Utilization by Family Physicians of Support Services for Elderly Patients

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Some elucidation of the functioning of the primary care physician in the role as gatekeeper to health and social services for elderly patients is provided by a survey of family practice preceptors. Analysis of knowledge and utilization patterns of 37 types of services by 38 family physicians revealed high utilization of most health services, but there were some gaps for respite, meal site, alert system, and insurance counseling programs. The recommendations of respondents for increasing knowledge and referral coordination could facilitate the access of elderly patients to the needed services.

While the case management model of integrated health and social services for elderly patients has recently been widely acclaimed and promoted, the current reality in most communities is that these services remain uncoordinated. Wide variations have been found to exist in the utilization of these individual services. There is general agreement, however, that the social services tend to be underutilized by older adults in relation to their needs.[1-3] Recent attempts to explain the pattern of utilization of geriatric health and social services have employed the theoretical framework originally developed by Andersen, Newman, and Aday in relation to the utilization of medical care by the general adult population.[1,4-6] This model suggests that characteristics of individuals or populations that predict actual use of services can be categorized as predisposing, enabling, and need variables.

Although need characteristics have been found in some studies to be the most powerful predictor of utilization of health care, the enabling characteristic, "knowledge of the availability of the service," has also been found to be very important.[1,4,6,7] In fact, in one study among a probability sample of 428 older Canadians, Snider[3] found that the knowledge of the availability of the service was actually a better predictor of health care utilization than health status or income. Concerning the primary care physician's role, Snider makes the following observation:[3]

> Physicians could have an important role regarding the elderly's use of ancillary health services. As providers of primary health care, physicians are traditionally perceived by the elderly to perform a gatekeeper function in directing them to health services, but physicians may in fact have no better knowledge base about those services than the senior citizen. Physicians not explaining the role or value of agency health services or not encouraging the elderly to use them might in turn explain why the health-service use and health-status outcome issues are so weakly related.

The physician's gatekeeper function seems especially important to the quality of life of elderly patients in view of the probability that the entry point for access to many needed support services is the primary care physician. The physician is cast into the role of the official "definer of need" for services if the elderly patient is to be eligible for reimbursement from Medicare, Medicaid, or Medi-Gap insurance for those services that are reimbursable. This role is reinforced by the unofficial cultural role definition of "physician as general authority," thought to be especially prevalent among older cohorts of Americans. Consequently, the role of the physician can be considered gatekeeper for the two most important variables that have been found to affect utilization of support services by older adults—the enabling characteristic of "knowledge of available service" as well as the definition of need for services.

This study was undertaken in an effort to clarify and

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TABLE 1. UTILIZATION AND KNOWLEDGE OF COMMUNITY RESOURCES FOR ELDERS BY FAMILY PHYSICIAN PRECEPTORS MEAN RESPONSE BY RESOURCE (n = 38)

Physician Utilization	Community Resources	Score 1-3
Have Referred (3)	Physical therapy	2.97
	Skilled nursing facility/home health	2.95
	Mental health/therapist	2.92
	Public health nurse	2.90
	Medi-Cal	2.87
	Discharge planner	2.84
	Psychiatrist	2.84
	Dietitian	2.82
	Voluntary health association	2.81
	Intermediate care facility	2.78
	In-home chore	2.74
	Health association education	2.74
	Meals-on-Wheels	2.67
	Transportation	2.65
	Senior center	2.61
	Hospice/community college	2.58
	Attorney	2.50
	Social Security	2.46
	Family service	2.46
	YMCA/YWCA	2.41
	Adult school	2.16
	Telephone visit	2.05
Acquainted, but Have Not Used (2)	Supplemental security income	2.00
	Respite	1.82
	Meal site	1.80
	Insurance counseling	1.69
	Consumer assistance	1.67
	Friendly visitors	1.67
	Senior legal assistance	1.50
	Employment	1.49
	Alert systems	1.30
Am Not Acquainted (1)		

possibly facilitate the role of the physician as gatekeeper for both social and health services for elderly patients.

METHODS

A survey was conducted as part of a pilot project soliciting input from community physicians on their knowledge of and referral patterns for community resources for elderly patients. Questionnaires were mailed to 55 physicians who were clinical faculty members in the Division of Family Medicine of Stanford University School of Medicine in February 1982. Responses were received from 49, for an 89 percent response rate. Of those 49, seven were eliminated from the analysis because responses were incomplete or because they were in inappropriate settings for geriatric practice (eg, University Student Health Service, obstetrics-gynecology practice). For the purpose of making the sample as homogeneous as possible, the following analysis is based on the 38 responses that represent only the family practice preceptors living in California, most of whom are in the northern part of the state. Sections of the questionnaire were designed to elicit from the physicians the following information: (1) estimated percentage of the respondent's practice who are aged 65 years and over and aged 75 years and over; (2) the physician's knowledge and utilization of 37 different types of agencies and support services for elderly patients in the categories of in-home services, financial, housing, health, nutrition, transportation, counseling, education, recreational or social, legal, consumer, and special; (3) their feelings about barriers to utilization by physicians; and (4) recommendations for format and type of information about community resources that physicians might profitably use.

