

**PUERTO RICO:
LONG TERM CARE ENVIRONMENTAL SCAN**
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Presented to:

A.A.R.P.

by:

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INTRODUCTION

The Island of Puerto Rico is part of the Greater Antilles, in the Caribbean. Its geographic coordinates are latitude 18.5N and longitude 66.3W, which places it about 1,000 miles (1,600 km) southeast of Miami, Florida. At present, it is a self-governing commonwealth with strong political and economic ties to the U.S. The Island was a colony of Spain from 1493 to 1898. As a result of the Spanish American War, Puerto Rico was handed over to the U.S. Puerto Ricans are U.S. citizens by birth, not naturalized. They were granted citizenship by a 1900 decree. Puerto Ricans in Puerto Rico do not vote for the President of the U.S., have one representative at the House (without a vote), and can be enlisted in the U.S. Army. Puerto Ricans have fought in all wars that the U.S. has been involved in since the First World War. Five percent of the civilian population 18 years of age and older in 2000 was a U.S. veteran. As U.S. citizens, Puerto Ricans contribute to Social Security and have a right to receive Social Security entitlements as well as Medicaid.

Puerto Rico has a population density of about 1,084 persons per square mile (418 per square kilometer), which is greater than the density of any U.S. state. The 2000 United States Census reported that Puerto Rico had 3,808,610 inhabitants. On a ten-year period, the island's population increased 8 percent over the 1990 figure of 3,522,037 inhabitants. In 1940, two-thirds of the population of Puerto Rico lived in rural areas. The Census of 2000 census reported that less than 5.61 percent of the population remained in rural communities (US Census Bureau, Census 2000 SF 1). The rural-urban shift of population has been accompanied by transfers of commercial centers, services and amenities, as well as by a concentration and imbalanced distribution of health services for everybody in large or medium-size metropolitan areas such as San Juan, Guaynabo, Bayamón, Carolina, Ponce, Arecibo, and Mayagüez but particularly those directed toward the elderly.

Ninety-one percent of the inhabitants of the Island were born in Puerto Rico, according to the Population Census of 2000. Puerto Rico's ethnic composition is overwhelmingly of Hispanic descent. According to the Population Census of 2000, 99 percent of the population in 2000 was Hispanic. Ethnic origin was distributed as follows:

PUERTO RICO 2000: ETHNIC ORIGIN

Ethnic origin	Percent
Puerto Rican	95.1
Cuban	0.5
Mexican	0.3
Other Hispanic	2.8
Not Hispanic	1.2
Total	100.0

Source: U.S. Census Bureau, Census 2000, SF 1

Spanish is the main language and one of the two official languages of Puerto Rico; English being the other. Spanish is the language spoken at home for 85.4 percent of the population 5 years of age and old (U.S. Bureau of the Census, Census 2000 SF 3). Many residents of Puerto Rico also speak English. Yet, according to the last census, 72 percent of those who speak Spanish at home reported that they speak English "less than very well" (U.S. Bureau of the Census, Census 2000 SF 3).

The median age for the population of Puerto Rico is 32.1. Eleven percent of the population was 65 years of age and older and 19 percent was between the ages of five and fifteen.

The median annual household income in 1999 was \$14,412.00 and the median family income was \$16,543 (U.S. Bureau of the Census, Census 2000 SF 3). The 2000 Census also reported that 45 percent of the families in Puerto Rico in 1999 were below the poverty level; 52.6 percent with related children less than 18 years of age and 54.8 percent with related children younger than five years. Sixty-one percent of families headed by a female with no husband present were below the poverty level. Forty-four percent of the adults aged 65 and older lived below the poverty level in 1999.

According to the 2000 Census, 89.4 percent of the population can read and write. The educational attainment of those 25 years of age and older is:

Educational Level	Percent
Less than 5 th grade	10.9
5 th to 8 th grade	14.5
9-12 th grade w/ no diploma	14.6
High school diploma	22.3
Some college, no degree	12.2
Associate degree	07.2
Bachelor's degree	13.6
Graduate/Professional degree	04.7

Source: U.S. Census Bureau, Census 2000, SF 3

This report will focus primarily on adults 65 years of age and older as advancing age is closely related to a higher probability of chronic diseases, disabilities, and difficulties to perform activities of daily living; all of which have repercussions for long-term-care issues. However, information on people with disabilities will also be presented. According to the Census of 2000, 23 percent of all residents in Puerto Rico confronted a disability. Twenty-eight percent of those in the age group 21 to 64 had one or more disabilities. This made up a total of 588,234 persons. The proportion for those aged 65 and older was 59 percent of all elderly (246,523) and for children aged 5 to 15 it was seven percent or 46,579 children with disabilities.

The American Association of Retired Persons (A.A.R.P.) has taken the first step to conduct a comprehensive overview of the long-term care services industry in Puerto Rico. The report offers a general idea of the social, demographic, and health characteristics of the older population of Puerto Rico as well as facts concerning the mentally, physically and sensory challenged. It also presents a synopsis of the laws and regulations that affect long-term-care services in Puerto Rico and the role of key agencies. Statistical data on long-term-care services, particularly residential establishments and adult day care facilities, are also described. This examination of services, laws, and population characteristics will assist **A.A.R.P.**'s policy efforts to lead to a long-term care reform and help to establish a comprehensive array of quality services in Puerto Rico.

PUERTO RICO:

LONG TERM CARE ENVIRONMENTAL SCAN

I. The Aging of the Population of Puerto Rico

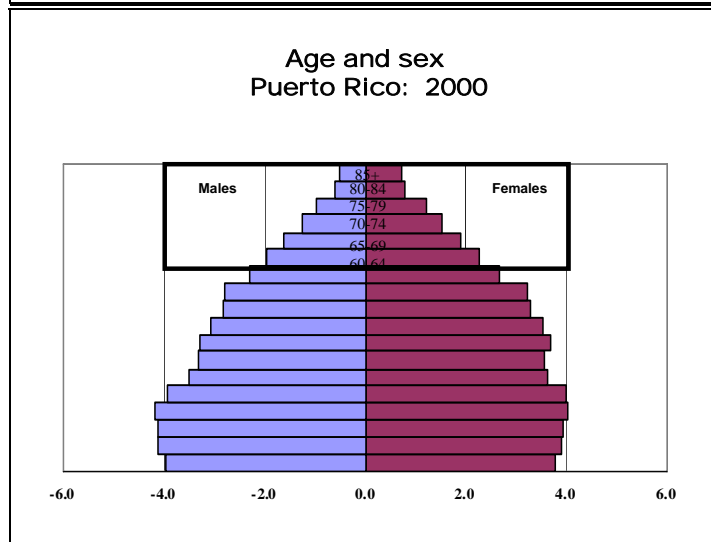
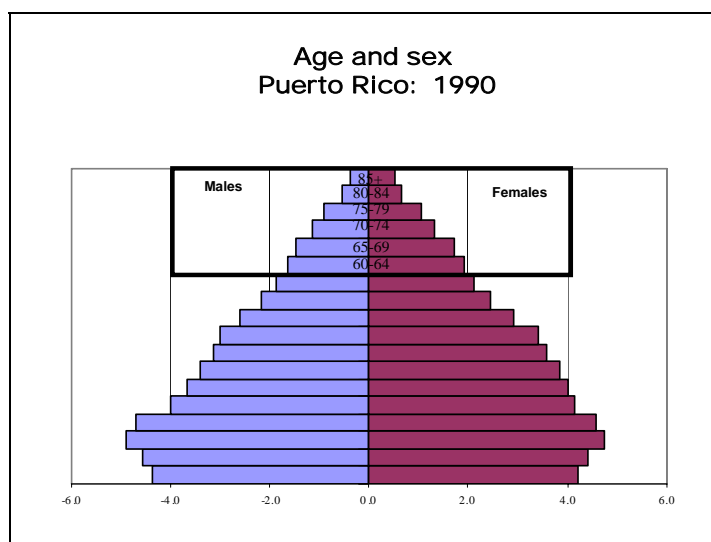
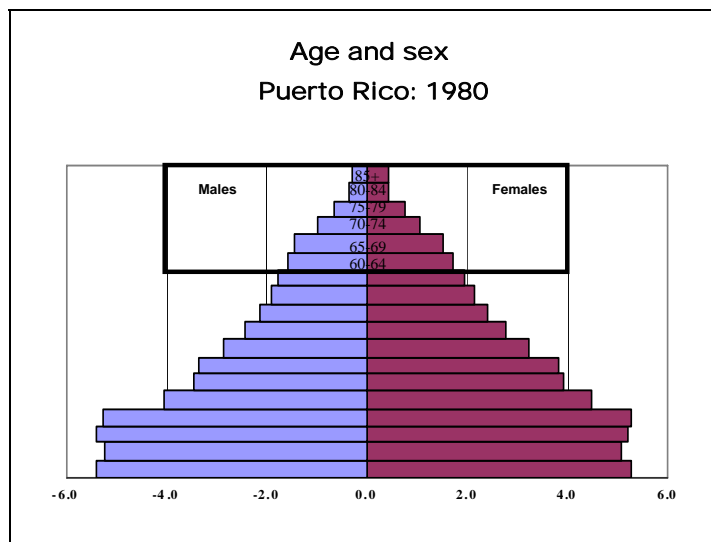
The rapid growth of the population 65 years of age and older in Puerto Rico, and the current and potential increase in the numbers of older adults presents a challenge to the long-term care services sector at a time when the country is undergoing important reforms of its health services. People 60 years of age and older accounted for 585,701 of the 3,808,610 inhabitants of Puerto Rico in the year 2000. According to the 2000 Population Census, 15.38 percent of the population of Puerto Rico had reached 60 years of age and over; 11.16 percent had reached 65, and older and 2.65 percent, 80 and older.

**PUERTO RICO 2000
PROPORTION OF POPULATION 60 YEARS OF AGE AND OLDER(
N= 3,808,610)**

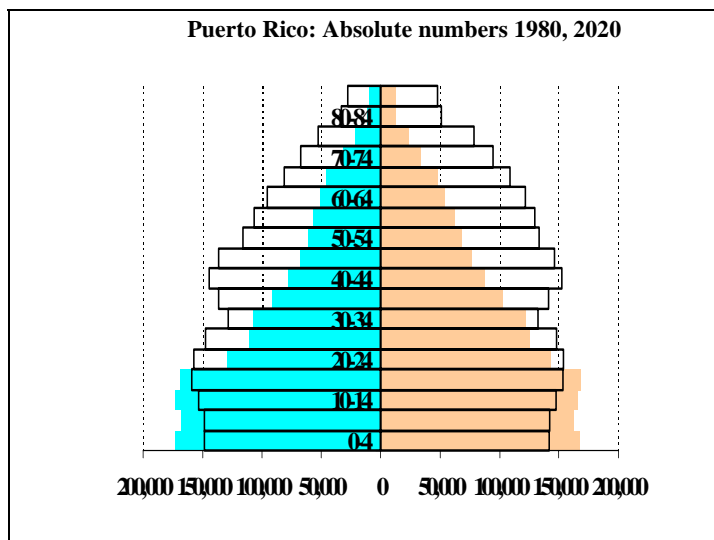
Age	Males	Females	Total
60+	14.21	16.46	15.38
65+	10.16	12.09	11.16
80+	02.28	03.00	02.65

Source: Mattei 2003

The composition of the population of Puerto Rico has changed sharply over the past 40 years. In a short span of time, the country experienced absolute and proportional increases of the population 65 years of age and older, comparable to those in more developed countries. The proportion of persons 65 and over in 1950 was only 3.88 percent, eight percent in 1980, and by 1990 it had increased more than twofold from 1950 to 9.68 percent. These proportions correspond to absolute increases from about 86,100 in 1950 to 341,443 in 1990 to 425,137 in 2000. The population pyramids that follow illustrate the trends in the aging of the population of Puerto Rico.



