AN EVALUATION OF AN IN HOME HEALTH CARE INSTRUCTIONAL PROGRAM IN NORTHWESTERN OKLAHOMA

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PREFACE

This study was developed to determine opionions of the providers of in home health care, the effectiveness of the information presented in the instructional program in helping them to give optimum care to a geriatric aged person, and also to determine the most effective manner for information presentation. The group studied consisted of 21 women who had attended in home health care instruction on the topics of arteriosclerosis and functional psychosis of the elderly and who are also currently serving as in home health care providers. The interview technique was used to obtain information regarding the provider's personal-social history, their opinions of the effectiveness of the information that had been presented in the instructional program, and their opinions of what subject matter and what site of presentation (in the home or in a class) should be used in teaching future groups of providers of in home health care.

As a result of an ever increasing senior citizen population in this nation, a continual spiraling of the costs of professional health care services, and an increase of government financed programs for the low income geriatric ill persons, more in home health care programs will no doubt be developed in the future as this nation moves toward National Health Insurance.

This writer wishes to express appreciation to all of those that made this study possible. Sincere appreciation is expressed to

Dr. Elaine Jorgenson, Thesis Adviser, whose untiring efforts, patient guidance, and understanding and encouragement were invaluable. Gratitude is also expressed to committee members, Dr. Althea Wright, Dr. Lora Cacy, and Dr. Margaret Callson. Appreciation is also expressed to those persons giving in home health care in northwestern Oklahoma who gave of their time in interviews to evaluate information that had been presented to them as in home health care providers.

Greatest appreciation is expressed to my husband, Eugene, and our six children. They have been most cooperative by increasing their personal workload so this project could be completed. Special words of consulation have been appreciated from our eldest daughter, Marsha, and our son, Bill, who are home economists. Of special concern to all of us during this period has been a geriatric aged mother and grandmother, who shares our family home and our love.

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CHAPTER I

INTRODUCTION

In 1970 over 20 million citizens in the United States were over 65 years of age. By the year 2000 this number is expected to increase to 30 million. About one in every 10 citizens in this country at the present time is in the over 65 age bracket (1) (2). These citizens, in their declining years, require special health services and considerations in order that they may remain dignified individuals.

The National Center for Health Statistics estimates that approximately one-quarter of the population over 65 have some chronic condition that limits them slightly. The general mild nature of the physical impairment problems is shown by the fact that 87 percent of the population age 65 and over did not enter the hospital even for a short stay during the year 1965-66 (3). Despite Medicare and Medicaid many of them are unable to find and pay for much needed medical care.

Even before January 1976 there was a "disasterous 13 percent increase in the Medicare deductible and an increase in the required co-insurance payments. Older Americans were paying more out of their pockets for health care than they paid in 1965, prior to the enactment of Medicare" (4).

One of the programs developed to help in the care of the elderly persons with low income was the non-technical medical care program. This was developed by the Oklahoma Department of Institutions, Social,

and Rehabilitative Services with assistance from the Oklahoma State Nurses Association as a result of a change in the Federal Regulations designed to expand and improve medical care to public assistance recipients. The program was designed to provide supervision and training for providers (individuals giving in home health care) of non technical medical care in the recipient's own home (5).

Need for agencies to meet the needs of our nation's "Golden Agers" is further substantiated by the fact that many of the elderly have found their later years to be a time of new opportunities, fulfillment, and growth (6). Furthermore, from the preamble of the Health Care Strategies, 1971 White House Conference on Aging, it is stated,

> We recognize that long-term care involves not only inpatient care but also services to people in their own home as well (7).

This researcher's former employment dealt with planning for the total in home health care of the elderly poor citizen residing in 14 counties of northwestern Oklahoma. In order to give optimum care to the assigned cases, this researcher supervised and trained persons (called providers) giving in home health care; assisted them in the care of persons residing in their own home; as the need arose, acted as a liaison between the elderly and the family members of the aged person and a social agency; and cooperated with the family physician in achieving in home health care as recommended by the attending physician.

The essential components of professional nursing are care, cure, and coordination. Care involves dealing with human beings under stress, frequently over a long period of time. It is providing comfort and support in times of anxiety, loneliness, and helplessness. It is listening, evaluating, and intervening when appropriate (8).

In order to give in home health care, when a patient is either bedfast or chairfast or psychologically chair or bedfast, a considerable part of the provider's responsibilities are in rendering homemaking duties such as shopping, menu planning with consideration for special diets, planning and assisting with diversional activities, and assisting the home bound person with activities of daily living (ADL). Besides this, according to the care needs, there may be bathing of the patient, changing of dressings or prosthesis, and the meeting of his psychological needs.

Statement of the Problem

The need for trained para-professionals (providers) to give in home health care has arisen due to the high cost of professional health care services and the personal desire of the elderly to remain in the security of familiar home surroundings. In order to have qualified providers, instructional programs have been developed on a limited scale. Just prior to this study one type of an in home health care instructional program was used with the providers served by this researcher. This study was developed to determine, in the opinion of the providers, the effectiveness of the information presented in the in home health care instructional program, and to determine the most effective location (home or in class) for information to be presented.

Objectives of the Study

The objectives of this study were:

1. To obtain opinions of the providers concerning the effectiveness of information that has been presented in the

instructional program.

2. To obtain the opinions of the providers regarding what subject matter and where (in home or in a class) the teaching should be done in the future for in home health care instruction.
3. To make recommendations regarding the instruction of providers that will be giving in home health care to elderly low income home bound individuals in the future.

Sample for Study

The 21 participants in this study were providers giving in home health care in northwestern Oklahoma who had attended in home health care classes on the topics of arteriosclerosis and functional psychosis of the elderly. They were currently giving in home patient care. The 14 counties in Oklahoma initially served by this researcher were Alfalfa, Beaver, Beckham, Cimarron, Custer, Dewey, Ellis, Harper, Major, Roger Mills, Texas, Woods, and Woodward.

Procedure

The following procedure was followed to obtain the desired objectives of this study:

1. A study was made of past, current, and future proposed health care delivery systems. From an earlier survey it was learned that the providers in the 14 counties of northwestern Oklahoma were most concerned with the geriatric health problems related to the ailments of arteriosclerosis and functional psychosis.
2. Persons were contacted who were currently serving as providers for the Department of Institutions, Social, and Rehabilitative

Services and who had received in home health care instruction under this researcher. By interview technique, opionnaires were used to obtain the opinions of the providers regarding previously presented teaching materials; what they would like to study about in the future; and in which type of a setting--the home or in a class situation.

3. Data regarding the provider's personal history (age, sex, experience, educational background, and work history) had been collected at an earlier time. This was verified at the time of the provider interviews in May 1976. There were 21 providers available for the study.
4. The data were analyzed by number and percentage. Tables were developed to present this information. From this information the researcher determined what recommendations to make for future in home health care instructional programs for persons giving care to low income home bound elderly citizens.

Limitations

The following limitations were placed upon this study:

1. The study was limited to providers working in the counties formerly supervised by this investigator.
2. The study was limited to those providers working during May 1976 in giving care to elderly homebound individuals suffering from arteriosclerosis and/or functional psychotic ailments.

Definition of Terms

These definitions were selected on the basis of the review of literature and will be accepted as the terminology used in this study.

Provider--An individual employed by the family of a patient and certified by the attending physician as capable of providing non technical medical care to a public assistance recipient of the Department of Institutions, Social, and Rehabilitative Services. The recipient has been determined by the Medical Evaluation Unit to be in need of these services. These services, without exception, were provided in the home of the recipient.

Recipient--An individual for whom the Medical Assistance Unit of the Oklahoma Public Welfare Department has deemed medical or medically related services are essential for the welfare of the patient (9).

Medicare--A federally operated health insurance service of the Social Security Department for almost everybody age 65 and older and for specially designated cases under 65 in the United States. It provides basic protection against the cost of inpatient hospital care, post hospital extended care, and post hospital and medical costs of those who are insured. This program is financed by a special payroll deduction or contribution by the insuree (10).

Para-professional--A term used interchangeably with the word "provider".

Class participants--Any person attending a non technical medical care in home health care class.

In home health care class--Is a group meeting of persons (providers) in a community for the purpose of studying about a particular health

care problem or ailment as related to the care of a patient in his own private home.

Setting for the class--A particular place such as a provider's home, a church basement, or a community room where the providers and the instructor could meet together for the continuation of provider learning on a specific body on in home health care information.

CHAPTER II

REVIEW OF LITERATURE

Health planners are concerned with the training of health care workers to take care of the elderly. Some persons desire to remain in the familiar surroundings of their own home. They feel they should be allowed to do so. For others, institutional costs of a nursing home or hospital are prohibitive to consider on the long term basis. Therefore, social agencies, both private and governmental have been created to assist those people (and their families) so they may remain in their own homes and receive care services there. The in home health care programs studied by this researcher is one of several. Such care makes it possible for those persons who choose to do so to remain in their own homes though unable to function in meeting their health care needs. This chapter is devoted to studying social changes which have occurred as a result of governmental control of the health care of the elderly; professional service modifications for the care of the elderly; and the providing of in home health care services.

Historical Overview of Social Changes

Smaller homes, an unstable economy, and social unrest created an urgent need for a change in the mode of health care for the elderly during the 30's. President Franklin Delano Roosevelt's social programs lead the way toward socialization of health services. In 1935 the

federal Social Security Act became a law. Welfare started in Oklahoma as a result of people voting in August 1936 for all sales tax monies to be earmarked for that agency. President Roosevelt's 1944 State of the Union Message specified the right of citizens to adequate medical care in his "Economic Bill of Rights". The Eighth Annual Report of the Social Security Board called for Compulsory Health Insurance which was the forerunner of Medicare (11).

