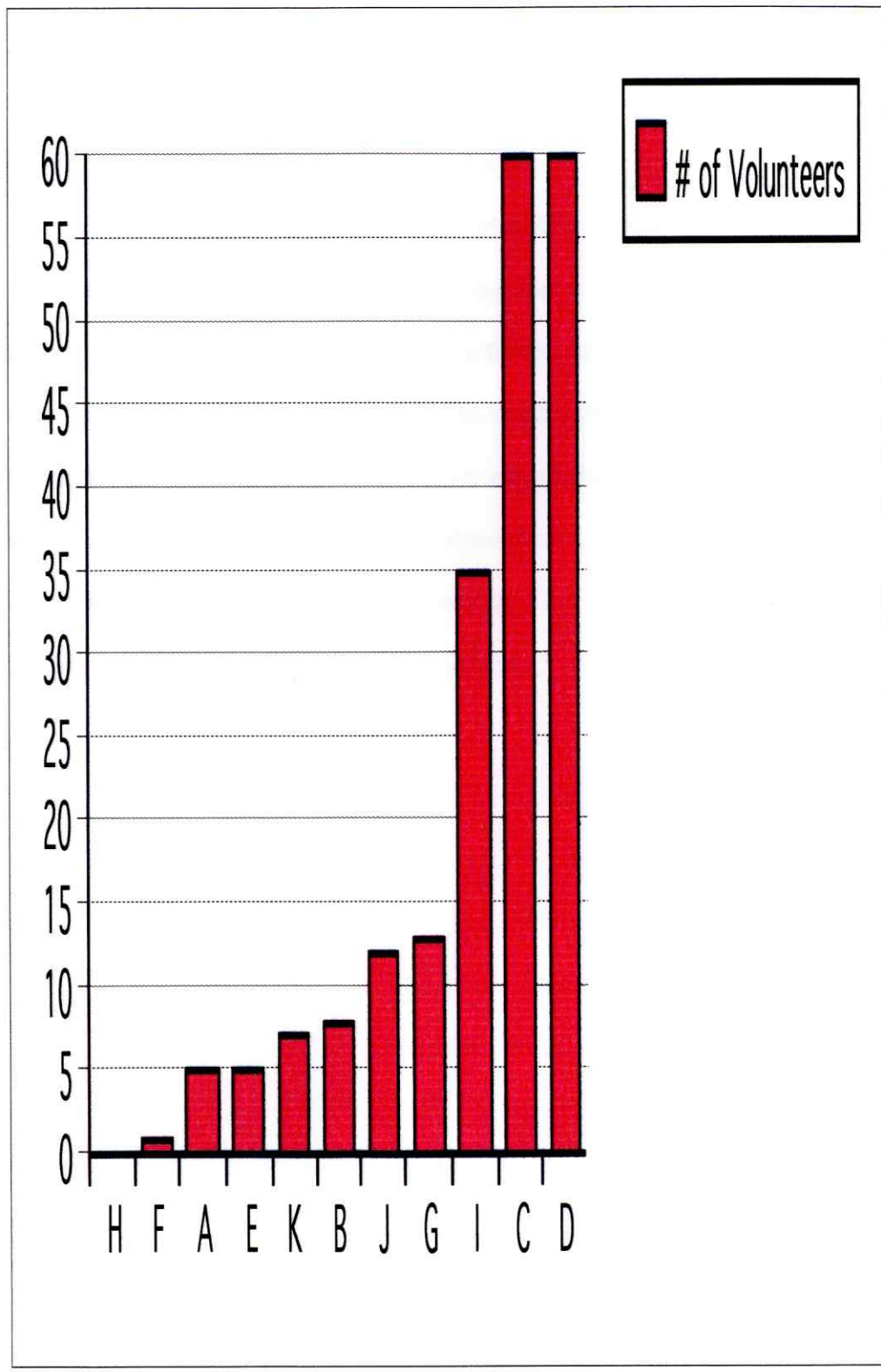
The written portion of the survey also gives information about the activity program and was tabulated carefully. Only nine of the surveys answered this portion of the survey. One of those nine gives the frequency of the one on one, small group, and large group activities. That survey reports daily one on one activities; twelve weekly activities for twenty or less; and three monthly activities for thirty or more.

The other eight surveys report that one on one activities include conversing with the resident, reading to the resident from the Bible, newspaper and other materials, and activities to provide some physical and mental involvement such as crafts, games, and puzzles. Personal care such as nail polishing is also mentioned by some.

