

Reviews

Joan Quinn, Joan Segel, Helen Raisz, and Christine Johnson (Eds.),
Coordinating Community Services for the Elderly, Springer, New York,
1982, \$16.95, ISBN 08261 3300 2.

Community care for older people in the United States has suffered from complex government reimbursement policies, restrictive and arbitrary client eligibility requirements, and the lack of coordination between medical and social services. The Triage Project, which is the subject of this book, was one of the handful of nationally funded community demonstration projects begun in the mid-1970s. The authors attempt both to describe and to analyse the project so that the features of Triage may be adopted in other communities.

The most innovative aspect of the Triage project, according to the authors, is the direct connection which is made between client assessment, case coordination, *and* governmental reimbursement for services. The Triage clinical team of a nurse and social worker determines the client's needs, arranges for medical or social services from a community provider, and monitors service delivery. The Triage administrative staff then processes payment to the provider. By centralising the functions of case coordination and payment for services, the Triage project attempts to control public costs while maintaining high-quality care.

Triage represents an advance over traditional practices of publicly funded community care in United States. Older people typically must seek out providers for different service needs, they may or may not be eligible for public payments for services, and the providers independently determine the clients' needs and process claims for government payment.

The Triage Project took place in a region of seven towns in central Connecticut. The communities are a mixture of urban and rural populations. They were rather deficient in in-home care and social services for the elderly when the Triage project began. One of the project goals was to encourage providers to offer new services or to expand existing services. Triage had an average caseload of 1,442 active clients in 1978, which is the year that the project became fully operational. Triage had an extensive set of providers who either operated under contract or submitted independent claims to Triage. Providers included physicians, hospitals, home health agencies, social service agencies, chore workers, homemakers, and companions, and even relatives who were compensated for their caregiving. The Triage clinical staff adopted a 'client-centred' approach by coordinating and linking these providers on an individual basis for each client.

Triage was designed to improve the availability and quality of care while controlling costs. The organisers of the Triage project anticipated potential

problems with rising costs as a result of the project. They wanted to expand services without significantly higher health-care costs for the target population. They wanted to avoid an add-on effect, where clients might receive a whole range of social and in-home services in addition to the conventional medical services which were currently being reimbursed by the government. Finally, they wanted to serve people in need without excessive numbers of new clients being brought into the community care system. The authors are convinced that Triage satisfied its objectives: costs did not increase and services were not used in excess. They contend that cost increases were avoided, at least in part, because less expensive community and in-home services were used in place of institutional care.

The authors are in an excellent position to describe the evolution of Triage because they represent the core staff of the project. The book contains many thoughtful observations about gaining community support, coordinating clinical and administrative staff, cultivating relationships with service providers, and conducting multidisciplinary assessment. Because of Triage and similar projects, policymakers in the United States are attempting to make eligibility requirements more flexible and to stimulate alternatives to institutional care.

Unfortunately, the authors seem unable to detach themselves from their project in order to present a thorough evaluation. Triage was presumably cost-effective, yet the authors report very general and inconclusive cost data. They fail to examine costs by level of functional impairment or service use; they do not have a control group of clients or service providers for comparison; and they have no valid information on cost trends.

The authors report their administrative costs (e.g. assessment, reassessment, coordination/monitoring and claims processing) to be \$267.44 per client for 1978, the year in which Triage became fully operational. They acknowledge that some clients (possibly a majority) were rather minimal service users, while others required intensive coordination and service delivery. If another community attempted to replicate the Triage model with a functionally impaired population it would no doubt encounter much higher administrative cost per client.

The authors adopt the unit of *client day* when standardising their figures on service costs. Clients day is not clearly defined in the book. The authors seem to be multiplying their average daily level of active clients (1,442 in 1978) by 365 days in order to obtain the largest possible denominator. Aggregate costs for each service category are then divided by client days in order to derive the average charge per client day. The resulting figures are difficult to interpret. For example, the reported charge per client day for hospital services is \$3.55, intermediate nursing home care is \$0.13, homemaker care is \$0.31, and so on. These charges are impossible to place in perspective without an analysis according to the number of clients using each service and the case mix within the service population.

The quality of care in the Triage project is evaluated through a pre-test and post-test comparison of assessment scores on activities of daily living (ADL), mental status (MSQ), and instrumental activities of daily living (IDAL). Change in the functional status of the Triage client population is difficult to evaluate because the scores are not analysed by level of impairment, there is

wide variation in the time between observations (e.g. 6 months to 4 years), and one-third of the client population was due to mortality and other factors. These methodological and analytical shortcomings would tend to under-represent the actual decline in functional status for the client population. Even with the bias towards lower rates of decline, over half (52%) of the clients experienced a decline in IADL, 28% declined in ADL and 29% declined in MSQ. The authors correctly point out that functional ability is difficult to improve or maintain among older people with multiple chronic conditions. However, it is impossible for the reader to determine whether the rate of decline in this population is within acceptable limits. The authors do not have a client control group, nor do they present normative rates of decline from other studies.

The authors also fail to evaluate certain qualitative aspects of their project. One of the most important of these is the role of the physician. The physician is the central decision maker for health care in the United States. The Triage project relied on the clinical decision making of the nurse and social worker. Physicians presumably received referrals and were reimbursed only for those services that were determined necessary by the Triage clinical staff. How did physicians respond to their loss of authority? Why weren't physicians included in the core project staff?

The authors also fail to explore the implications of their experience with case management which was the major administrative service of the Triage project. Case management (e.g. assessment, case coordination, and monitoring) can be an expensive service. Not all older people need this type of assistance. Many individuals have only routine problems, requiring little management, or they have their own resources to meet their needs. The authors do not indicate how the experience of Triage might assist other communities or agencies to optimise administrative resources by selecting clients who are most appropriate for case management.

In summary, the authors have presented a very readable and well-organised description of their project. One should be inherently sceptical, however, when the staff attempts an analysis and evaluation of its own project. Triage is an appealing concept. I wish that the authors had provided a more thorough and objective evaluation.

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Robert L. Lane, David H. Solomon, John C. Beck, Emmet B. Keeler, Rosalie A. Kane, *Geriatrics in the United States*, Lexington Books/D.C. Heath & Co., Lexington, Mass., 1981, 186 pp., no price given. ISBN 0 669 04386 9.

The demographic imperative is the rationale for this estimate of future needs for geriatric manpower in the United States. The rapidly growing numbers and proportions of the elderly, particularly the old-old, have forced consideration of how best to deal with their multiple health problems. Several years