The Home Economist in the Health Care Field

The five mission-oriented goals of the American Home Economics Association are vitally important in the projected planning for the nation's elderly citizens. These goals are:

1. Improve the conditions contributing to man's psychological and social development.
2. Improve the conditions contributing to man's psychological health and development.
3. Improve the physical components of man's near environment.
4. Improve consumer competence and family resource use.
5. Improve the quality and availability of community services which enrich family life (12, p. 7).

Services of the home economist in home health care can be grouped into five broad areas:

1. Professional education
2. Consultation
3. Direct services to the chronically ill and handicapped
4. Development of resource materials for professional education, consultation, and service
5. Research (13, pp. 350-353).

The advent of Medicare, a 1965 piece of social legislation designed to assist the elderly with their medical expenses, has played a major role in changing the direction of the various service professions. Li Wang, Maryland extension home economist, stated that:

> Home Economics should be extended to the health care services. The changing pattern of disease from infection to

> chronic illness, the increase in longevity in population, and the discovery that health is a right as our other human rights; all suggest to the home economics profession that it should expand its scope beyond traditional subject matter to the development of human resources. Home economists need to be prepared to be a part of the team effort in meeting the family needs and the community services (13, pp. 350-353).

No doubt in the coming months many studies will be made regarding in home health care services to substantiate the need for this type of health care and especially as this nation possibly considers National Health Insurance programs in the coming session of Congress in 1977. Without population shifting to a greater percentage of persons in the younger and the older groups and an ever smaller proportion of the population in the middle age groups, there is arising a greater demand for the home economist to expand her knowledge in the areas of community and family service. Inevitably, this work of the home economist will border on and overlap that of other service professions--social work, public health, family counseling, and nursing to mention only four (14). In this overlapping function of the future home economist, there is a growing need for the development of in home health care information for those giving or supervising the in home health care of the geriatric age group afflicted with chronic ailments.

The importance of nutrition to the health status of the elderly is a well recognized fact. In the 1971 White House Conference on Aging Report it was shown that one-half to one-third of the health problems of the aged were related to inadequate nutrition (15). Although all people need the same nutrients, the amount needed varies as the individual proceeds through the life cycle. For example, the elderly--particularly women--need considerably less food energy and lesser amounts of some nutrients than do younger people (16).

The Para-Professional Field is Created

The nutrition field developed their own group of para-professionals due to agencies expanding their programs to aid the disadvantaged, legislative measures enlarging the opportunities for job training, and technological advances providing new services that needed to be manned (17). Reasons that the para-professionals are now used include:

1. In the human services occupations there is a trend now to open up and enlarge opportunities for employment in them.
2. There are not enough professional personnel to deliver the services needed, so the para-professional is used.
3. Auxiliary personnel are proving their effectiveness.
4. Statistics indicate that jobs for professionals and technicians are growing at a faster rate than for skilled craftsmen.
5. Recent federal legislation encourages and sometimes requires the use of the para-professional (18, pp. 325-331).

As noted earlier there are public agencies created to help the senior citizen remain in his own home. These agencies utilize the services of the para-professional and include such programs as:

1. Expanded Food and Nutrition Education Program
2. Public Health Home Health Aide Program
3. Homemaker Health Aide Service Training Program
4. National Council for Homemaker-Home Health Aide Services, Inc.
5. Visiting Nurse's Association
6. Homemaker UpJohn's.

So rapid has been the increase in the number of para-professionals in the homemaker home health services that by 1966 a threefold expansion in three years of the programs had occurred. Seventy percent of the nation's citizens, if they applied for the service, had it in their respective communities (19).

Who Pays the Health Care Bills

The primary expenditure areas for the senior citizen are medical costs, housing related expenses, and food (1) (2). Medicare assists most persons over age 65 with the costs of professional medical services. For the low income persons, there is also Medicaid (in most states) and welfare can assist with the costs of living expenses for food and housing if the recipient has been approved by that agency.

Considerable emphasis has been placed on programs, agencies, and the costs of geriatric health care. But where do the dollars for these expenditures come from and which age group spends the most?

The government office of Research and Statistics gives us this picture. During the year 1970 for the persons under 19 years of age, $9.3 billion were spent on health care with the public paying 27% of this bill and the patient's family paying 73%. For the persons 19 to 64 years old, $33 billion were spent annually with the public picking up the tab for 22% and private individuals paying 78%. Looking at the older individual's health services in 1970, the public then paid 68%, and the individual 32% of the $15.7 billion spent.

In 1970 the major health expenditures were for hospitalization. The division of these costs were $372 per capita for persons over age 65; $141 for the 19 to 64 year old age group; and only $33 per person under 19 years of age.

Other health services were listed as $282 per capita for the elderly; $91 for the middle age group; and $49 for those under 19 years of age (20). Currently for an ill person these figures average much higher according to Blue Cross and the American Hospital Association.

They now calculate hospital charges per person per day at over $100. Due to these increased costs, in home health care becomes more important.

The Professional Nurse Gives In Home Health Care

The role of the professional nurse, like that of the home economist in the in home health care field, is changing as more management responsibilities in both the hospital and the community are assumed. In extending the scope of nursing practice in the field of gerentology, functions for which many nurses are now prepared include:

1. Assessing physical status of a patient at a sophisticated level.
2. Making adjustments in medications; initiating requests for laboratory tests and interpreting them; making judgements about the use of accepted pharmaceutical agents; and determining the care setting (institution or home); and making referrals.
3. Conducting community clinics for screening.
4. Assuming continuing responsibility for acquainting selected patients and families with the implications of health status, treatment, and prognosis (21).

The hospital personnel are realizing that they have an important function in getting the patient returned to his own home and in a state of health where he can fend for himself before the 90 days of Medicare are used by the patient. They are helping patients to adjust to living outside of the institution by encouraging self help wherever feasible, by having them wear street clothes in the wards as soon as they are ambulatory or able to get in a wheelchair (whichever comes first), assisting with their own medications (instruction given regarding side effects, purpose of medicine, etc.); and assisting or totally managing

personal care (22). One advantage of involving the patient in his care plan is that it helps to retain a favorable self image of the patient toward recovery and creates within him a sense of responsibility for his own recovery.

Some of the metropolitan hospitals maintain an "on the grounds" small cottage or apartment to help make the transition to in home health care and living easier for the patient, his mate, and other family members (23).

In a position paper prepared for the 1971 White House Conference, The National Council on Homemaker-Home Health Aide Service noted that Medicare provides funds for in home health care of some older people. Homemaker services have been mandated for the elderly receiving public assistance who are in need of such service (7).

For compliance with government regulations, guidelines regarding the role of dietitians and nutritionists were developed by the American Dietetics Association in collaboration with the Division of Chronic Disease, United States Public Health Services in a workshop held February 1964. These were later refined in 1966 with the ADA responsible for companion guidelines for dietitians and nutritionists (24).

In order to maintain high standards for Home Health Agencies, a nationwide program for accreditation was initiated in 1976 with 73 home health and community nursing services being listed on the accreditation list as of April 1, 1976. The in home health care services has on its board representatives from the American Dietetics Association, American Occupational Therapy Association, American Physical Therapy Association, American Speech and Hearing Association, National Association of Social Works, Inc., National Council of Homemakers-Home Health Aid Services,

Inc., and medical representation from the Medical Care Section of the American Public Health Association, as well as nurse members of the Accreditation Standards and Review Committee (25). Incidently, no agency for Oklahoma was listed among the 73 home health agencies, but a number of states were represented by the Visiting Nurses Association and the Public Health Nursing Association.

Two Ailments of Provider Concern

The two principal ailments of the patients that most concerned the providers in northwestern Oklahoma were functional psychosis and arteriosclerosis. The functional psychological disorders include paranoid state (associated with grandoise or persecution delusion), acute and chronic anxieties, depression, suicides, hyperchondriais, personality disorders, drug induced problems, and reversible brain syndromes. Communities, families, providers, and potential providers can help prevent some of the mental health problems of the elderly by taking steps to involve them. In 1969, Dr. Francis J. Thomas, R. N., confirmed her hypothesis that the patients in their own home remained mentally alert much better than the institutionalized person. Her studies showed that the greater the social involvement (interpersonal and non-interpersonal), the higher the level of mental health status of the person (26).

Arteriosclerosis was of great concern to the providers as the cholesterol blockage of the arteries to the brain frequently resulted in an uncooperative patient. Arteriosclerosis is one of the several forms of cardiovascular disease. Statistics from the American Heart Association show that 53% (1971) to 56% (1974) of all deaths in the nation were caused by cardiovascular disease. There are three million known cases of

arteriosclerosis plus an estimated three million unrecognized cases according to a 1970 figure (27).

In Home Health Care Program Studied

The particular in home health care program in which this researcher was involved, was found in 1970 as a result of federal legislation followed by the joint effort of the Oklahoma Nurses Association and the Oklahoma State Department of Institutions, Social, and Rehabilitative Services joining forces in their common concern to meet the state's need to improve care to low income elderly citizens. The first teaching done in the non technical medical care program utilized the Red Cross Home Nursing program of teaching. Later diversional activities, nutrition, rehabilitation and the use of commodity foods were added. As time passed a teaching manual was developed. After the providers had completed a series of classes using the ten chapter manual, the providers desired to expand their in home health care learning with in service education on topics of their choosing. In northwestern Oklahoma, two of the topics chosen were "Arteriosclerosis" and "Functional Psychosis".