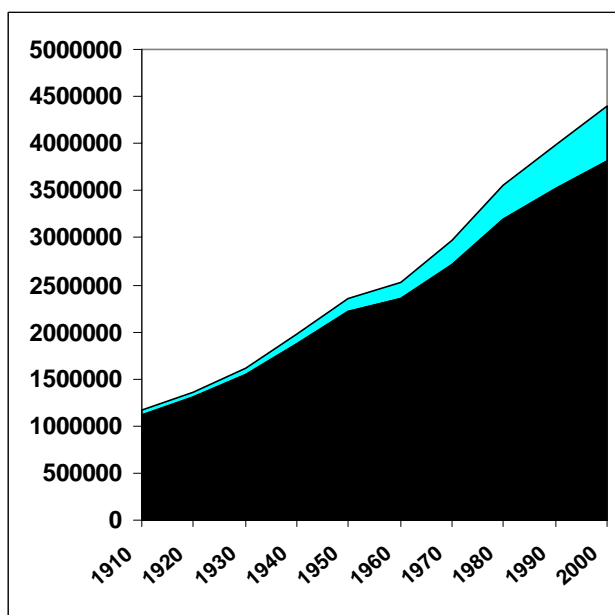
Source: Demography Program, Graduate School of Public Health UPR, 2003



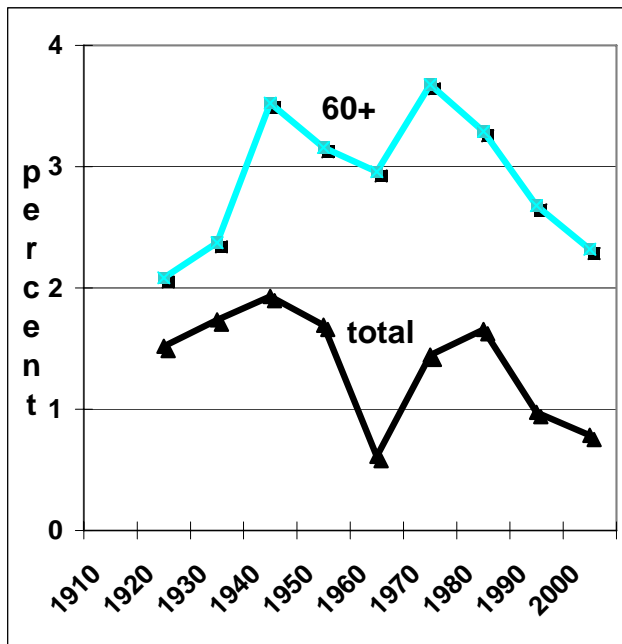
Source: Demography Program, Graduate School of Public Health UPR, 2003

Over the forty year period (1950 to 1990) of the rapid aging of Puerto Rico, the rates of increase of the population 65+ years of age and older hovered in the range .0310 to .0370, slightly less than twice the magnitude of the rates experienced by the same segment of the U.S. population between 1980 and 1990 (.0195) and considerably higher than the rates prevailing and expected to prevail in most developed countries (Palloni 1999). These trends remained virtually unchanged for the year 2000. When the baby-boom generation completes its entry into this age group around 2015, the relative size of the population 65 years of age and over will hover around 18 percent, very close to expectations for the U.S., Canada and most Western European countries (Sánchez-Ayénde & Carnivali, 1990). The graphs that follow illustrate the growth of the population aged 60 and older in Puerto Rico from 1910 to 2000.

PUERTO RICO, 1910-2000
TOTAL POPULATION AND POPULATION 60+, NUMBERS
 Project PREHCO, 2002



**PUERTO RICO, 1910-2000
TOTAL POPULATION AND POPULATION 60+, GROWTH RATE**



Source: Project PREHCO, 2002

According to the 2000 Census, the oldest-old (85+) comprise about 11.22 percent of the population aged 65 and older, 8.14 percent of the population aged 60 and older, and 1.25 percent of the total population. This is the segment of the elderly population that has increased fastest in the last decade, is expected to continue to do so, and is more likely to have functional problems, presents an increase in morbidity, shows more serious effects of chronic diseases, and has needs concerning long-term care. The Tables that follow indicate the growth of those 80 and older over the 10 year span between 1990 to 2000 and the distribution of the population 60 and older by age group in 2000.

**PUERTO RICO 1990-2000
ADULTS 80 YEARS OF AGE AND OLDER, GROWTH CHANGE,
IN PERCENTAGES**

Age	1990	2000	Change (%)
80+	73,665	101,108	37.3
85+	32,665	47,706	46.0

Source: Mattei 2003

PUERTO RICO 2000
DISTRIBUTION OF THE POPULATION 60 YEARS OF AGE OR OLDER
(N=585,701)

Age	Males	Females	Total	% 60+
60+	260,479	325,222	585,701	
60-64	74,276	86,288	160,564	27.41
65-69	60,982	73,299	134,281	22.93
70-74	47,461	59,209	106,670	18.21
75-79	35,996	47,082	83,078	14.18
80-84	22,697	30,705	53,402	9.12
85+	19,067	28,639	47,706	8.14
65+	186,203	238,934	425,137	72.59
75+	77,760	106,426	184,186	31.45
80+	41,764	59,344	101,108	17.26
85+	19,067	28,639	47,706	8.14

Source: Mattei 2003

The median age hardly suffered any significant changes from 1860 to 1960, staying at 18 years. However, it increased rapidly to 21.5 years in 1970 and to 28.5 in 1990. In 2000, the median age was 32.1 and it is projected that for 2020 it will have reached 37.3. It is expected that by the year 2020, 20.2 percent of the population of Puerto Rico will have crossed the 60 years of age threshold.

PUERTO RICO: MEDIAN AGE, 1950-2020

	1950	1960	1970	1980	1990	2000	2020*
Median	18.4	18.5	21.5	24.6	28.5	32.1	37.3
Males	18.2	18.0	20.8	23.6	27.3	30/4	
Females	18.6	18.9	22.1	25.5	29.6	33.7	

Source: Mattei 2003

The rapid rates of increase of the elderly population in Puerto Rico, and thus, the aging of its population, are the result of three factors: fertility decline experienced during the period 1950-1990, significant mortality improvements at all ages but particularly for ages 40 and above, and migration trends. Ten-year rates of increase of the population above 60 or 65 are affected by return migration from the U.S. by individuals who migrated young during the 1950s and 1960s and who return to spend their retirement years in the native land. Likewise, the fraction of the population older than 60 or 65 remains inflated by migration toward the United States by the adults 25 to 35 years of age. The decline in fertility has affected the proportion of elders in the population. During the period 1965-1980 the Total Fertility Rate (TFR) reached a value of about 2.6. Given that a decline of fertility also took place into the period 1980-1990, with TFR dropping to .50 children per mother, these changes will continue to have an effect on the aging of the population of Puerto Rico during the next decades. It is only when the birth cohorts born at the end of the period of fertility decline reach ages 60 or 65 (approximately during the year 2050) that fertility effects associated with the secular decline will cease to be important (Palloni 1999).

This aging process has also been affected by important gains in survival. Between 1940 and 1960, the crude death rate was reduced by more than half and life expectancy

increased from 46 to 69 years. By 1990, life expectancy had reached 74 years, a value that compares favorably with developed countries. An important part of this mortality decline is associated with the decline of mortality risks among infants and children. Infant mortality rate alone decreased from 55.1 per 1,000 to 13.5 per 1,000 between 1955 and 1990 (Palloni 1999). However, substantial improvements in survival have occurred also for young and middle aged adults and the elderly. The 1990 life table indicates that life expectancies at ages 65 and 85 in that year were about 17.55 and 6.64, respectively, slightly lower than values prevailing in the U.S. around the same time. (Palloni 1999). By the same token, the probability of surviving from age 65 until age 90 was .22 compared to .26 in the US around the same dates (Mattei 2003). This similarity can only be achieved through significant increases in survival among the elderly (Palloni 1999). During the period 1980 to 1990, life expectancies at ages 65 and 85 increased from 16.46 to 17.55 and from 6.19 to 6.74, respectively. During the same period, mortality in the age segment 45-64, a crucial factor determining the rate of increase of the elderly population in the next ten years or so, decreased substantially. The mortality rates in the four quinquennial age groups 45-49 to 60-64 decreased by 4.4, 15.1, 11.0, and 12.3 percent respectively; pushing the mean number of years lived between 45 and 65 from 18.65 to about 18.90 or about 26 percent of the total possible gains in years in the age interval (Palloni 1999).

Life expectancy in Puerto Rico for 2001 was 76.12; 72.28 for men and 79.90 for women (Demography Program 2003). The life expectancies for ages 65 and 85 were 18.26 and 6.44, respectively. The Table that follows contains information for ages 50 to 105 by five-year range age categories for the total population and by sex. Women show higher life expectancies than men from age 50 to 90. Beginning at age 90, men surpass their female counterparts in terms of life expectancy¹.

**PUERTO RICO
ABRIDGED LIFE TABLE FOR BOTH SEXES FOR AGES 50 TO 105, 1999-2001**

Age interval	Average number of years of life remaining at beginning of age interval		
	All	Males	Females
50-55	30.26	27.88	32.46
55-60	26.05	23.92	27.98
60-65	22.05	20.22	23.68
65-70	18.26	16.72	19.58
70-75	14.75	13.49	15.79
75-80	11.60	10.65	12.32
80-85	8.78	8.20	9.16
85-90	6.44	6.16	6.54
90-95	4.58	4.52	4.48
95-100	3.17	3.26	2.96
100-105	2.22	2.39	2.03

Source: Department of Demography, Graduate School of Public Health, UPR, 2003

The average annual period growth between 1990 and 2000 for the population of Puerto Rico was 0.8. It is expected that from 2000 to 2010 it will be 0.5 and for 2010 to 2020, 0.3 (Palloni 1999). Projections for demographic indicators for 2025 indicate a

¹ This trend could be attributed to extrapolations in the construction of the life table and should be considered carefully.

decline in annual rate of growth and births and an increase in deaths when compared to the year 2000.

