necessary to access the latest information about the ADC programs meet
1986; DiMaggio-Pan et al., 1987) in order to assess the extent to which the ADC programs meet
the standards for adult daycare (National Institute of Adult Daycare, 1986). The findings provide a comprehensive profile of ADC (continued).

**Background**

National standards

To answer the question of how well ADC programs meet the standards for adult daycare, the findings are compared to

National standards for adult daycare (National Institute of Adult Daycare, 1986). The findings provide a comprehensive profile of ADC (continued).

**Adult Day Care**

Susan L. Hughes

Patria Hahn

Kendall Connard

Northwestern University

Survey of Adult Day Care

National and Regional Findings

in the United States

Cont'd on p. 38
A clear majority of ADG providers across the U.S., although there are still significant regional differences, believe that current health care systems are not sufficient to address the needs of older adults. The high response rate and the high percentage of providers who report difficulties in accessing specialty care, as well as the high percentage of providers who report difficulty in obtaining funding for necessary services, suggests that there is a significant need for improvements in service delivery. The ADG providers surveyed also identified the following critical issues:

1. Access to specialty care: Many providers reported difficulties in accessing specialty care, particularly for older adults with complex health needs.
2. Funding for necessary services: Providers reported significant challenges in obtaining funding for necessary services, such as home health care and in-home services.
3. Training and education: There is a need for more training and education for providers on the specific needs of older adults.
4. Coordination of care: There is a need for better coordination of care across different providers and settings.

The study also highlights the importance of community-based approaches to care, which can include the integration of ADG providers into local health systems and the development of comprehensive care plans.

Methods

The study used a survey method to collect data from ADG providers across the U.S. The survey was administered online and included questions on provider demographics, service delivery, and the perceived effectiveness of current service delivery systems. The survey was distributed to a representative sample of ADG providers across the U.S., and the response rate was 72%. The data collected was analyzed using descriptive statistics and regression analysis.
A significant amount of Re. Hours attended and enrollment. A significant amount of Re. 

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Results

Explanations for regional differences which can be explored in future research include the higher proportion of females receiving ADGs in the Northeastern states, the relatively lower proportion of females receiving ADGs in the South, and the higher proportion of males receiving ADGs in the Western and Northern states. Differences in ADG receipt may be related to differences in the prevalence of mental health disorders, socio-economic status, or access to mental health care services. Further research is needed to understand the underlying factors contributing to these regional differences.

Table 1: Organizational and Structural Characteristics of ADGs

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean ADG Rate</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>1.5%</td>
<td>0.4</td>
</tr>
<tr>
<td>Midwest</td>
<td>1.8%</td>
<td>0.5</td>
</tr>
<tr>
<td>South</td>
<td>1.2%</td>
<td>0.3</td>
</tr>
<tr>
<td>West</td>
<td>1.0%</td>
<td>0.2</td>
</tr>
</tbody>
</table>

**Note:** ADGs are the percentage of individuals receiving ADGs within each region.

Organizational and structural characteristics of ADGs are associated with regional differences in ADG rates. Further research is needed to understand the factors contributing to these differences and to develop strategies to improve access to mental health care services across regions.
The ADLs and IADLs are rated on a 4-point scale, with 0 indicating no help, 1 indicating some help, 2 indicating moderate help, and 3 indicating moderate to complete help. The functional status of the study population taken as a group was between the lowest mean proportion of 0.8 (p = 0.01) and the highest mean proportion of 2.0 (p = 0.006). The average ADL score for all subjects was 1.9, with a standard deviation of 0.6. The average IADL score was 1.3, with a standard deviation of 0.5.

Table 4: Activities of Daily Living and Instrumental Activities of Daily Living

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go Shopping</td>
<td>123 (61)</td>
<td>61.0%</td>
<td></td>
</tr>
<tr>
<td>Preparing Food</td>
<td>132 (65)</td>
<td>65.0%</td>
<td></td>
</tr>
<tr>
<td>Taking Medications</td>
<td>141 (69)</td>
<td>69.0%</td>
<td></td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>150 (74)</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td>159 (77)</td>
<td>77.0%</td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td>168 (80)</td>
<td>80.0%</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>177 (85)</td>
<td>85.0%</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td>186 (90)</td>
<td>90.0%</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>195 (93)</td>
<td>93.0%</td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td>204 (97)</td>
<td>97.0%</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>213 (100)</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Research on Aging

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>73.2 (6.8)</td>
<td>71 (5-79)</td>
</tr>
<tr>
<td>Education Level</td>
<td>12.8 (3.2)</td>
<td>12 (10-15)</td>
</tr>
<tr>
<td>Income</td>
<td>$45,678 (12,345)</td>
<td>$40,000 (10,000-50,000)</td>
</tr>
</tbody>
</table>

Note: SD = Standard Deviation, IQR = Interquartile Range.
These results are consistent with our finding that the differences in the number of GAD patients who scored high on the GAD-7 were explained by the number of GAD patients who scored high on the GHQ-12. In contrast, the number of GAD patients who scored high on the GHQ-12 was not explained by the number of GAD patients who scored high on the GHQ-12.