The small-group activities include parties and clubs to provide social time for the residents. Activities that allow the residents to exercise are listed. Some of these activities include exercise classes, games that required movement, and outside walks. Games that involved mental power are incorporated into the small-group

Figure 10

Number of Volunteers Working in the Activity Program



activities. Crafts are used in the small group activities.

Social events are a major emphasis in the large-group activities. Entertainment from outside groups and other sources is provided. This in many cases includes sing-alongs. Bingo is an activity that is incorporated into the program. Activities that involve exercise are also offered to the residents

All eleven of the persons responding report that the purpose of the activity program includes meeting the physical and psychological needs of the residents. All of the activity programs have the goal of enhancing the quality of life for the residents. The major goal of all the activity programs is to meet the emotional, physical, spiritual, intellectual, and leisure needs of the residents. Each facility considered its activity program and having a caring environment as a major part of the strength of its facility.

CHAPTER 6

CONCLUSIONS

By analyzing the data from the surveys, several conclusions can be reached. From the fill-in-the-blank questions, some general demographic and activity programing statements can be made. The short-answer section of the survey contains the most helpful information in evaluating the cost-effectiveness of activities in extended-care facilities. Information from the fill-in-the-blank questions and short-answer questions are combined to make some of the conclusions.

From the demographic information given, some general statements can be made about the facilities. All but one of the eleven facilities provide skilled care. The majority of the residents are at this level of care. Only two of the facilities provide intermediate care. One of those facilities is the facility that does not provide skilled care. This probably means that most of the facilities are serving residents with severe medical and physical needs.

Another demographic question inquired about the length of stay. Of the nine surveys that include information on the length of stay, all but one report one year or more, but none reports over three years. This is similar to the six-month to three-year stay reported in the introduction. Since most facilities report few residents being rehabilitated and discharged to a lower level of care, it is assumed that most of the residents leave the facility due to death. It can be concluded that when a resident enters an extended-care

facility they have a limited life expectancy. Perhaps this time could be extended through a balanced activity program which includes activities that meet the life-satisfaction needs of the resident.

It is difficult to make an accurate determination of the effect of the number of bedridden residents to the length of stay. The facility with the most bedridden residents reports an average length of stay of two years. Another facility reports that it considers none of its residents bedridden and only twenty-one of their residents being rehabilitated and dismissed to a lower level of care. Yet, they have the shortest length of stay, nine months.

Some of the data collected from the fill in the blank section dealing with activities are difficult to interpret. It is possible that the question about budget allotment was interpreted differently or misread by some. The usual per patient per day allotment is ten cents or less. Four of the surveys report fifty cents or more. These surveys probably are reporting a per day allotment. If these are calculated as per patient expenditure, all of the facilities would be under twenty cents per day with most being under five cents a day. With this small amount of money allotted to activities, the Activity Directors must find creative ways to provide effective activity programs.

Most of the facilities were not able to answer the question about the number of residents admitted as a result of the activity program. However, that does not mean that the activity program is not an important factor that attracts people to a facility. Indeed

most of the facilities stated that one of the strengths of their facility is the activity program. If the activity program is the reason that people are coming to the facility, this makes the activity program cost-effective.

Each of the facilities surveyed considers the activity program to be an important part of its services to the residents. The activity program is an effective way to meet the emotional, mental, and physical needs of the residents. Since meeting these needs is the goal of an extended-care facility, activities are cost-effective.

The purposes of the activity programs reported on the surveys closely relates to the information about the purpose of activities reported in the literature review. Some of the activities are designed to meet the life satisfaction needs of the residents. Other activities are designed to provide therapeutic and health benefits. When the activities enhance the care of the residents, the activity program becomes cost-effective.

As stated in the literature review, two of the top four basic factors contributing to life satisfaction are interpersonal relationships and activities. Socialization is an important part of an activity program in the surveyed extended-care facilities. Approximately fifty percent of a normal activity budget is spent on entertainment. This expense coincides with the purpose of providing interpersonal relationships which all facilities report as one of their purposes. Entertainment provides an atmosphere in which residents can come together to develop interpersonal relationships. When the residents

participate, entertainment becomes a cost-effective way to meet the socialization needs of the residents, which has carry over into all aspects of the life of the residents.

One of the purposes of activities is to help improve or maintain the mental abilities of the resident. Many activities help the residents to reminisce about the past which helps them remember the past and connect to the present. Some games require the residents to use mental abilities. By using these abilities, their minds stay alert. When residents continue to use their minds, they are able to take care of themselves and require less care. Thus, activities that develop the minds of the residents become cost-effective.