**PUERTO RICO: DEMOGRAPHIC INDICATORS
2000 AND 2025**

INDICATOR	2000	2025
Births per 1,000 population	16	11
Deaths per 1,000 population	7	10
Annual rate of growth (%)	0.6	0.1
Total fertility rate (per woman)	2.0	1.9

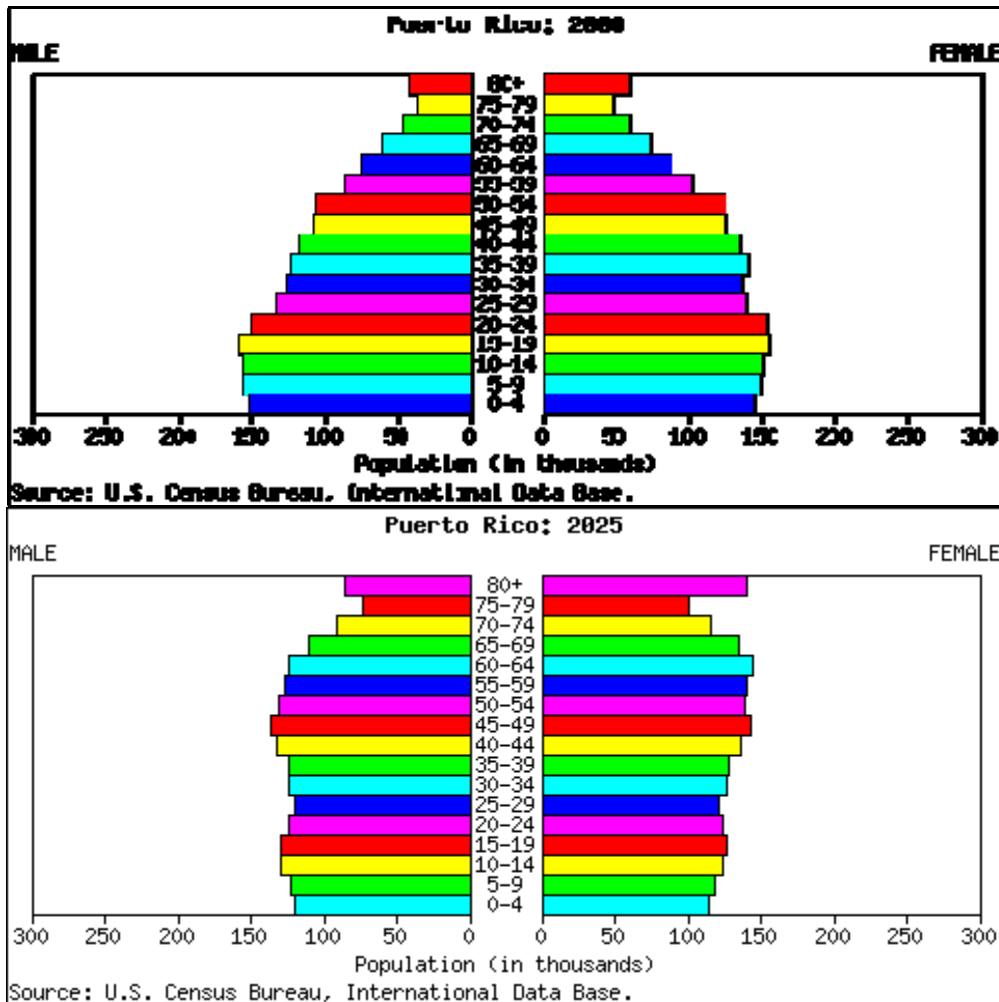
Source: U.S. Census Bureau, International Data Base, Oct. 2000 version.

**PUERTO RICO: 2000 AND 2025
MIDYEAR POPULATION, BY AGE AND SEX: (POPULATION IN THOUSANDS)**

AGE	-----2000-----			-----2025-----		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
TOTAL	3,816	1,837	1,979	4,181	2,003	2,178
0-4	296	152	144	234	119	114
5-9	306	157	149	241	123	118
10-14	306	156	150	253	129	124
15-19	314	160	154	256	130	126
20-24	302	150	152	247	124	123
25-29	272	133	139	242	120	122
30-34	263	126	137	251	124	127
35-39	265	125	141	253	124	128
40-44	251	116	135	268	132	136
45-49	234	108	126	280	136	143
50-54	230	106	124	270	131	139
55-59	189	87	102	266	127	140
60-64	161	74	86	268	124	144
65-69	135	61	73	245	110	135
70-74	107	48	59	207	91	116
75-79	83	36	47	175	73	101
80+	101	42	59	226	85	141

Source: U.S. Census Bureau, International Data Base, Oct. 2000 version.

As can be observed from the Table above, the population aged 65 and older, particularly 80 and older, will register important increases from 2000 to 2025. The population pyramids that follow illustrate this projection.



Puerto Rico's health transition was clearly ahead of the transition in most Latin American countries at the end of World War II, an historical hallmark for the dramatic transformation in survival conditions experienced by the continent. In the early 1950s, only a handful of countries had levels of infant mortality below 50 per 1,000 births around 1950 and Puerto Rico was among them. Yet, the country's mortality experience during the forty years that followed resembles more that of the rest of Latin America than the one of the U.S., Canada or other developed countries. In particular, the elderly of today residing in Puerto Rico (aged 60 or 65 and older) are likely to have had an experience with illnesses (particularly parasitic and infectious) more alike the experience of other countries in the continent than the one in the U.S. (Palloni 1999).

II. Profile of the Elderly Population of Puerto Rico

II. A. Select population characteristics

II. A. 1. Age, gender, education, marital status, and employment

Age and gender distribution

Women comprised the majority of adults 60 years of age and older in Puerto Rico, 55.53 percent in 2000. The proportion of women was greater than that of men in

all categories 60 years of age and over and this proportion increases with age. Females made up 56.20 of those 65 and older and 58.69 percent of adults 80 years of age and over. The Table that follows illustrates these trends.

**PUERTO RICO 2000
POPULATION 60+,
BY AGE CATEGORIES AND SEX**

	Males	Females	Total
Population	1,833,577	1,975,033	3,808,610
Age interval 60+			
60-64	74,276	86,288	160,564
65-69	60,982	73,299	134,281
70-74	47,461	59,209	106,670
75-79	35,996	47,082	83,078
80-84	22,697	30,705	53,402
85+	19,067	28,639	47,706
Population 60+ (N)			
60+	260,479	325,222	585,701
65+	186,203	238,934	425,137
80+	41,764	59,344	101,108
% Total population (N=3,808,610)			
60-64	04.05	04.37	04.22
65-69	03.33	03.71	03.53
70-74	02.59	03.00	02.80
75-79	01.96	02.38	02.18
80-84	01.24	01.55	01.40
85+	01.04	01.45	01.25
% 60+ N=585,701			
	44.47	55.53	

Source: Department of Demography, Graduate School of Public Health, UPR, 2003

Education

Fifty three percent of adults 65 and older in Puerto Rico in 2000 had an education of less than ninth grade while only 11.4% had an associate degree or higher university degree. The following Table illustrates educational attainment by age group and sex. Elderly women range lower than their male counterparts in all categories. Such a distinct trend is not observable in the age category 45 to 64.

PUERTO RICO 2000
EDUCATIONAL ATTAINMENT FOR THE POPULATION 45 YEARS OR OLDER,
BY SEX AND AGE

<i>AGE</i>	<i>MALES</i>	<i>FEMALES</i>
TOTAL 45 OR OLDER	558,194	676,873
45 to 64 years	372,710 (%)	437,995 (%)
• Less than 9th grade	104,668 (28.08)	116,706 (26.65)
• 9th to 12th grade, no diploma	68,604 (18.41)	70,535 (16.10)
• High school graduate (includes equivalency)	91,270 (24.49)	108,355 (24.74)
• Some college, no degree	35,781 (09.60)	39,885 (09.11)
• Associate degree	14,214 (03.81)	28,076 (06.41)
• Bachelor's degree	37,043 (09.94)	54,251 (12.39)
• Graduate or professional degree	21,130 (05.67)	20,187 (04.61)
65 years or older:	185,484 (%)	238,878 (%)
• Less than 9th grade	98,524 (53.12)	146,295 (61.24)
• 9th to 12th grade, no diploma	25,242 (13.61)	27,150 (11.37)
• High school graduate (includes equivalency)	27,884 (15.03)	29,251 (12.24)
• Some college, no degree	11,105 (05.99)	10,430 (04.37)
• Associate degree	3,261 (01.76)	5,553 (02.32)
• Bachelor's degree	11,524 (06.21)	13,977 (05.85)
• Graduate or professional degree	7,944 (04.28)	6,222 (02.60)

Source: U.S. Census Bureau, Census 2000, SF 4.

Marital status

Forty-eight percent of adults 65 or older in 2000 were married with their spouse present and 32 percent were widowed. Three times as many older women (45.73%) than men (15.21%) were widowed. The Table below summarizes marital status for adults 65 or older according to the Census of 2000.

PUERTO RICO 2000
ADULTS 65 YEARS OF AGE OR OLDER, BY MARITAL STATUS AND SEX

<i>MARITAL STATUS</i>	<i>MALES NUMBER (%)</i>	<i>FEMALES NUMBER (%)</i>	<i>TOTAL</i>
Never married	12,607 (06.80)	14,760 (06.18)	27,367 (06.45)
Married, spouse present	121,169 (65.33)	83,895 (35.12)	205,064 (48.32)
Married, spouse absent	9,705 (05.23)	8,676 (03.63)	18,381 (04.33)
Divorced	13,775 (07.43)	22,307 (09.39)	36,082 (08.50)
Widowed	28,228 (15.21)	109,240 (45.73)	137,468 (32.39)
TOTAL	185,484 (100.0)	238,878 (100.0)	424,362 (99.99)

Source: U.S. Census Bureau, Census 2000, SF 4.

Employment

The 2000 Population Census reported that 28.2 percent or 588,234 persons in the age group 21 to 64 years of age had one or more disabilities. The proportion for those 16 to 20 was 17.2 percent. Seventy-eight percent of the population 21 to 64 years of age with a disability did not work (U.S. Census Bureau 2000 SF 3). The Table that follows presents the employment status of persons 16 to 64 years of age with at least one disability. Two-thirds or more of those 21 to 64 years of age, either males or females, were not in the labor force.

**PUERTO RICO 2000
PERSONS 16 TO 64 YEARS OF AGE WITH AT LEAST ONE DISABILITY,
EMPLOYMENT STATUS (PERCENTAGE)**

	ONE DISABILITY OR MORE, 16-64 (N=641,572)			
	MALES by age		FEMALES by age	
	16-20 n=28,445	21-64 n=287,832	16-20 n=24,893	21-64 n=300,402
EMPLOYMENT STATUS				
In labor force	16.53%	34.29%	09.97%	22.54%
Not in labor force	83.47%	65.71%	90.03%	77.46%
TOTAL	100.00%	100.00%	100.00%	100.00%

Source: U.S. Census Bureau, Census 2000, SF 4

The overwhelming majority of adults 65 years of age and older in Puerto Rico in 2000 was not in the labor force, 94 percent. The proportion of older men in the labor force was threefold that of their female counterparts.