Summary

Chapter II reviews the factors in a nation's changing economic-social-political life that has given rise to governmental regulations of the health services for the elderly, especially the low income senior citizen.

CHAPTER III

METHODS AND PROCEDURE OF THE STUDY

This study was made to determine by an interview the opinion of providers concerning the effectiveness of information that has been presented in the instructional program presented. The second objective was to obtain the opinion of the providers regarding what subject matter and what location (in home or in a class) should be used in presenting future instruction to provoders of in home health care. The third objective was to make recommendations regarding the instruction of providers that will be giving in home health care to elderly low income home bound individuals in the future.

When work was started with the providers in 1970, there was marked hesitancy on the part of providers in some communities to have a group meeting or class. One fear (expressed later) was that the instructors would embarrass them with questions and give tests. Through sincere concern by this researcher, good rapport was established with the providers as concern was displayed in things of interest to them such as their tomato patch, prize winning quilt at the county fair, or worries about "Grandma Jones not eating any breakfast this morning."

At the beginning, teaching was done entirely during the home visit by this researcher, for example, helping change a dressing on the patient's decubitus. As the provider observed the procedure, the importance of personal cleanliness and the other needs of the patient could

be explained. By working side by side on equal terms with the patient and the provider, the researcher shared information. At the same time, hopefully, the patient would assume more care of himself as his health condition improved.

Gradually group meetings were initiated so the providers could get acquainted and could learn more about taking care of their patient. The first lesson for the providers in a group meeting usually dealt with personal care of the patient or learning how to take and record vital signs--temperature, pulse, and respiration. The providers later selected what they wanted to learn.

The lessons on arteriosclerosis emphasized the importance of nutrition in the selection of food. This class was presented by reviewing the basic food groups (which had been taught about previously), explaining how restricted blood circulation affected the patient, and consumer education. One aspect of consumer education was studying package labeling on such products as oleomargarine, salad dressing, non-dairy creamers, and vegetable oils commonly used by the typical homemaker in meal preparation and the serving of the food.

The lesson on functional psychosis stressed the importance of good family relations. Especially emphasized was the acceptance of all members of the family and the feeling of a bond among all members for the common benefit of the family unit.

Development of the Instruments

Two instruments were developed (see appendix). The first was used to determine the provider's opinion of the effectiveness of the in home health care instruction. The second instrument asked the providers their

opinion regarding how to improve instruction of future in home health care. Questions asked were related to the information presented during previous instruction periods. The providers responded to the opinionnaire as follows: (1) definitely improved my attitude and ability; (2) helped considerably; (3) helped some; (4) were of little value; and (5) did not apply to patient care.

The second instrument, "Provider's Opinion on How to Improve Instruction for Future in Home Health Care Teaching", was concerned with the improvement of instruction for future in home health care classes and if the information should be presented in a class (group session) or in the home (one to one basis). The responses used for this instrument were (1) more time; (2) same time; (3) less time; or (4) discontinue the service in question.

The providers were also given an opportunity to comment on both of these instruments. For efficiency in handling, the comments, with the provider's approval, were condensed into a summarizing statement. The actual discussion of a specific topic may have taken the provider up to half an hour.

The interview technique was used by the researcher to obtain the provider's opinion of the items under consideration on both of the instruments. From the interview the researcher learned modifications to incorporate into future proposed teaching and suggestions on how the changes might be implemented to be most effective. This detailed information would not have been possible to obtain except through a personal interview with the provider.

For the pretesting of the interview instrument, two groups were used since it was not feasible to use providers in another district of

the state. One group was composed of five college students in the College of Home Economics majoring in Family Relations and Child Development. They were not directly acquainted with geriatric health care problems but understood teaching needs and the concerns for health care of elderly citizens. Another group testing the same instruments, was composed of two individuals of the geriatric age group who were mentally alert and active citizens in their community. Both had good health, but were concerned for many friends and neighbors who had developed an increasing number of health problems as they grew older. Of special concern to them was future emphasis on illness prevention and health maintenance.

With the pretesting information as a guide, the statements for the instruments were re-written and refined when reviewed by the thesis committee. Item number 15 regarding special clothes for the handicapped (such as one with a paralyzed arm or the one without a foot) was suggested by one of the college home economics students. This student was concerned about the social impact on the patient in not having clothes that minimized the affliction.

Selection of Providers for Study

Twenty-one women who had participated in the initial series of ten in home health care classes as well as having attended the follow-up classes on arteriosclerosis and functional psychosis were asked to evaluate the home teaching program. All of the women chosen were still employed as providers. During the interview conducted in the provider's home, this researcher verified information previously obtained regarding the provider's personal social history. Following the verification, the

opinion of the provider was sought concerning the effectiveness of the information that had been presented in the instructional program, and the opinion of what subject matter and what location (in the home or in a class) should be used in the future in presenting information about in home health care.

Utilization of the Instruments

With the instruments ready for utilization, this researcher made phone calls to the providers in northwestern Oklahoma to arrange for tentative interview appointments. The shortest interview took about an hour and half including the discussion concerning general health information.

In conducting the interview, the items were asked as they appeared on the instruments and the provider's personal-social history information form was verified. Most of the providers discussed their answers as they gave them in order to explain why they gave the answers they did. During the interview a listing of questions the provider wished discussed were kept by the interviewer. After the interview these questions were discussed and the other information was sought for those problems for which the interviewer did not have the information.

Bulletins from the extension services, Heart Association, Cancer Society, Arthritis Foundation, Respiratory Disease Association, and others had been collected to distribute to providers as the visits were made. All of the information had been previously studied so it could be located quickly if needed.

All of the providers were cooperative and appeared anxious to participate in this study. This interest and patient care service indicated

these 21 women were dedicated in striving to give good health care and derived a personal satisfaction in helping a neighbor or friend less fortunate health wise than they were.

Sometimes a husband or children or both were in the room during the interview. They also expressed their concern regarding the plight of elderly citizens, their financial limitations in striving to obtain adequate medical services, and other similar senior citizen problems. In several instances a neighbor, recognized the interviewer's car, and came to the provider's home during the visit. In one case the visitor wanted a food exchange list for a diabetic relative and another the address of the state cancer society.

One of the providers graciously invited in several other providers after notification of plans of the researcher to be in the community on Monday. Using the instruments, the group members (that were qualified under the limitations) were interviewed. A lesson was then taught about the relationship of nutrition to some of our cardiovascular health problems.

The longest interview took about four hours. One of the biggest problems was to move along and avoid discussing points that would modify the provider's answers. It was a disadvantage to the researcher in these cases to know the providers so well--the very quality that enabled this writer to do the best work in helping the providers to give optimum patient care.

Chapter III has described an <u>in home health care</u> program as well as describing the sample selected, the development of the instruments, and the interview. Chapter IV will be concerned with analysis of the data.

CHAPTER IV

PRESENTATION AND DISCUSSION OF THE DATA

The purpose of this chapter is to summarize the results of interviews with the providers who participated in the study. Three objectives were developed for the study. The first objective was (1) to obtain the opinion of the providers concerning the effectiveness of information that has been presented in the instructional program; (2) to obtain the opinions of the providers regarding the subject matter and where (in the home or in a class) the teaching should be done in the future for in home health care instruction; (3) to make recommendations regarding the instruction of providers that will be giving in home health care to elderly low income home bound individuals in the future.

Table I gives the age grouping of the providers, their marital status, number of dependent children, and formal educational background. Eleven (52.4%) were over 61 years of age. Ten of the ladies (47.6%) were married with family responsibilities. Ten of the ladies in this study (47.6%) had never attended school beyond junior high. While verifying the provider personal-social history, three of the providers reported having acquired their 12th grade education as a result of the GED tests taken following the initial in home health care classes conducted in their community. Five providers (23.8%) were responsible for 15 children.

TABLE I

BACKGROUND CHARACTERISTICS OF THE PROVIDERS
N = 21

Description	N	%
Age of Providers by Age Brackets		
15 to 20	1	4.7
21 to 30	1	4.7
31 to 40	2	9.5
41 to 50	3	14.3
51 to 60	3	14.3
61 to 70	6	28.6
over 70	5	23.8
Marital Status of the Providers		
Married	10	47.6
Single	3	14.3
Widow	8	38.1
Divorced	0	0
Formal Education Level of the Providers		
6th grade	2	9.5
7th grade	0	0
8th grade	5	23.8
9th grade	3	14.3
10th grade	2	9.5
11th grade	3	14.3
12th grade	5	23.8
13th grade	1	4.7
Dependent Children of the Providers		
One with 4 children ..... ages 9, 12, 13, and 15		
One with 1 child ..... age 18		
One with 2 children ..... ages 7 and 9		
One with 4 children ..... ages 12, 15, 16, and 17		
One with 4 children ..... ages 7, 14, 17, and 18		

A number of these women had reared families of eight, nine, and ten children plus later rearing grandchildren (information reported to interviewer by the providers). Table II provides information related to the work experiences of the providers. These ladies gave provider services to in home health care patients for a grand total of 137 years and were also employed in other work areas for 104 years. In this study, homemaking was considered a type of employment because of the value of this service to the families involved.

