EVALUATION OF INSTITUTIONAL PROGRAMS *

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This paper is concerned with three separate and distinct aspects of institutional evaluation. These are evaluation of:

1. Institutional programs
2. Institutions *per se*
3. The long-term care system within which institutions are located.

For purposes of this paper, evaluation is defined as broadly as possible. Evaluation refers to any assessments of programs, institutions and the long-term care system.

I. INSTITUTIONAL PROGRAMS

Within institutions, three kinds of innovative programs are found currently: (a) Short-term intervention or treatment programs, (b) continuing education or training programs and (c) extramural programs. Short-term intervention or treatment programs are evaluated far more frequently than training or extramural programs.

(a) Short-term Intervention or Treatment Programs: Short-term programs are usually introduced into institutions with special funds, often under the assumption that, if they are successful, the institution will incorporate the short-term program into its routine service delivery system.

Typical of institutional programs which have received attention in recent years are psychosocial programs, so classified because they are aimed at altering the psychological and/or social status of patients in institutions. In the
In the late 1960's, there was a rash of publications about psychosocial interventions, only some of which were systematically evaluated. A partial list of funded pilot programs which were conducted in geriatric institutions or mental hospitals includes: group therapy (Gunn, 1967; Wolff, 1967); intensive treatment (Richman, 1969); sensory training (Richman, 1969); reality orientation (Oberleder, 1968); use of parent-child relationship (Rosen, 1968); crisis therapy (Oberleder, 1968); dance therapy (Siegel, 1968); the buddy system (Kosbab and Kosbab, 1962); wine serving (Kastenbaum and Slater, 1964); social clubs (Smith, Tonge and Mersky, 1966); resocialization (Weiner, 1972); and, remotivation (Arje, 1973).

In addition, some programs aimed at altering total environments in geriatric institutions or mental hospitals. Among these were the following programs: development of meaningful roles (Rosenblatt and Taviss, 1965); manipulation of physical structures of institutions (Lawton, Liebowitz, and Charon, 1968); work programs (Gottesman, 1965); setting up of crisis-laden milieu to strengthen egos (Cumming and Cumming, 1963); structured graduated activity programs (Margulies, 1968); and, therapeutic ward meetings (Gunn 1968).

Most of these programs were relatively short-term innovative programs. Almost all reported success on a short-term basis. Few if any gave long-term follow-up data, and we have found no literature that tells how many of the above listed pilot programs were incorporated into the routine services of the institutions in which they were introduced. Nor, do we know if these successful programs were diffused to any other institutions. Without this information, it is difficult to assess whether these programs are intrinsically useful or whether they were successful due to other reasons. Perhaps more serious, the lack of reports about short-term programs that were not successful makes it virtually
impossible to make systematic comparisons between successful and unsuccessful programs or to determine the factors that contribute to success or failure. In addition, there are a number of other conditions that typically confound the problem of making generalizations from evaluations of short term programs in institutions for the aged. Some of these are discussed below.

There is an obvious bias toward conducting innovative programs in selected institutions, conceivably only in the best. As a result, we have no way of knowing whether a given short-term treatment program would yield "successful" results in more representative institutions. Without a system for rating or classifying institutions, we can assume that innovative programs may succeed because anything would succeed in a good institution or that, conceivably, success is due to staff enthusiasm and cooperation or to some other factors rather than to anything the program has to offer.

We also know that patients in some institutions are more deteriorated than in others. While all may be described as senile or deteriorated, differences in degree of impairment may significantly affect program outcomes. Thus, the condition of residents across institutions may need to be known in order to determine whether a program effective in one institution would work in another. To label as senile all participants, does not give enough information about the program targets.

It is also of some interest to those concerned with the methodology of evaluating short term intervention programs to know who has conducted the program and who has obtained measures of program success or failure. If only intramural staff members are involved in both conducting and evaluating innovative programs, the question arises as to whether success has been objectively assessed.
Another question is whether regular staff members are capable of functioning in the manner desired by the program or whether only the more flexible staff persons, or other special groups, are selected for the program. In the latter case, it is essential to determine whether adequate control measures have been taken, such as rotating personnel through both experimental and control units. Few reports of innovative programs make data on either the degree of impair-ment of the patients or the attitudes of the staff available.