**PUERTO RICO 2000
ADULTS 65 YEARS OF AGE OR OLDER, EMPLOYMENT STATUS (PERCENTAGE)**

EMPLOYMENT STATUS	MALES (N=185,484)	FEMALES (N=238,878)	TOTAL (N=424,362)
In labor force	09.58	03.38	06.09
Not in labor force	90.42	96.62	93.91
TOTAL	100.00	100.00	100.00

Source: U.S. Census Bureau, Census 2000, SF 4.

II. A. 2. Income

Poverty status

Forty-four percent of non-institutionalized adults 65 and older in Puerto Rico during 2000 had an income that placed them below the poverty level (Mattei, 2003). Poverty is more prevalent among older females than among older males.

**PUERTO RICO 1999
BELOW POVERTY STATUS
FOR THE NON-INSTITUTIONALIZED POPULATION 65 YEARS AND OLDER, BY SEX**

	Total	Males	Females
65 years and older	N=417,218 (%)	N=182,870(%)	N=234,348 (%)
Income below poverty level	183,500 (43.98)	73,946 (40.44)	109,554(46.75)

Source: U.S. Census Bureau, Census 2000, SF 4.

The proportion of persons with a disability and with an income below the poverty level in 2000 was greater than for those without a disability and below the poverty level. The following Table depicts this trend that is observable for all age categories. When persons with disabilities and below the poverty level are compared, women tend to fare worse than their male counterparts, even though the difference in proportion is extremely slight.

**PUERTO RICO 2000
DISABILITY STATUS BY POVERTY STATUS FOR
THE NON-INSTITUTIONALIZED POPULATION 5 YEARS OF AGE AND OLDER, BY SEX**

DISABILITY BY AGE	MALES	FEMALES
5-15	340,976	326,138
With a disability:	26,472 (100.00%)	19,500 (100.00%)
• Income in 1999 below poverty level	18,303 (69.14%)	13,964 (71.61%)
• Income in 1999 at or above poverty level	8,169 (30.86%)	5,536 (28.39%)
No disability:	314,504 (100.00%)	306,638 (100.00%)
• Income in 1999 below poverty level	183,241(58.26%)	179,115 (58.41%)
• Income in 1999 at or above poverty level	131,263 (41.74%)	127,523 (41.59%)
16-20	156,300	153,126
With a disability:	28,432 (100.00%)	24,798 (100.00%)
• Income in 1999 below poverty level	17,500 (61.55%)	15,919 (64.20%)
• Income in 1999 at or above poverty level	10,932 (38.45%)	8,879 (35.80%)
No disability:	127,868 (100.00%)	128,328 (100.00%)
• Income in 1999 below poverty level	68,202 (53.34%)	71,615 (55.81%)
• Income in 1999 at or above poverty level	59,666 (46.62%)	56,713 (44.19%)
21-64	971,895	1,109,547
With a disability:	287,711 (100.00%)	300,324 (100.00%)
• Income in 1999 below poverty level	142,710 (49.60%)	158,678 (52.84%)
• Income in 1999 at or above poverty level	145,001 (50.40%)	141,646 (47.16%)
No disability:	684,184 (100.00)	809,223 (100.00%)
• Income in 1999 below poverty level	258,502 (37.78%)	339,297 (41.93%)
• Income in 1999 at or above poverty level	425,682 (62.22%)	469,926 (58.07%)
65 or older	182,870	234,348
With a disability:	102,904 (100.00%)	143,619 (100.00%)
• Income in 1999 below poverty level	45,934 (44.64%)	73,648 (51.28%)
• Income in 1999 at or above poverty level	56,970 (55.36%)	69,971 (48.72%)
No disability:	79,966 (100.00%)	90,729 (100.00%)
• Income in 1999 below poverty level	28,012 (35.03%)	35,906 (39.58%)
• Income in 1999 at or above poverty level	51,954 (64.97)	54,823 (60.42%)

Source: U.S. Census Bureau, Census 2000, SF 4.

Social Security

A statistically representative study of almost 5,000 adults 60 years of age and older throughout Puerto Rico (PREHCO) reports that for 2002 to 2003, the main source of income for 83.9 percent of those interviewed was Social Security (SS). The other two main sources of income were the Program of Nutritional Assistance (26.4%) and pensions (22.4%). Social Security data indicate that 376,580 of adults 65 years of age or older in Puerto Rico were SS beneficiaries in December 2001 (Annual Statistical Supplement 2002, p. 234). Women comprised 55.17 percent of older beneficiaries and men comprised 44.83 percent. The Puerto Rico Planning Board Population Estimates for 2001 indicate that there were 437,228 adults 65 years of age and older (2003). If this is taken as a base number, 86.13 percent of the older adults in Puerto Rico in 1991 were SS beneficiaries. The Table below illustrates the monthly benefits for SS beneficiaries 65 and older in Puerto Rico.

**PUERTO RICO, DECEMBER 2001
ENROLLMENT AND TOTAL MONTHLY BENEFIT (IN THOUSANDS DOLLARS)
FOR SOCIAL SECURITY BENEFICIARIES 65 YEARS OR OLDER, BY SEX**

SS BENEFICIARIES	NUMBER AND PERCENT	MONTHLY BENEFITS (IN THOUSANDS OF DOLLARS)
Males	168,810 (44.83%)	103,622
Females	207,770 (55.17%)	97,125
Total	376,580 (100.00%)	200,747

Source: Annual Statistical Supplement 2002, Social Security Bulletin, Table 5.J3.

Most of the SS monthly benefits that adults 65 and older receive come from retirement and disability.

**PUERTO RICO, DECEMBER 2001
TOTAL MONTHLY BENEFIT FOR SOCIAL SECURITY BENEFICIARIES
BY TYPE OF BENEFIT IN THOUSAND DOLLARS, 65 YEARS OR OLDER**

<i>Retirement</i>		<i>Survivors</i>	<i>Disability</i>	
Retired worker	Spouse	Widow(er)s and parents	Disabled workers	Spouse
174,711	14,695	40,703	88,430	1,539

Source: Annual Statistical Supplement 2002, Social Security Bulletin, Table 5.J4.

The total of Social Security beneficiaries in December 2001 in Puerto Rico was 677,130. The number of adults 55 years of age or older that received SS benefits in December 2001 was 501,320; for those younger than 55 it was 175,810. The Table below shows distribution by age.

**PUERTO RICO, DECEMBER 2001
NUMBER OF SOCIAL SECURITY BENEFICIARIES BY AGE**

<i>Age</i>	<i>Number</i>
17 or under	78,980
18-54	96,830
55-61	53,200
62-64	71,540
65-69	118,410
70-74	73,300
80-84	50,090
85-89	28,260
90-99	14,440
100+	400
Total	677,130

Source: Annual Statistical Supplement 2002, Social Security Bulletin, Table 5.J5.

The average monthly SS benefit for retired workers in Puerto Rico for December 2001 was \$577.30 and the median monthly benefit was \$532.00 (SS Annual Statistical Supplement 2002, p.238). Puerto Rico ranked below Washington D.C., whose SS beneficiaries had the lowest numbers in all of the nation; an average of \$741.00 a month and a median of \$665.00. It also ranked lower than South Dakota and New Mexico, the two states classified as those with lower average and median monthly benefits. South Dakota SS recipients averaged a monthly benefit of \$802.00 with the median falling on \$788.00 while those from New Mexico received an average of \$802.00 with a median of \$804.00 (SS Annual Statistical Supplement 2002, p.238). Older Puerto Ricans **residing** in Puerto Rico are not entitled to receive Supplemental Security Income as are their aged counterparts who reside on the mainland regardless of citizenship status. The Table that follows shows the distribution of SS monthly benefits for retired workers.

**PUERTO RICO, DECEMBER 2001
PERCENTAGE DISTRIBUTION OF SOCIAL SECURITY RETIRED BENEFICIARIES
BY MONTHLY DOLLAR AMOUNT OF BENEFIT**

Amount of benefit (in dollars)	Percentage
Less than 400	26.6
400-499.90	17.5
500-599.90	16.8
600-699.90	12.1
700-799.90	08.6
800-899.90	05.8
900-999.90	04.5
1,000-1099.90	02.9
1,100-1,199.90	01.9
1,200 or more	03.2
TOTAL	100.0

Source: Annual Statistical Supplement 2002, Social Security Bulletin, Table 5.J5.

Disabled workers in Puerto Rico also received lower average and median monthly benefits when compared to the 50 states. The average SS monthly benefit for disabled workers in Puerto Rico in December 2001 was \$693.70 and the monthly median was \$649.00 (SS Annual Statistical Supplement 2002, p.239). South Dakota, the state that ranked the lowest in terms of monthly benefits for disabled workers in the U.S., reported an average of \$742.30 and a median of \$688.00. The average and median monthly benefits for all types of disabled beneficiaries (disabled worker, disabled adult children, and disabled widows/widowers) were \$634.40 and \$610.60, respectively.

II. A. 3. Area of residence and living arrangements

According to the Census of 2000, the vast majority of persons 65 and older in Puerto Rico lived in households in the community (97.5%). The proportion that lived in institutions or homes for the elderly was less than two percent (1.45 % or 6,170 adults 65 or older). Older women tend to reside more in nursing homes than men but the difference is small as shown in the Tables that follow.

PUERTO RICO 2000 PROPORTION OF THE POPULATION 65 YEARS AND OLDER IN GROUP DWELLINGS, BY SEX

	<i>MALES</i>	<i>FEMALES</i>	<i>TOTAL</i>
Population 65+	186,203	238,934	425,137
Percent LIVING in group dwellings	2.34	2.59	2.48
Percent LIVING in homes for the elderly	1.24	1.62	1.45

Source: U.S. Census Bureau 2000, SF 3

PUERTO RICO 2000 POPULATION 65 YEARS AND OLDER IN GROUP DWELLINGS, BY SEX

	<i>MALES</i>	<i>FEMALES</i>	<i>TOTAL</i>
Population 65+	4,352	6,192	10,544
Institutionalized	2,790	4,245	7,035
Penitentiary	51	0	51
Nursing homes	2,308	3,862	6,170
Other institutions	431	383	814
Non-Institutionalized	1,562	1,947	3,509
Military	0	0	0
Other group dwelling arrangements	1,562	1,947	3,509

Source: U.S. Census Bureau 2000, SF 3

The Census of 2000 reported that the majority of older adults resided in family households (76.0%). Almost three-fifths (57.77%) of the elderly residing in family households were householders and 66.90 percent of them were males. About two-thirds (64.00%) of older family households were formed by a married couple and 97 percent of these couples did not have children younger than 18 years of age (US Bureau of the Census 2003, SF 4). Twenty-two percent of adults 65 and older in 2000 (93,889) lived

alone (Mattei 2003); an increase from 18 percent in 1990 (Dávila and Sánchez-Ayénde 1996). Sixty-five percent of those 65 years of age or older who lived alone were women (US Bureau of the Census 2003, SF4). Sixty-one percent of non-family households below the poverty level whose head of the family was an older man were comprised by a man 65 or older living alone in comparison to 70 percent headed by older women below the poverty level living alone (U.S. Census Bureau 2000, SF 3).