TABLE II

WORK EXPERIENCE AND TOTAL YEARS OF EMPLOYMENT OF THE PROVIDERS
N = 21

Description	Number
Work Experience of the Providers	
Hospital work	43 years
Baby sitting	11 years
Took in ironing	7 years
Telephone operator	13 years
Laundry worker	1 year
Bookkeeper	9 years
Cafe employee	11 years
Clerk	9 years
Total Years of Employment of the Provider	
Provider services	137 years
Employed in other areas	104 years
Family homemaker	over 650 years

Considering the cost of nursing home care ($450 to $650 for board and room services for 2 patient room in nursing homes in northwestern Oklahoma) it is important to note how many of the former patients (only one) had been transferred to a nurshing home. This is an economic factor to the taxpayer for the welfare cases and of sociological and psychological importance to the patient and his family. On the personal-social history the providers reported twenty-eight patients that they had served either died in their home or a hospital and were never admitted to a nursing home (see Table III). The providers further commented during the interview that when the cases merited it, the patients were hospitalized but not warehoused and forgotten. They further reported that the local family physician gave the patients their medical care. (See Comments in Appendix.)

TABLE III

REASONS IDENTIFIED BY PROVIDERS FOR CASE TERMINATION

Patients deceased	28 patients
Patient moved to live with children	3 patients
Provider became ill	1 case
Patient transferred to a nursing home	1 case
Patient became too difficult to handle in home	1 patient

One provider reported that she had served one patient for over 15 years. The shortest reported case was almost a month. The median provider service period by a provider was three years.

Analysis of the Effectiveness of the In Home Health Care Classes

Objective one of this study was to obtain the opinions of the providers concerning the effectiveness of the instruction in helping the providers learn how to give better in home health care. Through the use of an opinionnaire during the interview, the provider evaluated each of the 20 topics of information as (1) definitely improved my attitude and ability; (2) helped considerably; (3) helped some; (4) were of little value; and (5) did not apply to patient care.

Questions one through seven dealt with nutrition and foods (Table IV). Areas identified by the providers were the class had "definitely improved my attitude and ability" were "understanding the nutritional needs of the senior citizen" (14 persons or 66.6%); "plan better menus to meet dietary needs of an elderly person" (11 persons or 52.4%); "why I need to encourage my patient to eat prescribed diet" (11 providers or 52.4%); and "realizing that no one ever outgrows the need for a balanced diet" (14 providers or 66.6%). The area of "shop more efficiently for my patient" was marked as "helped some" by nine persons (42.8%). Some qualified this statement in their comments by the fact that the "patient's daughter does the shopping" or "patient orders groceries by phone and the store delivers them." (See Appendix B.)

Eight persons (38.1%) felt that the instruction helped considerably in "modifying family menus for the needs of the elderly." In a few cases the food was prepared in the provider's home then taken to the patient's home. In most instances the food was prepared for the patient in the patient's home so there is not the need for the family diet

TABLE IV

EFFECTIVENESS OF IN HOME HEALTH CARE CLASSES IN LEARNING ABOUT NUTRITION
N = 21

Home Health Care Classes Have Helped Me..	1*		2*		3*		4*		5*	
Item	N	%	N	%	N	%	N	%	N	%
1. Have a better understanding of the nutritional needs of senior citizens.	14	66.6	3	14.3	4	19.0	0	0	0	0
2. Plan better menus in order to meet the dietary needs of an elderly person.	11	52.4	5	23.8	5	23.8	0	0	0	0
3. Shop more efficiently for my patient.	6	28.6	2	9.5	9	42.8	4	19.0	0	0
4. Modify the family menus for the need of the elderly.	5	23.8	8	38.1	7	33.3	1	4.7	0	0
5. Understand the "high cholesterol" problem in relation to possible health changes as one ages.	8	38.1	4	19.0	6	28.6	2	9.5	1	4.7
6. Understand why I need to encourage my patient to eat the prescribed diet.	11	52.4	5	23.8	3	14.3	2	9.5	0	0
7. Realize that no one ever outgrows the need for a balanced diet.	14	66.6	2	9.5	3	14.3	2	9.5	0	0

1* Definitely improve my attitude and ability.
2* Helped considerably.
3* Helped some.
4* Of little value.
5* Did not apply to patient care.

In class, however, most of the providers indicated they felt they should be aware of diet modifications even if they were not currently doing this.

Only one person (4.7%) felt that the information regarding "high cholesterol" did not apply to patient care. She further qualified her statement by commenting that her patient was not afflicted with this problem. This was the only instance in the nutrition area where "does not apply to patient care" was marked (see Table IV).

Questions eight through 15 dealt with psychologically related problems of the elderly (see Table V). Part of the providers felt they were already interested in the elderly or they would not be doing the work they were. This may have affected their marking of number eight statement which stated, "definitely improved my attitude toward the elderly population." Eight persons (38.1%) gave it a "definitely improved" mark while eight persons (38.1%) felt it "helped considerably." No statement in the group between eight and number 15 received a mark of "little value."

The providers considered "realize the importance of attitude toward my patient" of greatest importance (14 providers or 66.6%) in being able to meet the psychological care needs of the patient and also in the provider being able to give optimum care. This point had previously been strongly emphasized during the instruction period.

In the teaching of the unit on psychological problems of the aged, a series of slides were used. From the slides of problems, possible causes for each problem was discussed. This slide program was considered beneficial to the providers so may have been a factor in their considering item 10 "realize there are many causative reasons why an elderly

TABLE V

EFFECTIVENESS OF IN HOME HEALTH CARE CLASSES IN LEARNING ABOUT PSYCHOLOGICAL PROBLEMS
N = 21

Home Health Care Classes Have Helped Me..	1*		2*		3*		4*		5*	
Item	N	%	N	%	N	%	N	%	N	%
8. Improve my attitude toward the elderly population.	8	38.1	8	38.1	4	19.0	1	4.7	0	0
9. Be more aware of changes in my patient's mental attitude which I need to observe.	10	47.6	4	19.0	3	14.3	4	19.0	0	0
10. Realize there are many causative reasons why an elderly person develops acute depression.	13	61.9	3	14.3	3	14.3	2	9.5	0	0
11. Communicate an understanding of the patient's emotional needs to others.	9	42.8	6	28.6	4	19.0	2	9.5	0	0
12. Realize that many of the emotional problems of the elderly are similar to ones that confront persons of all ages.	11	52.4	5	23.8	3	14.3	2	9.5	0	0
13. Realize the importance of my attitude toward my patients.	14	66.6	3	14.3	3	14.3	1	4.7	0	0
14. Realize the importance of personal care to the elderly person's mental outlook and feeling of self worth.	12	57.1	3	14.3	3	14.3	3	14.3	0	0
15. Realize that every individual must have the right to decision making and responsibility within his ability.	10	47.6	4	19.0	4	19.0	3	14.3	0	0

1* Definitely improved my attitude and ability.
2* Helped considerably.
3* Helped some.
4* Of little value.
5* Did not apply to patient care.

person develops acute depression" by 13 persons (61.9%) as being of second importance.

"Realize the importance of personal care affecting the mental outlook of the patient" was considered third in importance (12 providers or 57.1%). The patient who receives good care of his personal and physical needs feels better toward himself, so is motivated to recover and become a part of the social order rather than remain isolated (homebound) and forgotten by his fellowman.

In the opinionnaire, 11 providers (57.1%) indicated that by "realizing that many of the emotional problems of the elderly are similar to persons of all age groups" the provider could better accept the patient. No matter what the age that one is, there may be periods of loneliness, feeling rejected, isolated, and helplessness. With the elderly, loneliness may be accentuated because of their physical infirmities that limit their agility to be mobile on their two feet and have the hand dexterity formerly enjoyed. No items were marked in the last column "did not apply to patient care."

Turning to Table VI, we find that apparently the providers enjoyed most of the classes and the fellowship of meeting together as seventeen persons (80.9%) marked question number 16 "have an opportunity to exchange ideas with other providers giving care under a similar situation" as "definitely improved my attitude and ability." Two (9.5%) marked this item as "helped considerably."

"Understanding of scientific information presented in lay terms" was marked by 16 respondents (76.2%) as "definitely improved my attitude and ability" while five persons (23.8%) felt it "helped considerably" and two people (9.5%) credited it with "helping some."

TABLE VI

EFFECTIVENESS OF IN HOME HEALTH CARE CLASSES IN LEARNING ABOUT COMMUNICATIONS
N = 21

Home Health Care Classes Have Helped Me..	1*		2*		3*		4*		5*	
Item	N	%	N	%	N	%	N	%	N	%
16. Have an opportunity to exchange ideas with other providers giving care under similar situation.	17	80.9	2	9.5	2	9.5	0	0	0	0
17. Understand scientific information because it was presented in a way I understood it.	16	76.2	5	23.8	2	9.5	0	0	0	0
18. Become more observant of illness symptoms.	11	52.4	8	38.1	2	9.5	0	0	0	0
19. Know what I need to report to the family doctor before I contact him.	10	47.6	5	23.8	4	19.0	1	4.7	1	4.7
20. Be aware of the importance of telephone emergency numbers posted in large print by the patient's phone.	11	52.4	5	23.8	3	14.3	2	9.5	0	0

1* Definitely improved my attitude and ability.
2* Helped considerably.
3* Helped some.
4* Of little value.
5* Did not apply to patient care.

Questions 18, 19, and 20 were related to provider communications. Twenty was being prepared for an emergency with special telephone numbers being listed by the phone in large print for the patient (or the provider who has limited vision) to get help when it is needed. There were eleven (52.4%) that felt the telephone numbers were "definitely a help."

Recommendations of How to Improve Instruction for Future In Home Health Care Teaching

This section of the instrument, reported in Table VII, was divided into two parts. The two parts are "Information which should be taught by the supervisor in the home" and "Information which should be taught by the supervisor in class" with the same 16 items considered in both locations. When the items were considered under "taught by the supervisor in the home," the respondents (66.6%) indicated they preferred "more" time spent on in home teaching except for item 13 "medicine problems of the elderly" where 12 respondents (57.1%) indicated they were satisfied with the amount of teaching being done.