Exercise is incorporated into many activities. Besides having exercise classes, activities such as bingo, balloon volleyball, parachute games, and walking can also provide different forms of exercise. Any form of exercise is important to help residents maintain health and mobility. Disease and circulation problems can be decreased with activity. With this decrease, a reduced amount of money is needed for medical expenses. Exercise is a cost-effective way to help the residents maintain or improve their health.

The survey had some limitations. If the survey had been coded, a second contact to those who did not return the survey could have been made. Since evaluation is important to determine the cost-effectiveness of an activity program, the survey should have inquired about the methods used to evaluate the activity program. As previously stated, some of the questions were misinterpreted. Those

questions could have been more clearly stated to avoid confusion.

Even though the survey had some limitations, activity programs have been shown to be beneficial and cost-effective. While each activity may have a specific goal in mind, each activity serves the broader purpose of keeping the residents mobile and social. Going to the arts and crafts room in itself requires movement. Once there, the residents participate in an activity that requires them to use mental and motor skills. As they participate, they have the opportunity to be with others. The residents benefit from all aspects of an activity program which makes the activities cost-effective.

Further studies are needed to show conclusively that activities in extended-care facilities are cost-effective. The importance of the activities has been well supported by many studies and literature. Information needs to be used in further studies that have a greater emphasis on measuring the cost-effectiveness of activities in extended-care facilities.

APPENDIX A

GUIDELINES FOR PROGRAM EVALUATION

1. Increased number of patients attending .
2. Increased patient responsiveness as observers or participants.
3. Increased identification with group in team games.
4. Higher level of sportsmanship in competitive games.
5. Greater facility and improved quality of performance in individual recreational pursuits.
6. Increase number of patients seeking instruction in performance skills.
7. Movement of static patient population from simpler to more complex recreative activities.
8. More frequent expression of preference and choice by the patient.

(Haun 102)

APPENDIX B

GUIDELINES FOR GETTING THE MOST FROM BUDGET DOLLARS

1) Make sure that you and the Administrator agree on how much will be invested in equipment and supples to start or expand the program, and then make sure that you stay within those limits.
2) Decide with the Administrator on a maximum limit for any single outlay, beyond which you will consult before going ahead.
3) Agree on how to account for outside contributions of money of major equipment. Will they be deducted from the original budget, or can you take them as extras and use them as you see fit?
4) Spend the initial funds carefully, as needs become apparent.
5) Maintain a minimum petty cash account for purchases of everyday needs. . . . Record each expenditure in your desk book so that you can submit an accurate businesslike accounting along with your request for replenishment of the fund.
6) Develop, as early as possible sources of volunteer help and donated materials from the outside community. This is important, because if your have to buy or hire all of the goods and talent for your program you will have a difficult time making ends meet on the kind of budget to which a non-profit department is usually restricted. (Fish 28-9)

APPENDIX C

COVER LETTER SENT WITH SURVEY

September 12, 1996

«Name»

«Address»

«City»

Dear Administrator:

As an activity aide at Carrollton Manor I realize that education is important to understanding the residents' needs. I am also a graduate student at Lindenwood College working on my Masters Degree in Human Service Agency Management with an emphasis in Gerontology. As a part of that program I must complete a culminating project. The subject of my thesis project is "A Cost-Analysis of Activities in Extended Care Facilities". I am in the process of collecting data and I hope you might take a few minutes to assist me.

Enclosed is a brief survey. Please answer the questions and return the survey as soon as possible. I have enclosed a stamped, addressed return envelope for your convenience. Your answers will be kept anonymous and will be grouped with the responses of other Administrators and Activity Directors of Extended-Care Facilities. Thank you for your time and effort.

Sincerely,

Nancy Knapp

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Nursing Home Activity Survey

Answers to all question should be based on current Census.

1. What is your position? _____

2. How many of the following types of beds are there in your facility?

   Skilled___ Medicare___ Rehab____ICF ___ Alz.___

3. How many residents do you have? _____

4. What is a resident's average length of stay?_____

5. How many patients are bedridden?_____

6. What is the average age of the residents?_____

7. What is the number of residents that have been rehabilitated and discharged to a lower level of care from January 1996 to the present?_____

8. What is the ratio of activity staff to residents? _____

9. What is the per patient per day budget allotment for activities and supplies excluding salaries?_____

10. What is the estimated percentage of the budget being spent for the following?

    Entertainment___% Newsletter___% Bingo __%

    Transportation ___% Association Fees ___%

    Crafts ___% Other (specify)_____%

11. How many direct admissions were a result of the activity program? _____
    How is this measured?

12. What is the average number of volunteers for the activity program?_____

13. Give examples of activities in the follow areas.

One on One:

Small Group:

Large Group:

14. What is the purpose of the Activity program in the facility?

15. What are the strengths of your facility?

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