According to the Census of 2002, the proportion of heads of household 65 years of age and older who were grandparents to a grandchild younger than 18 years of age was 8.31 percent; over two-fifths of them (43.81%) were responsible for a grandchild under 18. Older adults made up 22 percent of grandparents of all ages who were heads of household and caring for grandchildren younger than 18 years of age. Older women heads of household comprised 56 percent of older grandparents caring for a grandchild less than 18 years old. When age categories 75 and over are considered for heads of households who are grandparents, the proportion of older heads of household who are males and are responsible for a grandchild under 18 exceeds that of their female counterparts by almost twice because it is males who are generally considered heads of household when a female spouse is present.

**PUERTO RICO 2000
HOUSEHOLDERS WHO ARE GRANDPARENTS 65 YEARS AND OLDER AND ARE
RESPONSIBLE FOR GRANDCHILDREN UNDER 18 YEARS OF AGE, BY SEX**

	<i>AGE</i>	<i>RESPONSIBLE FOR GRANDCHILD < 18</i>	
		<i>N</i>	<i>Percent</i>
	65-74	11,099	71.05
	75-84	3,675	23.52
	85+	849	05.43
	Total	15,623	100.00
Males			
	65-74	4,251	61.82
	75-84	2,116	30.78
	85+	509	07.40
	Total	6,876	100.00
Females			
	65-74	6,848	78.29
	75-84	1,559	17.82
	85+	340	03.89
	Total	8,747	100.00

Source: U.S. Census Bureau 2000, SF 4

The Census of 2000 listed 1,261,325 occupied housing units and 22.66 percent (285,841) were occupied by householders 65 years of age and older (U.S. Census Bureau 2000 File 3 SF 4). Homeownership was high among older persons in 2000, with slightly more than four-fifths (84.61% or 241,865 persons) owning their homes and 15.38 percent (43,076) renting their dwelling. However, 41.16 percent of homeowners aged 65 and older lived in homes that were at least 40 years old. These dwellings may present high costs for maintenance and not be architecturally adequate for some older adults with disabilities or mobility problems.

Of those 241,865 owner-occupied households by a householder aged 65 or older, 57.74 percent had at least one vehicle available in comparison to 34.21% of the 43,076 in rented dwelling. In other words, 54 percent (154,388) of occupied housing units by householders 65 and older in the year 2000 had at least one vehicle available while 46 percent did not have a vehicle. Three-fourths (74.87%) of all housing units with a householder 65 years of age or older had a telephone. Ninety percent (90.49%) of the houses inhabited by older householders were single dwellings, that is were single houses and not apartments or any other type of lodging.

III. Health and Mortality.

As in other countries, the decrease in mortality in Puerto Rico has been greater for females than for males. In 1940, the mortality rate for males was 7 percent higher than for females and since then the difference has increased to 58 percent in 1990 (Dávila and Sánchez-Ayénde 1996). As stated before, current female life expectancies at birth for males and females are 72.28 and 79.90, respectively (Demography Program 2003). The life expectancies for ages 65 and 85 for 2001 were 18.26 and 6.44, correspondingly. In 1990 life expectancies at age 65 were 18 years for women and 15 for men and by 2001 had increased, in that order, to 19.58 and 16.72. A familiar consequence of this disparity in survival is the acute imbalance in the male-to-female sex ratios at older ages. While in 1950 the ratio was of the order of .92, in 1990 it had decreased to about .85, and in 2000 to .80. The ratio of older men per women for the year 2000 appears in the Table below. As age increases, the ratio decreases for age categories 60+, 65+, 70+, 75+, 80+ and 85+.

**PUERTO RICO 2000
ADULTS 65 YEARS OF AGE AND OLDER, SEX RATIO BY AGE GROUP**

AGE	Males	Females	Sex Ratio
60+	260,479	325,222	0.80
65+	186,203	238,934	0.78
70+	125,221	165,635	0.76
75+	77,760	106,426	0.73
80+	41,764	59,344	0.70
85+	19,067	28,639	0.67

Source: Department of Demography, Graduate School of Public Health, UPR, 2003

The four leading causes of death for the total population of Puerto Rico for the year 2000 were: heart disease, cancer, diabetes mellitus, and hypertension. Together they comprise 48 percent of all deaths on the Island. The Table below presents the leading causes of death in Puerto Rico for the year 2000 by ranking order, percentage, and rate.

**PUERTO RICO 2000
LEADING CAUSES OF DEATH**

CAUSES OF DEATH	RANK	NUMBER	PERCENTAGE	RATE*
ALL CAUSES		28,550	100.0	738.4
INDIVIDUAL CAUSES				
<i>Heart disease</i>	1	5222	18.3	135.1
<i>Malignant tumors/Cancer</i>	2	4693	16.4	121.4
<i>Diabetes mellitus</i>	3	2273	8.0	58.8
<i>Hypertensive diseases</i>	4	1575	5.5	40.7
<i>All accidents</i>	5	1321	4.6	34.2
<i>Cerebrovascular diseases</i>	6	1166	4.1	30.2
<i>Chronic pulmonary disease</i>	7	1144	4.0	29.6
<i>Liver diseases</i>	8	820	2.9	21.2
<i>Pneumonia and Influenza</i>	9	785	2.7	20.3
<i>Nephritis and Nephrosis</i>	10	777	2.7	20.1
<i>Alzheimer's</i>	11	709	2.5	18.3
<i>Homicides and legal interventions</i>	12	698	2.4	18.1
<i>HIV/Human immunodeficiency</i>	13	643	2.3	16.6
<i>Septicemia</i>	14	601	2.1	15.5
<i>Conditions originated in perinatal</i>	15	375	1.3	9.7
<i>Suicides</i>	16	315	1.1	8.1
<i>Congenital abnormalities</i>	17	163	0.6	4.2
<i>Arteriosclerosis</i>	18	128	0.4	3.3

*Per 100,000

Source: Department of Health, ASPESIS, Division of Statistics, San Juan, Puerto Rico

The principal causes of death among the elderly in 1998 were: heart disease (24.1%), cancer/malignant tumors (15.8%), diabetes mellitus (8.6%), cerebrovascular diseases (6.0%), bronchitis/asthma (5.9%), hypertension (5.5%), and pneumonia and influenza (5.4%) (Mattei 2003). These causes of deaths account for 71 percent of all deaths in the age group 65 and above. The Table that follows depicts the causes of death for older adults in Puerto Rico for 1990 and 1998. Heart, cancer, diabetes, cerebrovascular diseases, pneumonia/influenza, and bronchitis/asthma were the six principal causes for the selected years. No change in ranking order was observed for these causes from one year to the other.

**PUERTO RICO 1990 AND 1998
CAUSES OF DEATH FOR ADULTS 65 YEARS OF AGE AND OLDER**

CAUSES	Both 1990		Men 1990		Women 1990	
	N	%	N	%	N	%
<i>Heart</i>	4,707	28.8	2,368	27.8	2,339	29.9
<i>Cancer</i>	2,725	16.7	1,630	19.1	1,095	14.0
<i>Diabetes mellitus</i>	1,269	7.8	504	5.9	765	9.8
<i>Cerebrovascular</i>	978	6.0	481	5.6	497	6.4
<i>Pneumonia-Influenza</i>	918	5.6	445	5.2	473	6.1
<i>Bronchitis, Asthma</i>	721	4.4	408	4.8	313	4.0
<i>Accidents</i>	293	1.8	170	2.0	123	1.6
<i>AIDS</i>	20	0.1	17	0.2	3	0.0
<i>Homicides</i>	25	0.2	22	0.3	3	0.0
<i>Hypertension</i>	652	4.0	284	3.3	368	4.7
<i>Cirrhosis, Liver</i>	272	1.7	184	2.2	88	1.1
<i>Septicemia</i>	304	1.9	162	1.9	142	1.8
<i>Nephritis, etc</i>	244	1.5	134	1.6	110	1.4
<i>Arteriosclerosis</i>	434	2.7	197	2.3	237	3.0
<i>Others</i>	2,773	17.0	1,517	17.8	1,256	16.1
TOTAL	16,335	100.0	8,523	100.0	7,812	100.0
CAUSES	Both 1998		Men 1998		Women 1998	
	N	%	N	%	N	%
<i>Heart</i>	4,747	24.1	2,358	23.3	2 389	24.9
<i>Cancer</i>	3,113	15.8	1,900	18.7	1,213	12.7
<i>Diabetes mellitus</i>	1,693	8.6	721	7.1	972	10.1
<i>Cerebrovascular.</i>	1,190	6.0	569	5.6	621	6.5
<i>Pneumonia-Influenza</i>	1,065	5.4	524	5.2	541	5.6
<i>Bronchitis, Asthma</i>	1,159	5.9	606	6.0	553	5.8
<i>Accidents</i>	392	2.0	228	2.2	164	1.7
<i>AIDS</i>	22	0.1	16	0.2	6	0.1
<i>Homicides</i>	16	0.1	11	0.1	5	0.1
<i>Hypertension</i>	1,109	5.6	531	5.2	578	6.0
<i>Cirrhosis, Liver</i>	255	1.3	168	1.7	87	0.9
<i>Septicemia</i>	459	2.3	211	2.1	248	2.6
<i>Nephritis, etc</i>	386	2.0	225	2.2	161	1.7
<i>Arteriosclerosis</i>	151	0.8	76	0.7	75	0.8
<i>Others</i>	3,961	20.1	1,997	19.7	1,964	20.5
TOTAL	19,718	100.0	10,141	100.0	9,577	100.0

Source : Mattei 2003

Many of the health problems that affect the elderly population and could impact LTC utilization cannot be inferred from mortality indicators since the declared main cause of death may not be a direct cause and is a poor indicator of the multiple factors that precipitate the death of the individual, particularly at older ages. Furthermore, death certificates are not useful to detect the prevalence of common health problems among the elderly, such as arthritis, depression, falls and fractures, and hearing and visual impairments.

The last available surveys carried out by the Department of Health indicate that elderly persons in Puerto Rico experience an average of 3 to 4 chronic conditions in comparison to 1 to 2 among those under 65 years of age (Dávila and Sánchez-AyéndeZ, 1996). The average number of chronic conditions for elderly women is higher (4.73) than for their male counterparts (3.77). The rates of chronic diseases among those 65+ were three times higher than for those under 65 (Dávila and Sánchez-AyéndeZ 1996). The four chronic diseases more frequently registered among the older adults were: arthritis and rheumatism (44.3/100), hypertensive diseases (35.6/100), diabetes mellitus (22.4/100) and heart diseases (21.0/100). Three fifths of the women in this age category who are afflicted by some chronic condition suffer from arthritis or rheumatism, a higher rate than among males.

The implications of this gender difference are very important as women live longer than their male counterparts, are less likely to have a living spouse, and could experience a larger burden caused by functional limitations. Also, according to the available data from the "Quality Improvement Professional Research Organization, Inc." (QIPRO 1997), the hospitalization rate (age and sex adjusted rate) attributed to hip fracture (main diagnosis) of Medicare patients 65+ during fiscal year 1993 was 324.8/100,000. Rates were much higher among women than males, and reached a peak in the age groups 80-84 and 85+ where the age-sex adjusted rates were of the order of 123.7/100,000 and 72.4/100,000 respectively.