Two questions were considered for "class only" instruction. These were item 14 (learning about legal rights of the elderly) to be taught by a member of the law profession and a listing of various "health problems of the elderly" (item 16). Nineteen persons (90.5%) wished more instruction while two persons (9.5%) suggested that the amount of instruction remain the same. For "legal rights of the elderly," 15 persons (71.4%) desired more classes while 18% wished the instruction level to remain the same.

TABLE VII

NUMBER AND PERCENTAGE RESPONSES TO OPINIONNAIRE ON HOW TO IMPROVE INSTRUCTION FOR FUTURE IN HOME HEALTH CARE TEACHING

N = 21

In Home Health Care Services to be Taught

Item	Supervisor Instruction in the Home								Taught by Supervisor in a Class							
	N	1* %	N	2* %	N	3* %	N	4* %	N	1** %	N	2** %	N	3** %	N	4** %
1. Preparation of special diets	17	80.9	3	14.3	1	4.7	0	0	17	80.9	3	14.3	1	4.7	1	4.7
2. Information to consider in purchasing food	15	71.4	3	14.3	3	14.3	0	0	9	42.8	2	9.5	9	42.8	1	4.7
3. Knowledge about a balanced diet	15	71.4	3	14.3	3	14.3	0	0	11	52.4	7	33.3	3	14.3	0	0
4. Dietary relationship to health	16	76.2	3	14.3	2	9.5	0	0	4	19.0	5	23.8	4	19.0	0	0
5. Relationship of physical and mental health	15	71.4	5	23.8	1	4.7	0	0	14	66.6	5	23.8	2	9.5	0	0
6. Common mental health problems of the elderly	16	76.2	5	23.8	0	0	0	0	14	66.6	6	27.1	1	4.7	0	0
7. Spiritual needs of the elderly	17	80.9	3	14.3	1	4.7	0	0	13	61.9	6	27.1	2	9.5	0	0
8. Stress factors affecting the aged	19	90.5	2	9.5	0	0	0	0	11	52.4	5	23.8	5	23.8	0	0
9. Leisure time activities to keep the elderly constructively occupied and happy	15	71.4	3	14.3	2	9.5	1	4.7	4	19.0	10	47.6	6	28.6	1	4.7
10. Personal care needs of the bed patient	15	71.4	5	23.8	0	0	1	4.7	13	61.9	7	33.3	1	4.7	0	0
11. How to move a patient to and from a wheelchair	17	80.9	3	14.3	1	4.7	0	0	11	52.4	9	42.8	1	4.7	0	0
12. How to obtain help from a community agency	15	71.4	4	19.0	2	9.5	0	0	11	52.4	7	33.3	2	9.5	1	4.7
13. Medicine problems of the elderly	8	38.1	12	57.1	0	0	1	4.7	16	76.2	5	23.8	0	0	0	0
14. Legal reights of the elderly (presented by a lawyer..for class consideration only)									15	71.4	4	19.0	2	9.5	0	0
15. Special clothes problems of the handicapped	14	66.6	2	9.5	5	23.3	0	0	9	42.8	6	27.1	3	14.3	3	14.3
16. Health problems of the elderly									19	90.5	2	9.5	0	0	0	0

1* Supervisor spend more time
2* Supervisor continue same amount of time
3* Supervisor spend less time
4* Discontinue

1** Conduct more classes
2** Conduct same amount of classes
3** Conduct fewer classes
4** Discontinue classes

From the comments, it was learned that in class teaching is preferred to "teaching in the home," though the reverse had been true before the class instructional service was initiated. When teaching is done in the home, more teaching was requested in almost all areas.

Review of Comments

Space was left below each item in the instrument to facilitate the writing of comments made by the provider (see Appendix B). Comments were usually summarized because the discussion was often long and detailed. In most cases the provider did the summarization in one short emphatic statement expressing her sentiments on the particular item under consideration. In comparing the personal-social history of the providers with their answers, it was noted that the older ones had no interest in foods and nutrition, while the younger providers were interested in this area of patient care. Examples of some of the comments in the various areas were:

Foods and Nutrition--

> I need extra help with certain dietary problems regarding my patient which will need to be taught in the home so he will accept the prescribed diet.
>
> I hadn't realized that my patient needed to stay on a special diet. She takes a diabetic pill and we both thought that took care of her problem. After class I realized the importance of diet for her.
>
> I'm worn out with years of cooking.

Psychology--

> The spiritual is a very important part of my patient's care. I read the Sunday School lesson and we have daily Bible reading. The minister sends taped sermons to her.

Nurses in the home and the family need to understand what is stress for a patient.

The minister is not the only one in the church. How about some of the 'people' helping my patient, too.

Each person has a responsibility when young to develop an interest in life outside of themselves.

The elderly have so little to look forward to. It's all downhill from here on out. I need to turn my patient around and help push her uphill.

If a person loses his right to decision making, he just as well be dead.

Communications--

It is necessary to make an elderly person feel needed. One learns from living . . . so there are a lot of things they can tell you. In their loneliness, they need to talk--to speak of their children. Most of them are really interesting to listen to as they reminisce.

. . . Home nursing is personal and we providers become deeply involved emotionally with our patient. My family is more involved with the patient than her own family.

These lessons made me aware of the help available from the police department.

The classes built up good relations between us doing in home health care--we know who to call in our community to discuss a patient's problems. Also the classes have made people in the community more willing to keep elderly in the home . . . that is if the older person chooses to remain in his own home. I know I want to stay in my own home as long as I can think.

The social order of society tends to group people rather than consider them as individuals. In their struggle to remain a "person," the elderly wish to retain their identity as a resident in their own home, though physical and mental infirmities limit some of the elderly from functioning independently. This struggle of the recipient to be so regarded can be seen throughout the provider's comments.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

As a result of an ever increasing senior citizen population in this nation, a continual spiraling of the costs of professional health care services, and an increase of governmental financed programs for the low income geriatric ill persons, more in home health care programs will no doubt be developed in the future. In order for these new programs to be of optimum value to the elderly, this study was proposed.

The three objectives developed for this study were:

1. To obtain the opinions of the providers concerning the effectiveness of information that has been presented in the instructional program.
2. To obtain the opinions of the providers regarding what subject matter and where (in the home or in a class) the teaching should be done in the future for in home health care instruction.
3. To make recommendations regarding the instruction of providers that will be giving in home health care to elderly low income homebound individuals in the future.

Interview instruments were developed to assist the researcher in studying the effectiveness of information presented to providers of in

home health care. An opinionnaire was used to obtain from the providers their recommendations for future teaching in both the home and the class setting as well as learning her opinions about the subject matter to be considered and where she preferred the teaching done--in the home or in a class.

The group studied consisted of 21 white female providers who gave in home health care to elderly low income individuals in their community. They were compensated for their services by the State of Oklahoma welfare department. The patient or their family had hired the provider to give this service.

The majority (14) of the providers in the study were over 50 years of age. Only one had any formal education above high school and three had taken the GED test after becoming involved in in home health care classes. For the 21 ladies of this study, their provider services totaled 137 years. They had also been employed in other services for 104 years and had over 650 years of service as a homemaker.

Analysis of the data showed that the providers preferred instruction given in class. They reported gains from both what the instructor had presented as well as the opportunity to exchange ideas with other persons giving care under similar circumstances. They indicated that the instruction in the home should be expanded, especially on items that need to be demonstrated and require the patient's cooperation to carry out the activity. They expressed a strong interest in psychological problems associated with the aging process. Understanding of scientific information expressed in lay terms was important to 16 providers (76.2%). During the interview, the providers displayed an interest in expanding the use of teaching aids such as slides, films,

charts, and other visuals.

According to the comments of the providers, information regarding special clothes for the handicapped should be presented to the patient's family since they were the ones that usually selected the patient's clothing. The providers considered this to be the supervisor's responsibility to initiate communication to the family as the supervisor should have a clearer understanding of the patient's needs and how to manage the problem correction. They did state that the supervisor needed to add more information in her teaching so the providers were aware of the various types of prosthesis for the mastectomy patient, special garment closures for the arthritic hand patient, and ways to de-emphasize through clothes that a patient did not have his or her leg or foot.

Over 70 percent of the providers recommended the supervisor spend more time teaching the following in the home:

1. Preparation of special diets (80.9%)
2. Purchasing food (71.4%)
3. Balanced diets (71.4%)
4. Relationship of diet to health (76.2%)
5. Relationship of physical and mental health (71.4%)
6. Common mental health problems (76.2%)
7. Spiritual needs (80.9%)
8. Stress factors (90.5%)
9. Leisure time activities (71.4%)
10. Personal care needs (71.4%)
11. Moving patient to and from a wheelchair (80.9%)
12. Assistance from community agencies (71.4%)

Over 70 percent of the providers recommended more classes be conducted on the following:

1. Preparation of special diets (80.9%)
2. Legal rights of the elderly (71.4%)
3. Health problems of the elderly (90.5%)

In general, the providers in this study indicated that they preferred group (class) instruction when the subject matter was directly related to the care problems of the person they were attending. Certain procedures, especially those where a demonstration was desired, needed to be taught in the home with both the patient and the provider involved, as they would actually both be actively participating in this service. Other activities which required decision making or when a specific body of information was needed were better presented in a class with no patient present. In the class the instructor could present new materials and the providers could exchange ideas about giving in home health care to a particular patient or to patients.