There is also a bias toward conducting innovative programs for the elderly in mental hospitals, the reasons for which are complex and probably also require investigation. Nursing homes often lack investigative staff or interest in studying the elderly. They also may be discouraged about the possibility of change, and they may even lack goals. As Bennett and Nahemow (1965) noted, the mental hospital is officially a temporary residence, while homes for the aged are permanent. Since one goal of a mental hospital usually is to discharge patients, mental hospitals may well be prepared to try alternative methods of treatment which might facilitate discharge. Clearly, surveys are needed to update our knowledge about the number and types of innovative geriatric programs there are in mental hospitals, homes for the aged, nursing homes and other residential settings for the aged. And, as noted above, we need to determine whether or not such programs are concentrated only in a few elite institutions.

From the measurement point of view, there is a bias toward studying only the psychological impact of programs, usually only the target population of the program, utilizing psychological tests and measures. Missing are such assessments as (1) impact of programs on organizational aims, policies and practices vis-à-vis elderly patients, (2) impact of programs on staffs'
attitudes toward aging and the aged, and (3) impact of programs on the external environment, for example, determining whether the external community grows more congenial or understanding toward the elderly by virtue of hearing about innovative programs being conducted on them.

Not only can the above listed factors intervene so that an innovative program may be more or less successful with the targeted elderly patients, but, they also can be the determinants of whether or not a program known to be successful is encouraged to continue in an institution. If successful innovative programs are discontinued, we must usually infer the reasons why. We have found no published information on whether funds simply ran out, whether the staff sabotaged the program, or whether relatives of the patients objected. Any and all of these factors may account for discontinuing a successful program. It would be helpful to those planning similar programs to know if and why they were not continued, despite their reported success. Obviously, social assessments of program impact going beyond measures of the individual patient can provide clues about whether or not innovative programs will be adopted by other institutions. Thus far, social assessments have not been obtained, probably because the methodology for obtaining them is not well developed or generally known by those doing the evaluations. (Some general suggestions as to how social assessment might be incorporated into evaluation studies of short term institutional programs can be found in Webb, et al 1966 and Weiss, 1972.)

(b) Training Programs: There are very few systematic evaluations of the outcomes of training programs. However, Stotsky's (1967a,1967b) work reflects some of the benefits of training programs. His findings indicate nursing home personnel can be successfully trained to work with discharged mental patients.
Stotsky compared a group of patients discharged to nursing homes with specially trained staff to a group regarded as candidates for placement in nursing homes but who remained in the mental hospital. He found that for the two groups of patients, short-term changes favored those in the nursing homes. For long-term changes, results were less straightforward.

Though training programs have seldom been evaluated systematically, the previous training of treatment program personnel has been found to be very important. A survey conducted by Gottesman (1970) showed that the better educated administrators are found in homes which give more services. Gottesman reported that nursing homes differ greatly in the scope of services provided, with many supplying basic and medical rehabilitative services and neglecting psychosocial needs. According to Gottesman, the characteristics of the home itself, of its residents, its staff, the public it serves and its administrator strongly influence the psychosocial services available. Of these, he saw the selection and training of the administrator as being the "most critical" factor, largely because the administrator is responsible for introducing new services.

Apparently, findings such as those obtained by Gottesman, as well as others, have been used as the basis for requiring administrators and other personnel of homes to spend a certain number of hours in continuing education courses, short-term education programs, skill upgrading programs, or special training programs. The fact that New York State requires nursing home administrators to be licensed, has resulted in setting up of special courses that the potential candidates for licenses are required to take. A certain number of hours of continuing education in courses geared to the skills needed by administrators also are required. Usually these courses are given in universities, but many are
given in other institutions. Unfortunately, while administrators take the course required for the license, little is known about how much of what they have learned is put into effect.

(c) Extramural Programs: A third type of innovative institutional program is the extramural program in which a service is performed by the institution for the community. Examples of such programs are day hospitals, home care programs and multi-purpose centers. While there are several descriptions of such programs, largely in England (Whitehead, 1967; Brookiehurst, 1970) there are virtually no systematic evaluation studies. Perhaps, most extramural programs are too new to have been evaluated. There is one early evaluation study of a related but not identical program by Shrut (1958) in which those in an apartment residence belonging to the Jewish Home and Hospital in New York City were compared to others in the more confined institutional branches. Findings indicated that those in the apartment residence enjoyed better mental health, were less suspicious, more socially alert and more interested in planning for continued living than were their counterparts in the more traditional institutional setting. Whether the apartment residence produced the better adjustment or whether those residents who were better adjusted were selected at the outset for the apartment residence was not clear. However, on the basis of intake policy it is known that those in the apartment residence were in better physical health at the outset of the study.

While many think extramural programs can serve as substitutes for institutional residence, we have found no published hard data to confirm this belief.