Adults 65 and older made up 26.37 percent of the population 5 years of age and over with at least one disability in 2000. When age categories are considered, the proportion of older adults with at least one disability is 59.1 percent. The proportion, of children 5 to 15 years with at least one disability is 06.9 percent and that of persons 16 to 64 is 26.8 percent. It is worth noting that 56 percent of children 5 to 15 with one disability or more suffer from a mental disability; the highest proportion for all disabilities in this age category. Physical disabilities make up the highest proportion of those disabilities faced by individuals 16 and older; one-third for those in the ages 16 to 64 and 67 percent for those 65 and older. The Table below presents the comparison by age groups 5 years and older and also by sex and by type of disability.

PUERTO RICO 2000
DISABILITY STATUS FOR THE NON-INSTITUTIONALIZED POPULATION
5 YEARS OF AGE AND OLDER, BY SEX AND AGE

<i>AGE CATEGORIES</i>	<i>BOTH SEXES</i>	<i>MALES</i>	<i>FEMALES</i>
<i>5 years and over</i>	<i>3,482,047</i>	<i>1,655,717</i>	<i>1,826,330</i>
With a disability	934,674	446,014	488,660
% with a disability	26.8	26.9	26.8
<i>5 to 15 years</i>	<i>671,936</i>	<i>343,624</i>	<i>328,312</i>
With a disability	46,579	26,833	19,746
% with a disability	06.9	07.8	06.6
Sensory	16,306	8,287	8,019
Physical	8,986	4,737	4,249
Mental	26,055	16,689	9,366
Self-care	11,492	6,039	5,453
<i>16 to 64 years</i>	<i>2,392,893</i>	<i>1,129,223</i>	<i>1,263,670</i>
With a disability	641,572	316,277	325,295
% with a disability	26.8	28.0	25.7
Sensory	125,805	59,697	66,108
Physical	214,469	101,035	113,434
Mental	151,473	78,510	72,963
Self-care	80,336	41,060	39,276
<i>65 years and over</i>	<i>417,218</i>	<i>182,870</i>	<i>234,348</i>
With a disability	246,523	102,904	143,619
% with a disability	59.1	56.3	61.3
Sensory	106,418	47,129	59,289
Physical	165,562	65,407	100,155
Mental	94,348	37,641	56,707
Self-care	66,790	26,054	40,736
Going outside the home	143,423	55,836	87,587

Source: U.S. Census Bureau, Census 2000, SF 3.

As stated above, data from the Population Census 2000 indicate that 59 percent of non-institutionalized older adults suffered from one or more disabilities. One-fifth faced only one disability while almost two-fifths reported facing two or more. The proportion of women 65 years of age and older with one or more disabilities is greater than that for men (61.28% vs. 56.27%). Although self-care disabilities alone did not rate high for older adults, when they are considered jointly with another or more disabilities they achieve a proportion of 21 percent in the combined category. As is to be expected, a much lower proportion of the non-institutionalized adults 21 to 64 years of age (28%) than their aged counterparts confronted one or more disabilities.

PUERTO RICO 2000
DISABILITY STATUS FOR THE NON-INSTITUTIONALIZED POPULATION
21 YEARS AND OLDER, BY SEX AND AGE GROUPS

AGE GROUP	TOTAL	MALES	FEMALES
DISABILITY			
65 and older	417,218 (100.00%)	182,870 (100.00%)	234,348 (100.00%)
Only one type	87,311 (20.93)	40,011 (21.88)	47,300 (20.18)
• Sensory disability	17,417	9,632	7,785
• Physical disability	32,289	13,836	18,453
• Mental disability	5,849	2,741	3,108
• Self-care disability	1,104	469	635
• Go-outside-home disability	30,652	13,333	17,319
Two or more types	159,212 (38.16)	62,893 (34.39)	96,319 (41.10)
• Includes self-care disability	65,686 (15.74)	25,585 (13.99)	40,101 (17.11)
• Does not include self-care disability	93,526	37,308	56,218 (23.99)
At least one disability	246,523 (59.09)	102,904 (56.27)	143,619 (61.28)
No disability	170,695 (40.91)	79,966 (43.73)	90,729 (38.72)
21 to 64 years of age	2,082,609 (100.00%)	972,542 (100.00%)	1,110,067 (100.00%)
Only one type	234,746 (11.27)	110,604 (11.37)	124,142 (11.18)
• Sensory disability	44,113	20,690	23,423
• Physical disability	56,960	25,940	31,020
• Mental disability	19,385	10,070	9,315
• Self-care disability	1,782	821	961
• Go-outside-home disability	45,037	15,283	29,754
• Employment disability	67,469	37,800	29,669
Two or more types	353,488 (16.97)	177,228 (18.22)	176,260 (15.88)
• Includes self-care disability	73,797	37,589	36,208
• Does not include self-care disability	279,691	139,639	140,052
• Go-outside home and employment only	126,203	65,572	60,631
• Other combination	153,488	74,067	79,421
At least one disability	588,234 (28.24)	287,832 (29.60)	300,402 (27.06)
No disability	1,494,375 (71.75)	684,710 (70.40)	809,665 (72.94)

Source: U.S. Census Bureau, Census 2000, SF 3

According to the U.S. Census 2000, one-fourth (25.51%) of non-institutionalized adults 65 years of age or older in Puerto Rico suffered from at least one sensory disability, 39.68 percent from a physical disability, and 12.26 percent from a mental one. There is a correlation between aging and suffering from a disability in general as well as for different categories, such as: sensory, physical, mental, self-care, and ability to leave the house. As age increases there is a rise in the proportion of elderly with a disability by each category. The following tables display this trend.

**PUERTO RICO 2000
SENSORY DISABILITY FOR THE NON-INSTITUTIONALIZED POPULATION
65 YEARS OR OLDER, BY SEX AND AGE CATEGORIES**

	Males	Females
65 years or older: Total: 417,218	182,870	234,348
65 to 74 years	108,868 (100.00%)	133,304 (100.00%)
• With a sensory disability	20,274 (18.62)	24,296 (18.23)
• No sensory disability	88,594 (81.37)	109,008 (81.77)
•		
75 years or older	74,002 (100.00%)	101,044 (100.00%)
• With a sensory disability	26,855 (36.29)	34,993 (34.63)
• No sensory disability	47,147 (63.71)	66,051 (65.37)

Source: U.S. Census Bureau, Census 2000, SF 4.

**PUERTO RICO 2000
PHYSICAL DISABILITY FOR THE NON-INSTITUTIONALIZED POPULATION
65 YEARS OR OLDER, BY SEX AND AGE CATEGORIES**

	Males	Females
65 years or older non-institutionalized TOTAL: 417,218	182,870	234,348
65 to 74 years	108,868 (100.00%)	133,304 (%)
• With a physical disability	30,772 (28.26)	44,491 (33.37)
• No physical disability	78,096 (71.74)	88,813 (66.63)
75 years or older	74,002 (100.00%)	101,044 (100.00%)
• With a physical disability	34,635 (46.80)	55,664 (55.09)
• No physical disability	39,367 (53.20)	45,380 (44.91)

Source: U.S. Census Bureau, Census 2000, SF 4.

**PUERTO RICO 2000
MENTAL DISABILITY FOR THE NON-INSTITUTIONALIZED POPULATION
65 YEARS OR OLDER, BY SEX AND AGE CATEGORIES**

	Males	Females
65 years or older: TOTAL: 417,218	182,870	234,348
65 to 74 years	108,868 (100.00%)	133,304 (100.00%)
• With a mental disability	16,036 (14.73)	21,605 (16.21)
• No mental disability	92,832 (85.27)	111,699 (83.79)
75 years or older	74,002 (100.00%)	101,044 (100.00%)
• With a mental disability	21,605 (29.19)	35,102 (34.74)
• No mental disability	52,397 (70.81)	65,942 (65.26)

Source: U.S. Census Bureau, Census 2000, SF 4.

The proportion of those suffering from a disability related to self-care or being able to go outside the home also increases with age, as illustrated in the Table below. According to the last population census, 13.61 percent of non-institutionalized older adults were faced with a self-care problem and 34.38 percent with a not being able to go-outside-the-home problem.

PUERTO RICO 2000
SELF-CARE OR GO-OUTSIDE-THE- HOME DISABILITY FOR THE NON-
INSTITUTIONALIZED POPULATION 65 YEARS OR OLDER, BY SEX AND AGE
CATEGORIES

	Males	Females
<i>65 years or older: TOTAL: 417,218</i>	<i>182,870</i>	<i>234,348</i>
65 to 74 years:	108,868 (100.00%)	133,304 (100.00%)
• With a self-care disability	10,114 (09.29)	13,248 (09.94)
• No self-care disability	98,754 (90.71)	120,056 (90.06)
• With a go-outside-home disability	25,934 (23.82)	37,407 (28.06)
• No go-outside-home disability	82,934 (76.18)	95,897 (71.94)
75 years or older:	74,002 (100.00%)	101,044 (100.00%)
• With a self-care disability	5,940 (21.54)	27,488 (27.21)
• No self-care disability	58,062 (78.46)	73,556 (72.80)
• With a go-outside-home disability	29,902 (40.41)	50,180 (49.66)
• No go-outside-home disability	44,100 (59.59)	50,864 (50.34)

Source: U.S. Census Bureau, Census 2000, SF 4

IV. Health Care Utilization and Insurance

IV. A. Definitions

A number of definitions will be used from this point forward. The following definitions set up by the Home and Community-Based Services Resource Network (2003) will be employed:

- 1) **Long-term care (LTC)** - range of medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short or long-term and may be provided in a person's home, in the community, or in residential facilities (e.g., nursing homes or assisted living facilities).
- 2) **Home and community based services** - offer services and other supports to help people with disabilities of all ages to live in the community. Each state has a mix of programs and funding sources. The Medicaid program pays for many of these services in all states. There is also other federal, state and local dollars that fund home and community based services, including the Social Services Block Grant (SSBG), Older Americans Act (OAA), Education and Rehabilitation funds and State General funds.
- 3) **Community-based services** – services designed to help people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meals site, visiting nurses or home health aides, adult day care, and homemaker services.

- 4) **Board and care home** – a residence that offers housing and personal care services for a small number of residents (usually 3 to 16). Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home.
- 5) **Home health agency** - a public or private organization that provides home health services, supervised by a licensed health professional in the patient's home, either directly or through arrangements with other organizations.
- 6) **Home health aide** - a person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled persons with household chores, bathing, personal care, and other daily living needs. Social service agency personnel are sometimes called personal care aides.
- 7) **Home health care** - includes a wide range of health-related services such as assistance with medications, wound care, intravenous (IV) therapy, and help with basic needs such as bathing, dressing, mobility, etc., which are delivered at a person's home.
- 8) **Homemaker services** - in-home help with meal preparation, shopping, light housekeeping, money management, personal hygiene and grooming, and laundry.
- 9) **Hospice** - a program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. The whole family is considered the unit of care, and care extends through their period of mourning.
- 10) **Home and community-based waivers** - Section 2176 of the Omnibus Reconciliation Act of 1987 permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.
- 11) **Senior center** - provides a variety of on-site programs for older adults including recreation, socialization, congregate meals, and some health services. Usually a good source of information about area programs and services.