Conclusions and Recommendations

This researcher foresees an ever increasing demand for in home health care due to the personal wishes of long-term patients and the ever mounting cost factors. People need to be offered health care information in their own communities in order for them to feel secure in caring for a loved one safely and efficiently at home. Perhaps more high schools should add a unit on geriatrics and/or utilize the American Red Cross Home Nursing Program in Home Economics III and IV. Gerentology is being studied by some extension clubs and perhaps these programs will need to be expanded as a greater percentage of our

population becomes age 65 and older.

Federalization of in home health care regulations to a greater degree will no doubt bring about more changes in the health care delivery systems. On going research by home economists and other groups involved in the giving of in home health care is needed to provide further input for modifications for future programs. The past five years of Medicare have resulted in the creation of changes in the concepts of care for the elderly persons. The next five years with National Health Insurance being contemplated will no doubt result in vast reorganization of the health care. New programs are being written with these changes in mind. Studies need to be conducted to find better ways of communicating the need for in home health care services to the citizens in this state.

REFERENCES CITED

(1) U. S. Department of Health, Education, and Welfare, Office of Human Development, Administration of Aging. New Facts About Older Americans. Washington: U. S. Government Printing Office, DHEW Publication No. (SRS) 73-20000006, June, 1973.

(2) Research Study, Special Unit on Aging, Department of Health Studies, University of Oklahoma. The Older American. University of Oklahoma Press, 1971.

(3) U. S. Department of Health, Education, and Welfare. Health in the Latter Years of Life. Rockville, Maryland: National Center for Health Statistics, 1971.

(4) American Association of Retired Persons. "Older Americans United to Reform Medicare." American Association of Retired Persons News Bulletin, Vol. 17, No. 2 (February, 1976), p. 6.

(5) "Non Technical Medical Care in Own Home: Introduction to the Program." Handout written by Nurse Supervisors II. Oklahoma City: Department of Institutions, Social, and Rehabilitative Services, August, 1971.

(6) U. S. Department of Health, Education, and Welfare, Unit on Aging, 1971 White House Conference on Aging. 1971 White House Conference on Aging--Recommended for Action--Planning. Washington: U. S. Government Printing Office, 1971.

(7) U. S. Department of Health, Education, and Welfare, Unit on Aging, 1971 White House Conference on Aging. 1971 White House Conference on Aging--Recommended for Action--Health Care Strategies. Washington: U. S. Government Printing Office, 1971.

(8) American Nurses Association. Position Paper: Educational Preparation for Nurse Practioners and Assistants. New York: American Nurses Association, 1965.

(9) Department of Institutions, Social, and Rehabilitative Services. (Handout prepared by staff). Oklahoma City, Oklahoma. (No date or page number.)

(10) U. S. Department of Health, Education, and Welfare. Medicaid-Medicare. Medical Service Administration, Social, and Rehabilitative Services. Washington, D. C.: DHEW Publication No. (SRS) 73-24901 (No date or page number).

(11) "The Time Has Not Come." New Republic, Vol. 149, No. 60 (November 9, 1963), pp. 27-28.

(12) Association of Administrators of Home Economics. National Goal and Guidelines for Research in Home Economics. East Lansing, Michigan: Information Services, Michigan State University, 1970.

(13) Wang, Virginia Li, and A. M. Hill. "Extending Home Economics to Health Care Services." Journal of Home Economics, Vol. 63, No. 5 (March, 1971), pp. 350-355.

(14) McGrath, Earl J., and Jack T. Johnson. The Changing Mission of Home Economics, A Report on Home Economics in the Land-Grant Colleges and State Universities. New York City: Teacher's College Press, Columbia University, 1968.

(15) Montgomery, James E. "Magna Carta of the Aged." Journal of Home Economics (Special Issue; Working With the Elderly), Vol. 65, No. 4 (April, 1973), pp. 6-13.

(16) Pao, Eleanor M., and Mary M. Hill. "Diets of the Elderly, Nutrition Labeling and Nutrition Education." Journal of Nutrition Education, Vol. 6, No. 3 (July-September, 1974), pp. 96-99.

(17) "Paraprofessionals in Connecticut Human Service Agencies." Journal of Home Economics, Vol. 63, No. 9 (December, 1971), pp. 681-682.

(18) Mallory, Bernice. "Auxiliary Workers in Today's Society." Journal of Home Economics, Vol. 63, No. 5 (May, 1971), pp. 325-331.

(19) Prichard, Keith, and Mary R. Hall. "Attitudes of Aides and Clients." Journal of Home Economics, Vol. 63, No. 7 (October, 1971), pp. 545-548.

(20) The Size and Shape of the Medical Care Dollar: Chart Book for 1970. The Office of Research and Statistics, Social Security Administration. Washington, D. C.: U. S. Government Printing Office, 1970.

(21) "Extending the Scope of Nursing Practice." American Journal of Nursing, Vol. 7, No. 12 (December, 1971), pp. 2346-2351.

(22) McGriff, Dr. Erline. "Humanistic Approach in Caring for the Aged." (Workshop report) Department of Continuing Education for Nursing, Division of Nursing Education. New York: New York University, August 14-18, 1972.

(23) Shepard, Katherine F., and Louise M. Barsotti. "Family Focus--Transitional Health Care." Nursing Outlook, Vol. 23, No. 8 (September, 1975), pp. 574-577.

(24) "Home Health Services." Journal of the American Dietetics Association, Vol. 52, No. 5 (May, 1968), pp. 381-385.

(25) "Home Health Agencies and Community Nursing Services Accredited by NLN/ALPHA." Nursing Outlook, Vol. 24, No. 4 (April, 1976).

(26) Thomas, Dr. Frances J. "Social Involvement and Other Correlates of Psychological Health and Longevity: A Prospective Study of Other Subjects." (Report of Dissertation reviewed in Nursing Research Report), Vol. 5, No. 3 (September, 1970), pp. 1-6.

(27) National Nursing Conference: Post Hospital Care of Coronary Patient. A report from the National Nursing Conference held at John Marshall Hotel, Richmond, Virginia, February 25-26, 1970, p. 13.

APPENDIX A

INSTRUMENTS

PROVIDER PERSONAL-SOCIAL HISTORY

Name_____Birth year_____

Address_____

Marital status: ____married; ____single; ____divorced; _____widow.

Ages of dependent children_____

Formal education_____

In home health care experience, how long worked, and why case terminated.

Comments:

OPINIONNAIRE OF THE EFFECTIVENESS OF IN HOME HEALTH CARE CLASSES

You, as a provider, have attended in home health care classes. In order to give guidance to improvement of the quality of future teaching for provider, will you please answer the following questions regarding previously presented class information. Check (✓) in the appropriate space. This information will remain confidential.

The in home health care classes have helped me to.....	Definitely improved my ability and attitude (1)	Helped considerably (2)	Have helped some (3)	Were of little value (4)	Did not apply to patient care (5)
1. Have a better understanding of the nutritional needs of senior citizens.....					
2. Plan better menus in order to meet the dietary needs of an elderly person.....					
3. Shop more efficiently for my patient.....					
4. Modify the family menus for the needs of the elderly.					
5. Understand the "high cholesterol problem" in relation to possible health changes as one ages.....					
6. Understand why I need to encourage my patient to eat the prescribed diet.....					
7. Realize that no one ever outgrows the need for a balanced diet.....					
8. Improve my attitude toward the elderly population....					
9. Be more aware of changes in my patient's mental attitude which I need to observe.....					
10. Realize there are many causative reasons why an elderly person develops acute depression.....					
11. Communicate an understanding of the patient's emotional needs of others.....					
12. Realize that many of the emotional problems of the elderly are similar to ones that confront persons of all age groups.....					
13. Realize the importance of my attitude toward my patient.....					
14. Realize the importance of personal care (bath, combed hair, neat clothes) to the elderly person's mental outlook and feeling of self worth.....					

Rating Scale	1	2	3	4	5
15. Realize that every individual must have the right to decision making and responsibility within his ability.....					
16. Have an opportunity to exchange ideas with other providers.....					
17. Understand scientific information because it was presented in a way I understood it.....					
18. Become more observant of illness symptoms.....					
19. Know what I need to report to the family doctor before I contact him.....					
20. Be aware of the importance of telephone emergency numbers posted in large print by the patient's phone.....					
21. Do you have suggestions for other things that need to be taught? Please list.					

INTERVIEW FOR PROVIDER'S OPINION ON HOW TO IMPROVE INSTRUCTION FOR FUTURE IN HOME HEALTH CARE TEACHING

Considering the economics of in home health care costs, more support will become necessary in our society. To enable persons to become qualified to give this type of care, there is a growing need to form organized classes as well as to give individual instruction in the home.

Below is a list of services which may be needed in giving care to the elderly in his own home. Please indicate the ways you believe would be the best way to learn about these by checking the appropriate place under TAUGHT IN A CLASS AND SUPERVISOR INSTRUCTION IN THE HOME. This information will remain confidential.

HOME HEALTH CARE SERVICES TO BE TAUGHT	TAUGHT IN A CLASS: Discontinue classes	Conduct fewer classes	Conduct same amount of classes	Conduct more classes	SUPERVISOR INSTRUCTION IN THE HOME: Discontinue	Supervisor spend less time	Supervisor continue same amount of time	Supervisor spend more time
1. Preparation of special diets.....								
2. Information to consider in purchasing food..								
3. Knowledge about a balanced diet.....								
4. Dietary relationship to health.....								
5. Relationship of physical and mental health..								
6. Common mental health problems of the elderly.....								
7. Spiritual needs of the elderly.....								
8. Stress factors affecting the aged.....								
9. Leisure time activities to keep the elderly constructively occupied and happy.....								
10. Personal care needs of the bed patient.....								
11. How to move a patient to and from a wheelchair.....								