As we have indicated, it is difficult to generalize about short-term in-
stitutional programs because the literature consists of evaluations of many
discrete innovative programs that failed to provide certain types of information
which would allow us to make generalizations. As a result, one is led to suspect
that there are systematic bias regarding the institutions where innovative pro-
grams occur and are evaluated, and little is known about whether such programs
are usually continued or discontinued.

II. THE EVALUATION OF INSTITUTIONS PER SE

With an increasing proliferation of different types of institutions serv-
ing the elderly, such as skilled nursing homes, intermediate care facilities,
chronic disease hospitals, etc., there has emerged a concern about appropriate
standards for them. Stotsky (1970) pointed out that, although nursing homes
had no mandate to care for the mentally ill, in fact they have done this, and
done it creditably. Dressler (1971) has noted that there are no standards of
care for the ill aged in extended care facilities. A variety of organizations,
agencies, and groups have issued guidelines and standards. They include ANIA
(1971), Brecher and Brecher for Consumer Reports (January 1964; February 1964),
Larson (1969), ANA (1966), ANA (1968), Clare Townsend of the Nader Committee
(1971) and the Senate Special Subcommittee on Aging (1971).

This emphasis on the setting of standards reflects the heretofore dom-
inant pattern of assessment for institutions serving the elderly. The most
commonplace examples of this pattern are the bureaucratic inspections of nursing
homes and similar institutions conducted by health and fire boards. The dis-
tinctive mark of the inspection is its concern with a priori standards (Schwartz et al.
1973) in lieu of direct measurement of organizational goal attainment.
At best, inspection is a checklist approach which may protect society from gross organizational negligence.

Routine evaluation of a more systematic and comprehensive nature does not presently exist for institutions serving the elderly, although there are many institutional studies. The absence of serious attempts at evaluation is surprising in light of both the large number of institutions which serve the elderly and the periodic attention that they receive in the media spurred by the discovery of scandalously substandard conditions at one or several institutions. Perhaps this reflects a lack of motivation among the public to evaluate an institutional sphere which exists in large part because of the dissolution of the extended family in America. Also, there may be resistance to evaluation due to the proprietary nature of many of these institutions. Regardless, nursing homes and similar institutions exist in a growing abundance and their unexamined status poses a challenge to the many families in search of a suitable living arrangement for an aged person.

In this section, we will make note of a variety of studies which relate to evaluation concerns, and we shall note their shortcomings as evaluation per se. We shall focus mainly on client impact studies and suggest a model for institutional evaluation which may solve some of the practical and methodological difficulties that hinder existing efforts.

Two kinds of institutional research in this area are of particular relevance to evaluation. First are studies that relate selected institutional characteristics to an assessment of institutional quality. Thus Townsend (1962) suggests that voluntary homes in England and Wales tend to be of better quality than either private or local authority-sponsored homes. Gottesman (1970)
selects out the training of the chief administrator as the single most critical factor in accounting for institutional quality, whereas Beattie and Bullock (1964) suggest that large size favors quality. All of these studies marshall evidence to support their contentions, but in no case are these data directly tied to the effects of the homes on their resident populations.

This same failure to cross-validate judgements of institutional quality in terms of patient outcomes is evident in a second important type of gerontological research which focuses on the psychosocial impact of institutionalization on the elderly. Goffman (1960), Barton (1959), Aldrich (1954), and Lieberman (1969) all take note of the deleterious effects of mass custodial care in institutions. Similarly, Brown (1961) wrote on the harmful effects of the hospitalization process on patients whose stay was short-term in contrast to the prolonged stay referred to by Goffman (1960). Researchers have also noted the dangers of inter-institutional transfers for elderly patients (e.g. Aldrich and Mendkoff, 1963; Jasman, 1967). These and similar studies leave unanswered the critical problem from the point-of-view of evaluation. That is, we do not know whether the discovered effects of institutionalization stem from the poor overall quality of the organizations studied, or if they are indeed general phenomena. Thus, client impact studies which fail to control for institutional quality necessarily confound general with organization-specific phenomena.

Several factors complicate the systematic evaluation of nursing home type institutions in terms of their impact on clients. For example, we are constrained to assess the institution in terms of the needs of clients — whether these needs are being served in a satisfactory manner. But client needs are generally not uniform from one institution to another. For example, one skilled nursing
home may take in many clients who are acutely ill, whereas another might take in a large proportion of patients with chronic conditions. We can not utilize mortality rates as a straight forward indicator of quality between these two homes since the former will display a higher rate even if it is doing its job exceptionally well.