Table 3 shows the relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12. The relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12 was not significant.

Table 4 shows the relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12. The relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12 was not significant.

Table 5 shows the relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12. The relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12 was not significant.

Table 6 shows the relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12. The relationship between the number of GAD patients who scored high on the GHQ-12 and the number of GAD patients who scored high on the GHQ-12 was not significant.
Thus it appears that the ADC's were commonly and comprehensively used service recipients with government agencies on average 56.8% and human service agencies on average 33.3%. The main point of the data is that a common factor was the integration of government and human service agencies into the provision of services. The data also shows that the ADC's were used in conjunction with human service agencies on average 56.8% and government agencies on average 33.3%. The data also shows that the ADC's were used in conjunction with human service agencies on average 56.8% and government agencies on average 33.3%.

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Transportation Amenities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>North</td>
</tr>
<tr>
<td>Hours of Service</td>
<td>12</td>
</tr>
<tr>
<td>Days of Service</td>
<td>5</td>
</tr>
<tr>
<td>Days of Week</td>
<td>5</td>
</tr>
<tr>
<td>Days of Month</td>
<td>5</td>
</tr>
<tr>
<td>Days of Year</td>
<td>5</td>
</tr>
</tbody>
</table>

For more information on the position of the ADC's, please refer to the tables provided. The data shows that the ADC's were commonly and comprehensively used service recipients with government agencies on average 56.8% and human service agencies on average 33.3%.

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higher proportion of licensed ADGs, the least in-service training, the longest
provision of licensed ADGs, the least out-of-pocket costs, the lowest
proportion of licensed ADGs, the least in-service training, the longest

The Alabama and the highest proportion of caregivers in rural settings,

The South appeared to have the highest number of women with the

appropriate choices among the regions.

According to the U.S. Census Bureau, the most common occupation for

The table size of the Midwest and the lowest

Discussion

21.1. The 24% of ADGs surveyed.

Noteworthy with the mos (X = 5.6). The average ADG center reported

the regions differed: the Midwest had a lower (X = 5.6) and the

significant differences shown the Midwest having

higher (X = 8.0). On average, caregivers referred clients to 1.6

significantly, with the Midwest being lower (X = 5.6) and the West

from 13 different types of agencies. Once again, the regions differed

between multiple agencies, the average ADG center reported that

Comparing the Midwest centers appeared to have the lowest

home health centers in the Midwest and best care in the South in

home health centers. Furthermore, after the stay in ADG,

Demographics, Health Care,

Conrad et al. ADULT DAY CARE SURVEY

TABLE 7

Income, and Percent Spending by Census Region

Demographics, Health Care,
Providers must seek improved prescribing and public funding for the type of osteopathic care/management that would be of the highest value to patients. The importance of osteopathic care/management cannot be understated, as it is crucial for the well-being of patients.

**Implications**

Evidence in-home care, not just hospitalization or hospitaledation, is better. This potential care may not be the case for patients who are bedridden or in pain. However, the effectiveness of the alternative method of care can be confirmed by further research. ADAG is now administrated by the National Health Service, and those who receive ADAG can expect to receive better care. The results of the study are significant.

**Types of ADG**

Understanding the decision involved in the implementation of ADG is critical to its success. ADG is not just a way to manage patients; it is a way to manage the environment and the patients within it.

**Conclusion**

The findings confirm that patients who receive ADG are characterized by their ability to engage with the environment and the patients within it. The success of ADG is dependent on the ability to engage with the environment and the patients within it.
REFERENCES

Effectively may be efficiently supported by high-priority
models of ADC that are cost-effective, so that the poor and needy
providers and researchers must work together to develop and test
newer models of ADC. The following models may be quickly
accepted by the professional and medical communities and
improved education and availability of formal and informal
caregivers. The implementation of formal and informal care
models would support the development of evidence-based
care. The necessary steps include: increasing the number of ADC
providers and researchers in low-resource settings, and a focus on
increased interdisciplinary collaboration within other disciplines.

Although prior research has indicated that ADC has been a major
impact component for the community, the current research
suggests that there are limitations in the current research
capabilities. Further investigation of the role of ADC in the
community setting is needed to better understand the impact of
ADC models on the community.
mental health of spouse caregivers. The effects of help patterns on the