IV. B. Health care utilization

The last available information from the Department of Health of Puerto Rico on health care utilization of older adults (1993²) indicates that adults 65 years of age and older made up 17 percent of all visits to the physician in Puerto Rico during 1993 (Dávila & Sánchez- Ayéndez 1996). Older adults visited a physician with an average frequency of eight times per year, and a majority of the elderly (88.1%) visited the physician at least once a year. The rate of hospitalization for adults 65 years of age and over was

² Last year for which this data is available.

160/1,000 (Dávila and Sánchez-Ayénde 1996). More men (174/1,000) than women (147/1,000) were hospitalized. The average hospital stay for adults 65 or older was 11 days; 9.2 days for older women was 9.2 and 12.8 days for older men. The average stay of adults 45 to 64 was 7.8 days.

IV. C. Medicare

An overwhelming majority of older adults in Puerto Rico are Medicare beneficiaries. During 1991, 93.74 percent of adults 65 years of age and older were Part A beneficiaries and 72.05 percent were enrolled in Parts A & B. The Tables below depict aged and disabled beneficiaries for Medicare Plan A and/or B for July 2001, beneficiaries by age groups for July 2001, and changes in enrollment for years 1999 through 2001.

PUERTO RICO JULY 2001 MEDICARE ENROLLMENT, BY TYPE OF BENEFIT

Enrollment	A &/or B	A	B	A & B
<i>Aged</i>	410,320	409,850	315,512	315,042
<i>Disabled</i>	139,418	139,418	95,465	95,457
<i>All</i>	549,746	549,268	410,977	410,499

Source: Centers for Medicare and Medicaid Services, 2003.

PUERTO RICO YEAR 2001 MEDICARE ENROLLMENT BY AGE GROUP AND ENTITLEMENT

Age group	Part A &/or B	Part A	Part B	Part A & B
Under 19	47	47	33	33
Age 19 to 24	1,634	1,634	726	726
Age 25 to 29	2,690	2,690	1,290	1,290
Age 30 to 34	4,606	4,605	2,514	2,513
Age 35 to 39	8,609	8,605	4,940	4,936
Age 40 to 44	13,746	13,746	8,664	8,664
Age 45 to 49	18,909	18,909	12,378	12,378
Age 50 to 54	26,451	26,450	18,069	18,068
Age 55 to 59	31,349	31,349	22,881	22,881
Age 60 to 64	31,385	31,383	23,970	23,968
Age 65 to 69	118,827	118,706	95,018	94,897
Age 70 to 74	94,438	94,348	78,971	78,881
Age 75 to 79	75,326	75,240	62,979	62,893
Age 80 to 84	48,660	48,587	40,835	40,762
Age 85 to 89	28,607	28,559	24,970	24,922
Age 90 and over	44,462	44,410	12,739	12,687
TOTAL	549,746	549,268	410,977	410,499

Source: Centers for Medicare and Medicaid Services, 2003.

**PUERTO RICO
MEDICARE ENROLLMENT, July 1999 - 2001, PERCENT CHANGE**

Enrollment years			Percent change	
1999	2000	2001	1999-2000	2000-2001
525,000	537,341	549,746	2.4%	2.3%

Source: Centers for Medicare and Medicaid Services, 2003.

The number of hospitalizations paid by Medicare in Puerto Rico for fiscal year 2002 was 135,247 (QIPRO 2003). The total spending in hospitalizations paid by Medicare was \$387,407,434.14 (QIPRO 2003), an average total of \$2,864.44 per hospitalization.

A study of short hospitalization rates during 1999 for Medicare beneficiaries found lower rates among residents of Puerto Rico than among those in the mainland U.S. (Barosso, McBean and Conde acc. for pub.). The rate ratio (PR/US) of age, gender-adjusted hospitalizations among elderly Medicare A beneficiaries in Puerto Rico was 0.78 compared with 0.92 among beneficiaries of both part A and B coverage. Rate ratios were higher among the young-old. The study also found that a much larger percentage of Medicare beneficiaries in Puerto Rico than on the mainland had only Part A; a reflection of the economic situation of a considerable amount of older adults in Puerto Rico.

Jencks and collaborators (2000) found that despite condition specific managed-care reports no systematic program has been developed for monitoring the quality of medical care that Medicare beneficiaries receive. They studied some process-of-care measures pertinent to primary and secondary prevention or treatment of six medical conditions (acute myocardial infarction, breast cancer, diabetes mellitus, heart failure, pneumonia and stroke) from 1997 to 1999. Across all states³, the percentage of patients receiving appropriate care in the median state ranged from a high of 95 percent to a low of 11 percent. The median performance of an indicator was 69 percent. Puerto Rico ranked the lowest in terms of the overall performance of the median state on each measure rank and 48 in terms of average performance/rank on the selected 22 indicators. Puerto Rico received the lowest rank; a rank of 8 out of a maximum of 52 based on the average rank.

Jencks, Huff and Cuerdon (2003) also studied 22 quality indicators on the measure delivery of service for Medicare beneficiaries from 1998-1999 to 2000-2001. Puerto Rico had the lowest average state rank (52) for both periods. Mississippi ranked 51 in 1998-1999 and 50 in 2000-2001 and Arkansas ranked 50 and 48 respectively for both time periods.

Medicare home health agency utilization payments in Puerto Rico for the year 2000 add up to \$49,722,196.00 (CMS 2003). A total of 100,286 claims were received and the total of patients served was 29,406. The average reimbursement per patient during the calendar year 2000 was \$1,691.00.

³ Fifty states, Washington D.C., and Puerto Rico.

Medicare reimbursements for hospice utilization for calendar year 2000 totaled \$21,567,311.00. A total of 4,481 patients received hospice services. The average reimbursement per patient was \$4,813.00 (CMS 2003). The total covered days for calendar year 2000 for hospice utilization was 303,330 and the average number of days per patient was 68 days (CMS 2003). The number of covered procedures was 14,852.

IV. C..Medicaid

In the United States, Medicaid is the primary source of long-term care coverage for older adults and people with disabilities. In Puerto Rico, Medicaid is referred to as *Asistencia Médica* (Medical Assistance). The annual budget cap for Medicaid in Puerto Rico for fiscal year 2002 was \$200 millions (González 2003). The maximum that matching funds can amount to is 50 percent. In the U.S., the Federal Government made a Medicaid contribution to Mississippi of 85 percent and to richer states such as New York of 50 percent. According to HCFA (2000), the average Medicaid expenditures in 1998 for Puerto Rico per person served was \$346 in comparison to \$525 for the Virgin Islands. California was the lowest state with an average Medicaid payment per person served of \$2,040 followed by Tennessee with \$2,075. The table that follows illustrates these differences.

MEDICAID EXPENDITURES FOR 1998

	Puerto Rico	Virgin Islands	California	Tennessee	Georgia	All Jurisdictions
\$ in Medicaid Expenditures	334,000,000	10,381,533	16,845,448,072	3,826,379,693	3,845,448,072	175,065,785,063
Federal Medical Assistance Percentage	50%	50%	51.2%	63.4%	60.8%	57%
Medical DSH Payments	0	0	2,450,659,581	0	409,567,607	14,961,830,000
Average \$ Payment per Person Served	346	525	2,386	2,075	3,147	4,307
Average \$ Payment per Person Served w/out DSH	346	525	2,040	2,075	2,812	3,939

Source: FY 1998 HCFA Form 64 and FY 1998 HCFA Form 2082

DSH=disproportionate share hospitals which receive higher reimbursement than other hospitals because they treat a disproportionately high share of Medicaid patients

Puerto Rico recently underwent a drastic transformation of its health services for the medically indigent. The *Reforma*, as the government health reform insurance plan for the medically indigent is referred to, covers one million persons (González 2003). The monthly payment per individual is \$60 and Medicaid or *Asistencia Médica* pays \$18 of each \$60 per individual, (to the maximum limit of its resources), regardless of age; the rest is disbursed by the Government of the Commonwealth of Puerto Rico. The expenditures for the universal health plan for the indigent is approximately \$ 1,300 millions and Medicaid's budget in Puerto Rico is \$200 millions. Therefore, it becomes impossible to cover any other health expenditures. In order to qualify for Medicaid payments under the *Reforma*, besides being economically indigent (200% of the level of

poverty in Puerto Rico), the following criteria are also considered: blind person, adults 65 and older, children from impoverished families under the 200% level of poverty, dependent children living with one parent and below the level of poverty, and persons with disabilities. The enrollment of beneficiaries for Medicaid in Puerto Rico in April 2003 was:

Beneficiary	Number
Adults 65 and older	133,725
Persons with disabilities	61,978
Blind persons	144
Children	179,359
TOTAL	375,206

Source: Medicaid Puerto Rico, May 2003.

The Puerto Rico Health Insurance Administration (*Administración de Seguros de Salud de Puerto Rico /ASES*), a public corporation of the government of Puerto Rico, is the agency that administers the *Reforma*. Its main duty is to guarantee health insurance coverage for the medically indigent. Among the participating health carriers in the *Reforma* are: APS Healthcare, FHC Healthcare, La Cruz Azul de Puerto Rico (Blue Cross/Blue Shield), SSS Inc, and Humana Health Plan of Puerto Rico Inc. Transportation services under the *Reforma* only include emergency ambulance services. Vision and hearing services mainly include physician services and auxiliary services but vision and hearing equipment is not included.

Puerto Rico does not generate any of the health measures listed for Medicaid (HCFA 2000). In the U.S., most of the Medicaid long-term spending is for institutional care (HCFA 2000). Puerto Rico is not able to utilize Medicaid dollars to purchase long-term care services of any kind (residential settings, assisted living, board and care, home care, meals, transportation, adult day facilities/senior centers, and respite or any other support to caregivers) partly because of the current cap on the Federal share.

Medicaid program waivers play an important role in the delivery of Medicaid services. Waivers permit states to implement new approaches in service delivery and benefits. States can choose to subsidize home and community based services (HCBS) by modifying their state Medicaid plan. Applying for a Medicaid waiver allows the state to have certain requirements waived, such as state-wideness, eligibility criteria, populations served, etc. Puerto Rico has no Medicaid long-term care expenditures, thus, Puerto Rico does not use Medicaid waivers to fund HCBS since these services cannot be covered by the assigned annual budget.

IV. D. Private health plans

Private health coverage per individual ranges from \$55.75 to \$117.70 a month. Benefits do not include nursing home or bed and board expenses. Number of permitted therapies varies and must be recommended by a physician.