The client impact model of institutional evaluation involves an important measurement premise which can be symbolized in the following way:

\[ G_I = \sum \frac{(N_{Chn} - S_{Chn})}{(N_{Cl} - S_{Cl})} \]

To wit, the goodness of the institution \( G_I \) is equal to the sum of the discrepancies, for each client, between the client's needs for service \( (N_0) \) and the institution's provision of services \( (S_0) \). The implications of this formula from a measurement point of view are complex. First it suggests that we must have intake data on each client sufficient to characterize his needs as of time of entry. Next, we must have sufficiently detailed information about his treatment to be able to judge the extent to which it responds to the client's prior (or emerging) needs. Obviously this model of evaluation is far removed from the use of global statistics such as mortality rates or number of square-feet per patient, and quite clearly, research based on this model will be costly as it is labor intensive. At the same time, it is difficult to have confidence in an uncrossvalidated global measure of institutional quality. For this reason a compromise approach to the general problem of evaluation may be worth considering.

The compromise that we would like to suggest and very briefly describe is premised on the ultimate need to rely on global institutional level measures such as staffing ratios and square footages per patient. The critical caveat is that
these measures must receive highly systematic and meaningful prior cross-validation. That is, cross-validation in terms of the satisfying of client needs. For this purpose, special longitudinal studies would be undertaken, focused on specific institutional sub-categories. Information would be collected on background and entry status for each patient at each sample institution and the treatment deliveries would be carefully monitored. The format for this kind of individual based data file approach has been extensively described (Blumner). Periodic assessments of client statuses would be joined to the data file and these would provide a basis for assessing the success of treatment vis à vis client need. Once this was determined for each patient at each facility within an institutional sub-category, a secondary analysis would determine which global institutional characteristics seemed to be most clearly correlated with overall institutional success.

One significant advantage of this approach over designs which do not focus systematically on the individual clients is that it allows the specification of sub-classes of clients for whom particular institutions or sets of institutions seem to work best. This kind of information may be an important bonus. Perhaps we would find that patients with certain conditions fare better in intermediate care facilities rather than skilled nursing homes. This transcends ordinary institutional evaluation since it reports a general system property, yet it would be of great interest to social planners and government officials eager to maximize the effectiveness of Medicare dollars.

Nonetheless, the problems of rating institutions as distinct from well-defined projects within institutions are many and we do not believe that any solution, including the one suggested above, will greatly diminish the challenge
of this task. For the most part, the institutions that we are concerned with attempt to provide a total living environment so that their evaluation must report upon a wide range of services. We can think of no satisfactory substitute for the kind of comprehensive, albeit, compromise approach sketched out above, but we are aware that this is a very large assignment. In summary, however, it seems clear that the existing level of institutional studies will have to become a great deal more sophisticated - especially in working with client-centered output measures - if evaluation is to become a systematic rather than an impressionistic undertaking.

III: EVALUATION OF THE LONG TERM CARE SYSTEM

According to Reader (1972), "institutions in the United States constitute a spectrum, based on intensity and complexity of care, that includes home care, day care (and the day hospital), infirmary care (in homes for the aged or retirement communities), nursing homes, extended care facilities, chronic disease hospitals, and acute general care hospitals." More and more individual long-term care institutions are becoming integrated into long-term care systems. For example, Mental Health News of October 12, 1973 published by the New York State Department of Mental Hygiene contained the following news item: "Geriatric Coordinators Discuss Unified Services." Dr. Harvey Brill, Director of Brentwood Mental Hygiene Facility, was quoted in the article as saying, "to be effective, care for the elderly must include a whole range of health, social, and mental health services. Providers of Geriatric services have an opportunity to lead the way to a truly comprehensive single delivery system which emphasizes early intervention and prevention." Clearly, there is movement among agencies and institutions providing long-term care for the elderly to form a better co-
ordinated system of providing care. The job of evaluation is to (1) specify
the components of the system, (2) discover the system's processes, (3) assess
the functioning of the system in and of itself, and (4) assess the consequences
of the system for specific institutions and programs. Below are presented some
rudimentary conceptualizations of the system of long-term care for the elderly
and some questions which need to be addressed in evaluating the system. Know-
ledge about these system level properties is as yet very primitive. As of now,
there are more questions than answers.

Long-term care for the elderly may be seen as consisting of two components.
The first is the treatment of any non-acute illness in which the treatment is
of an extended duration. (Bloom, 1974) The second component we wish to include
in our definition is the provision, for an extended period of time, of services
which are preventive of illness. Table I classifies all the services included
in this definition according to whether they are medical or non-medical, pro-
vided in a residential facility or not, and whether the service is provided
by public or private (voluntary and proprietary) agencies. Such a typology
helps us to see exactly where we are putting the resources of our long-term
care for the elderly.