Responses on familiarity and use of resources for older patients by the physicians were used to construct a scale as follows: 1 = am not acquainted, 2 = acquainted but have not used, and 3 = have referred (an older patient or patients). Four of the resource categories were collapsed into two based on redundancy and similar scores, leaving 35 resources to be placed on the "Familiarity or Utilization Scale" (Table 1).

RESULTS

The family practice preceptors, on the average, estimated that about 20 percent of their patients were over 65 years of age with about 8 percent over 75 years of age. These estimates tend to be in the same range as those found in other reports by family physicians, although internists tend to report higher percentages of elderly patients in their practice.[8]

KNOWLEDGE AND USES OF RESOURCES

The greatest mean utilization rates by the family physicians tended to be those health-related services with which physicians would be expected to have the most knowledge and direct contact: physical therapists, nursing homes, home health agencies, public health nurses, hospital discharge planners, and dietitians. Other highly utilized agencies included all categories of mental health professionals (psychiatrists, mental health clinics, other therapists), Medi-Cal (Medicaid), board-and-care homes, and voluntary health associa-

tions (eg, Heart Association, Lung Association, Red Cross). Relatively high knowledge and utilization patterns were found for homemaker-chore services, Meals-on-Wheels, transportation, attorneys, senior centers, hospices, community colleges, hospital social workers, family services, and the YMCA or YWCA educational programs. Since senior centers play such a vital role in services and opportunities for older adults, it is notable that 11 percent knew nothing about them, but 79 percent of the preceptors who knew about senior centers had referred elderly patients there.

The lowest familiarity and utilization scores were found for Micro-Alert systems, with 76 percent denying any acquaintance, which seems significant based on their potential for increased independence for elderly patients who live alone, especially those with some mobility impairment. Senior employment programs, legal and consumer assistance, supplemental security income, and adult school education also had low familiarity. Three other health-related resources with low familiarity or utilization rates that could be very profitably utilized by physicians to increase their older patients' quality of life are respite programs for caregivers of chronically ill elders, congregate meal-site nutrition programs, and health insurance counseling. In fact, approximately one half of the respondents were not acquainted with any of the three programs. Some of the responses that indicated lack of familiarity and referral might be attributed to variation in availability of services or variation in the name by which they are designated from one community to another.

In an effort to discover whether those physicians with the higher percentages of patients in older age ranges knew and used the resources more than others, the familiarity or utilization scale was correlated with the estimated percentage of practice attributed to patients aged over 65 and over 75 years. The analysis revealed no significant correlations, with two exceptions, which were in the use of (1) community college programs and (2) senior centers. Although neither of the correlation coefficients was high, it is interesting to note that familiarity with and utilization of community college programs were correlated with estimated percentage of patients aged over 65 years, but not over 75 years, while the opposite was true with senior centers. Those physicians with a higher estimated number of patients aged over 75 years (but not over 65 years) were more likely to say they knew and used senior centers.

FACILITATIVE STRATEGIES

Most respondents did not identify specific barriers to their utilization of support services for elderly patients in their practices. Some suggested that others could be effective in identifying such resources (social worker, senior center, discharge planner, family, patient). The two most commonly recommended strategies to facilitate the use of support services for elderly patients were (1) combination waiting room booklet for patients and reference book for office and (2) education of office nurse and staff to assist in identifying needs and making referrals.

DISCUSSION

Some interesting patterns of recognition and referral emerged from this study. A rough scale of familiarity and utilization revealed a relatively high rate of use for many of the resources, especially those support services that are specifically involved in medical management. Twenty-one of the 35 categories had mean scores reflecting very high utilization responses (2.5 or above on the three-point scale). Even some of the resources not directly related to the medical profession were reported to be well utilized, such as board-and-care homes, Meals-on-Wheels, transport services, senior centers, and community college educational programs.

There were, however, some important resources that might be considered to be underutilized in relation to their potential for assistance to the lives of elderly patients. These resources include the following:

1. Respite programs, to strengthen the ability of caregivers to care for their chronically ill elders
2. Congregate meal-site programs for decreased isolation and increased nutrition for low-income seniors
3. Electronic alert systems that enable elders living alone to summon assistance in an emergency
4. Insurance counseling for patients in need of assistance with claims procedures or purchase decisions, especially in relation to Medicare and Medi-Gap insurance
5. Friendly visitors or telephone reassurance for homebound or frail elderly patients living alone

Most respondents seemed, to some extent, receptive to referring patients to such resources, with only three respondents saying that referral for social support was not the physician's responsibility. There was, however, a strong indication that these physicians would prefer to include other professionals or office staff in the responsibility and time burden of referring patients.

The need for the gatekeeper to be better informed was recognized, and efforts in this direction are underway. With the assistance of a medical student, a small resource guide for elderly patients and their families has been developed at Stanford to be used in primary care physicians' waiting rooms. This guide is

currently being tested in the local Santa Clara County area, along with a reference manual to be used by physicians and other office staff members. The reference manual could be conceptualized as a "Social Physicians' Desk Reference," as recommended by Eisdorfer.[9] It is designed to inform the physician of other professional services available, to encourage cooperative care for elderly patients, and to give the details needed for referral. The goal is to assist the gatekeeper to keep the gate open so that elderly patients who could profit from support services will have not only adequate knowledge of the services but also professionally assisted access to them.

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