IN HOME HEALTH CARE SERVICES TO BE TAUGHT	1	2	3	4	1	2	3	4
12. How to obtain help from community agencies.....								
13. Medicine problems of the elderly.....								
14. Legal rights of the elderly (presented by a lawyer...for class consideration only).....								
15. Special clothes problems of the handicapped.....								
16. Health problems of the elderly (class only)								
a. Cancer.....								
b. Kidney problems.....								
c. Arthritis.....								
d. Stroke.....								
e. Heart.....								
f. Mental health.....								
g. Others...please list.....								

17. Please list on the reverse side of this page areas of health care which should be considered for future classes and if you prefer them taught in the home or in a class. Thank you for your help with this project.

APPENDIX B

COMMENTS FROM PROVIDERS

COMMENTS FROM PROVIDERS

OPINIONNAIRE OF THE EFFECTIVENESS OF THE IN HOME HEALTH CARE CLASSES

The in home health care classes have helped me to.....

1. Have a better understanding of the nutritional needs of senior citizens.

   My patient prepares her own meals so I am not responsible for helping her with her nutritional needs.

   Definitely liked this provider's meeting. Want more foods classes.

2. Plan better menus in order to meet the dietary needs of an elderly person.

   This lesson helped, plus the experience I have had with other patients. I am now a better cook.

   My patient is not on a special diet.

   Lesson made me stop and think. It carried over into improving my cooking at home for my family as well as that of the patient.

3. Shop more efficiently for my patient.

   Daughter of the patient does the shopping.

   Patient orders groceries by phone and they are delivered.

   I have always had difficulty shopping for myself. These lessons were a help since I now have to shop for my patient.

   Patient is very finicky in diet planning. Suggestions helpful.

4. Modify the family menu for the needs of the elderly.

   Must consider this family resources...information helpful.

   Excellent ideas, as I take some food from my home for the patient's meals.

5. Understand the "high cholesterol problem" in relation to possible health changes as one ages.

   Need more lessons on this. I am trying to buy groceries differently, but feel it is too late to really help me or my patient a lot.

   Had difficulty in understanding some of the information.

   Especially enjoyed this information.

Can this be discussed more in our schools. My children just gripe about school lunches. Maybe if they understood nutrition (and I understood it better) their health would be better. I don't want my family to have the nutrition problems that I see in my patient.

This is not a health problem of mine or my patient...at least the doctor never has told me it was. Maybe this is why my patient is so difficult at times. Maybe her blood vessels are "clogged" partway and she can't think like she wants to.

I can understand the use of corn oil and not lard, but can't see why it takes so long to bother one and how it (cholesterol) piles up inside of a blood vessel.

6. Understand why I need to encourage my patient to eat the prescribed diet.

Patient will stay on diet only part of the time. She has no teeth.

Hadn't realized my patient needed to stay on a special diet because she took a diabetic pill. After class realized the importance of the prescribed diet for her. She used to always be clammy or want to sleep all of the time. Now she eats the diet the doctor wants her to and does not have to take the pill. It is more economical for her as far as her food bill goes.

It has been very difficult to keep my patient on her diet. The lesson you taught in our home really helped both of us. The patient would accept what the nurse said about her diet, but refused everything she should eat before. She wanted to eat just what she liked. Diabetics, especially, need to be taught in the home.

I need more patient cooperation. It is impossible to get my patient to eat right. You quit at the wrong time. Someone needs to teach both of us together so any food problem can be worked out with the three of us planning together.

No special diet.

Patient is cooperative...has salt free diet.

7. Realize that no one ever outgrows the need for a balanced diet.

Can't help my patient here. She has lived so long eating in her own way that she is not going to change now. I am not even going to try to get her to change.

I want to know more about vitamins, minerals, proteins, fats, and carbodhydrates. Nurse needs to discuss this with many patients for their sake.

8. Improve my attitude toward the elderly population.

"I have always loved old people."

"I try to go along with my patient's views and be cooperative."

"Already loved the elderly..that is why I am working with them."

9. Be more aware of changes in my patient's mental attitude which I need to observe.

"My patient's mind tends to wonder at times, but now I realize that I can help her more than I was."

"I do a better job looking for little things now."

"Don't think I understand and know when a person first starts thinking not right, but am aware when the problem gets bigger. I will start trying to help my patient earlier."

"My patient is still mentally alert and almost 90."

10. Realizing there are many causative reasons why an elderly person develops acute depression.

"I can better understand this problem now."

"My patient is very jealous and wants lots of attention. Lesson helped."

"Lesson helped me understand myself."

"Haven't they (elderly people) always gotten the "blues" easily? I can sure see why they do, too."

"The elderly have so little to look forward to. It's all downhill from here on out. I need to push my patient uphill."

"Kindness really helps."

11. Communicate an understanding of the patient's emotional needs to others.

"Best child gets worse treatment from elderly parent. Nurse can help correct this."

"I still can't really tell someone how I feel an elderly person is thinking."

"I have discussed my patient's emotional needs with her son, but he can't do anything to help his stubborn mother."

"Got a lot of help out of this."

12. Realize that many of the emotional problems of the elderly are similar to ones that confront persons of all age groups.

"This helped so much in raising my four grandchildren and in taking care of my patient. They are <u>really</u> a lot alike."

"Everyone needs to be wanted and have attention."

"We should have known this, but when we forget the "Golden Rule" we lose consideration. Old people are not different, just older and more experienced."

13. Realize the importance of my attitude toward my patient.

"Remember they may think like children and most of us realize how important our attitude is with our children."

"Definitely important."

"My patient has a terrific fear of storms, tho I try to help her. My attitude toward storms is seeming to help."

14. Realize the importance of personal care to the elderly person's mental outlook and feeling of self-worth.

"My patient is immaculate."

"Most definitely...Personal care is a big lift. My patient goes regularly to the beauty shop."

"I think I have always understood this as I know how important it is for me to be clean and neat."

"I know, but can't get this point across to my patient."

15. Realize that every individual must have the right to decision making and responsibility within his ability.

"My patient likes to make decisions."

"If they have no right to decision making they just as well die."

"Give the patient credit for his ideas."

"My patient makes out grocery list and selects pills of her medicine."

"I don't like to be bossed and don't suppose others do either."

16. Have an opportunity to exchange ideas with other providers giving care under similar situation.

"This has made my work so much more enjoyable. It is not a job but rather a service."

"Get lot of good ideas at our meetings."

"Winderful" "Excellent".

17. Understand scientific information because it was presented in a way I understood it.

"Nurse excellent in explaining...very few have ability to do this."

"Liked this, but did not understand a few things. I know I can always ask and that is something."

"Teacher did OK."

18. Became more observant of illness symptoms.

"I use this daily at home and at work."

"Am trying to do better. Needed this information 50 years ago."

"Very definitely helped."

19. Know what I need to report to the family doctor before I contact him.

"My patient objects to my going to her doctor for information, but somethings I have to know to give patient care."

"Managed a nursing home once so this is no problem for me."

"I can help patient more now."

20. Be aware of the importance of telephone emergency numbers posted in large print by the patient's phone.

"Very helpful."

"My patient can't see, but I use the idea at her home and at mine."

"I had experience before doing this."

"Did this after suggested in class instruction."

Have started this...Also started a 'phone club' for the welfare of us Senior Citizens.

21. Do you have suggestions for other things that need to be taught? (Only one did not make a suggestion.)

Improve school food and health education. Teacher brush over this part of teaching rather than realize that kids will learn if the subject is made fun. You did it in our class on foods and mental health problems...yet made us love the elderly. Even grade school

kids are smarter than some teachers realize. If we reach them, problems are less for them when they grow older.

I recommend that classes be taught more often and be offered community wide rather than just to the providers of welfare patients.

I am getting old. Hope someone stays with me when I need it. I want to stay in my own home and want someone who loves me to stay with me. Love makes the world go around.

Love they neighbor. You may be in their boat some day.

More of the same things we have been taught needs to be presented to more people. One never knows when you will be responsible for a homebound individual.

Make older persons feel needed. Remember they are older, and one learns from living...so there are a lot of things they can tell us...and in their loneliness, they do need to talk; to speak of their children. Most are really interesting as they reminisce.

If you hadn't "forced me to go that first time, I'd have missed all of this learning". I needed it for myself and the raising of my grandchildren. What you talked about in mental health sure has helped me deal with my grand kids... I think I am now more understanding and tolerant of them and my patient. At least we sure get along better. Sure wish you had more classes and taught more groups. Sure like the discussion part. It makes the lesson "jell" because we all think harder when you get to that part. You never get rattled when we stop you all along in class.

Like group meetings. We learn from teacher then improve our understanding my discussion with others in the class. Sometimes you teach so much we need time for it to "soak in" so glad you always have "handouts".

You need to reach high school girls, teen clubs, and other youth groups. Boys need to learn about nutrition, too. We like to be healthy as we get older. You have helped me to feel better acquainted with "old folks".

Appreciate teaching references and still use them. Would encourage you to do more teaching programs. Especially liked films and slides.

21. Desire more frequent clases. We felt important to learn and liked the papers you gave us to read at home. We could show these to a neighbor with a health problem.

Want more classes offered and would like them repeated as there is so much to learn. Need to have patients attend classes so they will understand why of nursing and medical care.

Get younger people involved. It is hard for older people to start to school. Like the lessons best that are about my patient or my own health problems.