Residential medical care is what is classically known as long-term care.
The other quadrants contain services known as "alternatives", or "preventive
services".

(Insert Table I here)

The conceptualization of the system of long-term care for the elderly
that is advanced in Table I calls attention to precisely those areas in which
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services and facilities are inadequate, namely non-residential services (both medical and non-medical) and non-medical services of all types. Will not decent public and private programs in non-medical areas serve to maintain the health of the elderly, and reduce medical expenditures? A *New York Times* report (Nov. 10, 1973) on the 101st annual meeting of the American Public Health Association stated that "...the theme of many of the papers presented to the 10,000 delegates was that health encompasses more than medical services – air pollution, poor housing, unemployment, and crowded environments." (sic)

A broad conceptualization of the system of long-term care for the elderly allows us to frame hypotheses about system operation and begin the job of assessing the system and its components. From the point of view of delivering optimal care to the elderly, there are obvious problems with the functioning of the system. Among the many documented system problems are the following:

1. The size of the system of long-term care for the elderly versus the need for the services it includes. (Susser, 1969)

2. The emphasis on institutional care for the elderly, to the detriment of non-medical, and non-residential programs. (Morris, 1969)

3. The difficulty individuals face in moving from one to another level of the system. (Lasagna, 1969)

4. The lack of regular monitoring of program and institutional performance within the system of long-term care for the elderly, as
discussed above.

5. The seeming non-diffusion throughout the system of successful programs and treatment modes, as outlined above.

To properly evaluate the system of long-term care for the elderly, a conceptual scheme outlining the scope of the long-term care system and the units that comprise it, along the lines put forward in Table I, is necessary. A theoretical model of the interaction of the forces in the system needs to be developed and tested. Any evaluation of the system will need a set of goals with which to measure system performance, and these will have to be derived from the goals of clients of different backgrounds, as well as from public officials, medical professionals, and other groups. Evaluation of the long-term care system could begin with a simple input accounting, to monitor where in the system resources are being expended. Subsequent studies will, of course, have to deal with the relationship of effort to efficacy of system processes and programs.

Below are suggested some areas for research about processes within the system of long-term care for the elderly. Our contention is that knowledge about these system processes is necessary for dealing with many of the problems of long-term care for the elderly, such as those outlined above, which are systemic in origin. The following three topics seem to be of considerable significance in determining the adequacy of system operation:

1. The degree of integration among the units that comprise the system.

   We know that associations, journals, and the interchange of personnel facilitate communication within any one level of the system. However,
what mechanisms of coordination are there between different levels of
the "spectrum of care" (Reader, 1972), between medical and non-medical
programs, between residential and non-residential care?

2. The criteria which determine the reputation and success of an institu-
tion or of a program within the system of long-term care for the
elderly. Visibility and reputation among professionals probably are
the most important criteria of success. What role does evaluation
research play in this process? What percentage of institutions be-
long to the visible, innovative, elite?

3. The causes of innovation at any level of the system of long-term care
for the elderly. Some possible dynamics of change are the following:

a. Population growth, changing age distribution, and longer life ex-
pectancy.

b. Technology, including drugs, therapies, and their suppliers.

c. Professionals within the system, including physicians, social workers,
and gerontologists.

d. National government policy and legislation, e.g. Medicare.

e. State, County, and City policy and legislation, e.g. zoning.

f. System staff recruitment and occupational processes. Who are re-
recruited as nurses, administrators, and paraprofessionals? How are,
they trained? Processes of professionalization and unionization
are taking place within these occupations. The ethnic and racial
discord found throughout America exists also within the system of
long-term care for the elderly.

g. Economics. The profitability of private investment in facilities
for the elderly, the availability of financing, and new corporate
ventures alter the availability of various types of services.

* Preliminary results of a recent survey of residential facilities for the elderly
in the New York City Metropolitan region (Edelman and Farkas, 1974) show that of
374 responding institutions, only about 93 report any formalized mental health
program such as group therapy.
SUMMARY

Starting with a discussion of the evaluation of programs in institutions, this paper turned next to a consideration of the institutions themselves, and finally to the whole system of long-term care for the elderly, of which institutions are just one component. This was done to make one central point. Evaluation research in this field must be alert to the social context of the program being evaluated. The evaluation of programs in institutions is insufficient without an appreciation of the organizational context of the program, i.e. the whole institution. Likewise, evaluation of institutions per se is inadequate without consideration of the system of institutions, programs, and services within which any given institution is located. If, as evaluation researchers, we desire that our findings have maximum impact, then we must understand the larger social systems which mold programs and institutions for the elderly.
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