Definitely like group meetings. I like the way they are taught and the teacher's respect of us. Like films and slides and use of blockboard. Nurse had personal relationship with each provider. Home care results in the provider becoming deeply involved with her patient emotionally. Families need to be more concerned about their old loved ones.

I now use teaching materials to help myself as I'm now a senior citizen. Classes very helpful...like exchange of ideas and films. This type of education needs to be included as part of program at senior citizen centers rather than the way some of them operate with all card playing and dominos. We also need more crafts or something we can do as a home activity and sell for money. We are all living on a limited income and Social Security. This is not enough to meet expenses of living in my own home that I have owned for years.

Classes build up good relationship between those doing in home health care--we know who to call in our community to discuss a patient problem. Also in home classes have made people more willing to keep the elderly in the home if the older person wants to live in his own home. I want to stay in my own home as long as I can think.

Most information better taught in class. The lessons teach how to make things more convenient for patient care (like a commode on newspapers and set at the bedside). This is important in keeping the patient happy and the provider not overworked.

Like group meetings as I get ideas from others. Like about home safety in regard to protection from thieves.

Would like more information on:

- Importance of medicine
- Activities for the homebound person
- Nursing tricks, such as the box at the food of the bed to prevent foot drop and the cardboard box cut to use as a cradle for caring for a diabetic ulcer on the foot.
- Was not aware of all the help available from the local City Police Department or the Cancer Society. Teaching helpful regarding the sick elderly as a person of worth to mankind.

The person I take care of has helped her neighbors when she could. Now she is old and sick. I still think of her as she once was. Now she wants to live at home and not feel like she is in a warehouse and forgotten; away from her friends in a big city nursing home. Her children live in the city, but they are too busy to give her the attention us neighbors do. She and others like her have faith in the family doctor. She has a right to find peace of mind among those she has loved and helped all of these years. She knows

her life is near the end. I feel she has a right to die at home (if her heart should suddenly stop) or in our local hospital if that is where she is at that time. I feel this way because she has told me this many times. The desires of the elderly should be respected. They are not puppets or machines.

COMMENTS FROM PROVIDERS

INTERVIEW FOR PROVIDER'S OPINION ON HOW TO IMPROVE INSTRUCTION FOR FUTURE IN HOME HEALTH CARE TEACHING

1. Preparation of special diets

   "Need extra help with certain special dietary problems regarding a patient which needs to be taught in the home so he will accept the diet."

   "Want 15 to 30 minutes on any problem that I need information. Don't rush teaching. Like in home teaching."

   "Hope I don't need this as diets always confuse me."

   "Want at least 15 to 30 minutes to discuss patient's problems. More time in teaching if I am having a problem."

   "Definitely want more classes!"

   "Spend at least 15 minutes on each topic in a home visit so I understand all you are trying to help me with."

   "I am not interested in foods."

   "Like supervisor to come often."

2. Information to consider in purchasing food.

   "Want more on how to buy for small families."

   "Don't buy food. Daughter buys food."

   "More on how to shop efficiently."

   "I'm worn out with years of cooking. Now just eat 'cause I have to and not right food. Use convenient food. I don't cook for my patient."

3. Shop more efficiently for my patient.

   "Not sure my meals are right."

   "Need knowledge about a balanced diet."

   "Can't change way old people eat."

4. Dietary relationship to health.

   "I've cooked so many years I'm tired of the subject."

4. (Continued)

"Some things need to be taught in the presence of the patient in the home or demonstrated in the home."

5. Relationship of physical and mental health.

"Need more information."

"Can't change the way I think now."

"Classes taught me a lot I never knew existed in this problem. I think more about a problem now and it saves me money on my doctor bills."

"Good to teach in the patient's presence so information can be explained to him."

6. Common mental health problems of the elderly.

"If we understand these in our patient, maybe we can prevent the same problems in ourselves when we get older."

"Definitely needed this lesson."

"Like to work with people that really need me."

7. Spiritual needs of the elderly.

"This is a very important part of my patient's care. I read Sunday School lesson and we have daily Bible reading. Minister sends taped sermon to patient."

"Minister is not the only one in church. How about the "people" helping my patient, too."

"Important with some patients. Don't change their religious beliefs. Need more big printed religious materials."

8. Stress factors affecting the aged.

"Nurses and family need to understand what is <u>stress</u> for a patient."

9. Leisure time activities to keep elderly constructively occupied and happy.

"My patient prefers to do her own housework tho she is blind."

"My patient can be happy with religious programs and is limited in things she can do. She has a good personality."

"Each person has a responsibility when young to develop an interest in life outside of themselves."

"Don't like to plan for anyone else. They need to know what they want to do before they get old."

"Start playing when young."

"My patient is not the temperment to do crafts."

"Senior citizen activities should have a worthwhile meaning to society."

10. Personal care needs of the bed patient.

"Need to review this information."

"Start younger to form good habits...then patient is cleaner to work with."

"Teach more about bed sores and why turning is essential. I use air mattress for my patient."

11. How to move a patient to and from a wheelchair.

"Teach in home and involve patient. He is the one moved."

"This help extra good in class. I didn't have to have home teaching then."

"Most providers don't know how to do this safely. Emphasize how to use a lift."

"I can't lift."

"Need to review information."

"I want extra help with patient when I have to move him."

12. How to obtain help from community agencies.

"I still don't understand about all of these. Doctor's need to tell patients more about these services."

"Doctor's need to know more about Red Cross and the Public Health Nurse...and use this information."

"Few community agencies in northwestern Oklahoma. It is not like in the city area."

"Not enough publicity in the rural areas about community agencies."

13. Medicine problems of the elderly.

"Need more knowledge."

"This is a confusing problem. Medicine bottles don't tell enough."

13. (Continued)

"Need to learn more."

"Continue to emphasize the importance and the relationship of one medicine to another and how they affect each other."

"We need to know more about reactions and how medicine acts when combined."

"Remember patient is forgetful. Provider may need to manage for safety of patient."

14. Legal rights of the elderly. (For class consideration only.)

"Very much needed."

"Involve patient in class if they are mentally and physically able."

"Really don't understand my rights so am not qualified to help someone else. Would welcome this lesson."

"Emphasize wills, estates, burial policy, etc."

"Need to know for management of my business and myself. Can't explain to someone else."

"Like to know my role...especially my rights."

"Very definitely needed lesson."

15. Special clothes problems of the handicapped.

"Be nice, but don't need for my patient."

"Home nurse does not select or purchase patient's clothes."

"No problem for my patient."

"Family needs to know how to choose garments!!! They don't appreciate my suggestions."

"Involve family as they are the one that buy clothes."

"Children of my patient buy too tight of clothes. They consider looks, not problems of putting it on patient."

16. Health problems of the elderly...Cancer, kidney problems, stroke, arthritis, heart, mental health, others. About everyone indicated need to discuss all of these, plus following comments.....

"Teach in class where we can ask questions."

16. (Continued)

"Need to reach more people."

"Definitely. Several classes on each subject."

"All important as classes."

One lady requested a special lesson on problems of the hard of hearing and how to improve care for them.

17. Discussion question.

"Like classes. Social part gives a chance for me to absorb the lesson as we visit about our own patients and problems. Like papers to take home and read. My children can read this information and do. It helps them in school."

"Sure appreciate home visits. You made me feel important in my job so I like it."

"I have enjoyed coming to all of the home nursing classes. Also I have learned a lot. Hope they will continue."

"Reach people before they get old. Then they will be better patients and more cooperative. Health care will be fun with a good instructor. My children are not getting this in school and they should. How do we reach school kids better? Everyone may someday have to be in a nursing home. How about upgrading them--get them out of politics. Why can't citizens be heard more in the nursing home business."

"Discuss with providers about making themselves mentally adjusted now for their golden age years."

"How about activities at Senior Citizens for fishing...locate the Centers near a pond. They can do minor repairs of household appliances. Utilize the potentialities of the elderly instead of warehousing them."

"Supervisor home visit just backs up what we learn as a group. Because of group, I can now phone neighbor with my problems and we can work some of them out. Saves doctor fees, too."

"Classes are a way to learn. Then when I see a problem on someone that is old and ill, I feel I have learned something in class so I can help the one in need."

"Like classes and the visiting we do reinforces the lesson."

"Would like this information given at church circles and women's clubs. I have enjoyed all of the classes and feel I've learned a lot."

17. (Continued)

"I truly think we have gained as much from the care of the elderly as they themselves have received. We realize more fully what we are facing, in our care and understanding of them, will--I hope--know and try to be prepared for our future old age. I don't like the word old, for it infers something of "no use", "worn out" and therefore we must learn we are still of some use as we grow older.

"Need to help patients to face problems realistically."

"Try to reach younger women. What you talk about now, I needed to start learning over 30 years ago."

"Need information on hearing problems. It is important to do a job the way the patient wants it done. Be sure and put things where the patient can find them. Encourage patients to write letters and when needed, write for them. Patients get lonely. They need more company...frequent short time visitors. Have churches have special senior citizen covered dish dinners one Sunday a month with a service keyed to their interests. Our church tried this. Remember the "provider is the most important person in the world to her patient."

"Liked classes as the instructor brought up interesting materials that I'd never think to ask about. I'd miss this if you did home visits only. This teaching has helped me to prepare for my "Golden Years". I want them to be full rich years."

VITA

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Candidate for the Degree of

Master of Science

Thesis: AN EVALUATION OF AN IN HOME HEALTH CARE INSTRUCTIONAL PROGRAM IN NORTHWESTERN OKLAHOMA

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