V. Long-Term Care Establishments (LTCEs) in Puerto Rico: Overview of Relevant Legislation and Definitions

The increasing demand for more and better services for older adults in Puerto Rico has increased in the last twenty years. This demand has given rise to nursing homes, foster homes for the elderly, and senior day centers. The demand for increasingly complex services is growing, especially as increases in life expectancy for older adults augment. As the population ages and develops chronic illnesses or physical and mental disabilities, the need for establishments that cater to the needs of the elderly, increases. The government of Puerto Rico has tried to respond to these demands by creating special agencies or sections within existing ones and passing laws to serve the interests and needs of the older population. Act Number 16 of May 22 of 1962 created *La Comisión Puertorriqueña de Gericultura* (Puerto Rican Gericulture Commission). This new agency was placed under the hierarchal structure of the Department of Health. Its objectives were to: provide advocacy leadership for the well-being of older adults, coordinate planning efforts in state and municipal agencies as well as voluntary organizations toward this well-being, promote and finance research on issues relevant to welfare of the aged population, organize and celebrate conferences and workshops aimed at training professionals in issues relevant to health and social needs and services to the aged, and provide counseling to various public and private agencies and organizations for the improvement of services to older adults.

In June 1968 the government of Puerto Rico created the Department of Social Services of the Commonwealth of Puerto Rico and the *Comisión Puertorriqueña de Gericultura* was transferred to the new agency. By virtue of Act 68 of July 11 of 1988, the Commission ceased to exist and a new agency to advocate for the rights of the older adult was created as a division directly responding to the Governor of Puerto Rico, the Office of the Governor for Elderly Affairs (*Oficina del/la Gobernador/a para Asuntos de la Vejez/OGAVE*). *OGAVE* is not only the main governmental advocate for elderly issues but also compiles statistics, develops pilot projects, provides services to older adults, conducts research, provides consultancy to various agencies --particularly governmental agencies—as well as to older adults, and houses the Office of the Ombudsman for Long-Term Care Establishment. Jointly with the Department of the Family (former Department of Social Services) it is responsible for the welfare of elderly individuals and both aim to provide comprehensive services for the elderly. The efforts of both agencies have been complemented by the specific bylaws that are discussed below.

V. A. Laws and regulations that specifically address older persons and long-term-care establishments

Act Number 94 of June 22, 1977: This Act bestows on the Department of Social Services (now the Department of the Family/*DFPR*) all jurisdiction over any matter related to the establishment, development, operation, licensing, supervision, and implementation of norms and procedures pertinent to the protection, provision of services, protection, and care of older adults in institutions, congregate residential establishments, day-care establishments, and other facilities established with the objectives of this law. It establishes that these facilities must comply with the social developments and improvements that promote the well being of the population in the various residential environments available to the elderly. It defines the terms that will be used for the different residential facilities (institution, day-care home, foster or substitute

home, day care center, camps) and that will be explained in the section that follows. It also defines an elderly individual as one who is 60 years of age or older.

The Measure determines that the Department of Social Services (*DFPR*) is the only agency authorized to issue licenses to establishments servicing the elderly. It gives the Department the right to inspect these establishments for the purposes of granting, renewing, suspending or canceling a license. It also allows the owners of the establishments the right to appeal the decision to a Reconsideration Board (*Junta de Reconsideración*) within 15 workdays after having received the ruling.

The establishments are required to comply with certain stipulations such as: adequate economic resources to provide services, qualified and capable employees, adequate physical facilities, availability of medical services, meals, clothing, provision of social services, security, and accessibility to means of transportation. Other requirements such as reports to the *DFPR* and compliance with Department of Health specifications are detailed under this law. The following amendments were introduced to Act Number 94 of 1977: 70 of July 11 1988, 98 of August 23 1997, 162 of August 2000, and 190 of December 28 2001. The amendment of July 1988 determined the frequency in which LTCEs would be inspected by representatives from the Department of Social Services (*DFPR*) (at least every three months) and the length of time in which the facilities had to attend their shortfalls (a maximum of six months). The 1997 amendment established that any person found guilty of running an establishment for the care of older adults in violation of the law and ordered to close it could not operate another establishment for the same purposes anywhere in Puerto Rico. The 2000 amendment introduced new penalties. The amendment of December 2001 revolved about the qualifications of the personnel in the establishments caring for the elderly. It stated that, at the moment of the required annual report, the person administering any establishment and the rest of the staff are compelled to present evidence of having taken during that year one training seminar or course in gerontology, preferably with emphasis on care, health, nutritional, recreational, and socialization needs of older adults.

Act Number 121 of July 12, 1986: Bill of Rights for the Older Person: This law establishes the public policy of the Commonwealth of Puerto Rico toward older persons and establishes a Bill of Rights for the Older Person. Various amendments were added by means of Acts Numbers 189 of 1995, 192 of 1997, 9 of 1998, and 260 of 2000. This ruling basically establishes the rights of older individuals to live in a peaceful environment where they are treated with respect and dignity and where their physical, emotional, mental, social, and spiritual needs are attended. The regulation institutes the preference for the use of the term person of advanced age (*persona de edad avanzada*) instead of the elderly or aged (*anciano*⁴) as expressed in Act Number 94 of June 22, 1977 and defines an older person as an individual who is 60 years of age and older. It recognizes that the Government, to the point that its resources allow, has to improve the living conditions of older adults. The measure and its amendments guarantee the planning and provision of services to older persons as well as accessibility to services by means of transportation and complementary and alternate resources. It makes specific reference to the rights of individuals in long-term care and hospital establishments (articles four and five). Among those rights are the right to: information, not be discriminated, not be physically or emotionally abused, privacy, and not be physically restricted. It also states in its Article six that the older person herself or by means of

⁴ In Puerto Rico the term *anciano* is associated with an old-old person or an old-old infirm adult.

another person or government official has the right to present her case at the Civil Rights Division of the Department of Justice or court in her residential district to defend her rights or claim any benefits as established in the Bill of Rights for the Older Person. The amendments of 1997 and 1998 elucidate that, to the extent possible, the older adult should be assured the services and means that will allow her/him to remain in a family setting and in an environment of tranquility, respect, and dignity; free of stress and manipulations. The amendments incorporated in 1995 ascertain that an older person cannot be discriminated in the labor force by reason of age and that elderly individuals have the right to attend seminars and receive assistance that will enable them to develop their potentialities. The 2000 amendment guarantees the removal of an older adult from a residential long term care facility in the circumstances of abuse and also expands visiting hours to the establishments to adjust to the needs of relatives.

Regulation Number 4701 of March 28, 1992: This decree is the edict that establishes all requirements for licensing, administration, and operation of long-term care residential facilities for older adults and/or persons with special needs in Puerto Rico or for any program or facility that caters to their rehabilitation or therapeutic needs for twenty-four hours or less. Its objective is to establish standards to guarantee that the facilities act in response to the wellbeing and bio-psychosocial needs of their clients. It addresses a multiplicity of aspects related to service provision: required licenses, provision of health and related services, physical structure concerns, staffing issues, education and training of staff, required reports, rights of the clientele, and others.

Any establishment that seeks to provide services to the elderly and/or persons with special needs must submit an application in the forms provided by the Department of Social Services (now of the Family) at least two months prior to the expected opening date. The Department will evaluate the petition and emit a decision within sixty (60) days from the submission and/or compliance with the requirements established in Regulation 4701. The maximum amount of time that a license will be granted for is two years. If a licensed establishment continues to meet the requirements, its license will be renewed. The petition for renovation of the license must be submitted ninety (90) days prior to the expiration date of the current one.

Each facility is required to develop a manual of operations. The manual must include: description of objectives, description of potential clients, operational norms and procedures, admission criteria and procedures, description of the services that are or will be offered, and release/discharge/expulsion procedures. All establishments that are a separate legal entity from their owner (s) must have a board of directors comprised by no less of three persons from the community.

Admissions to any establishment will be limited by the capacity determined by the Department of Social Services (now of the Family). The person or entity responsible for the facility must submit an annual financial report at the end of its fiscal or natural year that demonstrates the economic feasibility of the facility to offer services. The report is subject to revision and evaluation. The financial accounts of any establishment are open to inspection by authorized representatives from the Department.

The decree addresses aspects related to physical structure and basic household services. All establishments must have a dining room, kitchen, bedroom(s), bathroom(s), laundry area or services, and recreation area. Residential facilities must have one bathroom for each ten residents that include a shower with hot and cold water,

a toilet, and a basin. The physical structure of the facility must be free of architectural obstacles and integrate equipment that will facilitate safety precautions.

All residential facilities with an enrollment of **less than 50 residents** must have a director with at least a high school diploma. Those with **50 residents or more** must have a director who has approved either two years of studies in a certified university and preferably (but not required) university courses in gerontology or social work/welfare studies or high school with certified evidence of at least two years experience caring for older people.

The regulation also specifies that the establishments will have enough employees with the knowledge and training to offer the required services and supervise the programmed activities. The by-law demands one staff member for each eight older adults or persons with special needs as well as at least two person per turn, including the Director. The staff must comply with the following minimal requisites: annual health certificate, and police certificate of good conduct, evidence of first-aid course, and evidence of attending seminars or workshops offered by the Governor's Office on Elderly Affairs (*OGAVE*) or the Licensing Division of the Department of the Family.

Each facility must also present a plan for emergencies and/or natural disasters. The establishment must also comply with regulations and requirements from the following government agencies: Administration of Regulation and Permits (*ARPE*), Division of Environmental Health of the Department of Health, and the Division of Fire Prevention of the Firefighters Corps of Puerto Rico⁵. Each establishment is also obliged to own or provide the equipment and supplies needed to render services according to the physical and emotional needs of its customers. Establishments with **ten clients or more** must have a nutritional program certified as adequate by a nutritionist. Those with **less than ten persons** must offer proof a balanced menu. Daily menus will be posted and special diets will be provided. All residential facilities must offer three meals a day and snacks. Non-residential centers or day-care establishments must offer snacks and or meals according to their time schedule.

All establishments must offer health services according to the existent private or public services at their respective communities or nearby areas. The facility must also coordinate emergency services with a board-certified physician or licensed health center. Those establishments with an enrollment of **50 or more** residents must hire a licensed social worker or a social services technician with experience on a full-time basis. Those with **less than fifty** will offer social services through existent public services or private agencies.

All establishments must prepare a program of activities (social, cultural, recreational, and religious) that caters to the interests and health conditions of their clientele. All clients will be informed of their rights and responsibilities as well as of the norms and rules of the facility prior to their admission. Likewise, each client will receive a copy of the Bill of Rights for the Elderly Person (Law 121 of 1986) prior to admission. The names, addresses, and telephone numbers of all agencies that advocate patients' and elderly persons' rights will be displayed in a place accessible to all residents or customers as well as will be articles three to six of Law 121 of 1986. The by-laws of

⁵ Residential facilities with clients placed by the Department of Health do not have to comply with *ARPE* regulations.

Regulation 4701 also prohibit explicitly any act, omission or attempt that is defined as negligence, abuse or violation of rights. Each client must have a personal record that includes vital information and a medical record with evidence of medical and dental services and evaluations. All members of the staff must have a personal file that includes job description, academic level, trainings, work experience, and required certifications. All establishments must have public liability insurance. The Department of the Family will notify a facility by certified mail of the termination or denegation of a license. The by-laws also establish the process for appealing the decision.

As this report is being written, Regulation 4701 is under revision (López 2003). Some of the basic issues that are being readdressed are: staff preparation, shortage of workers, supervision for licensing and license renewal, licensing supervisors' preparation, and clear explanations of services offered.

Act Number 67 of August 7, 1993: This decree establishes the Administration of Mental Health and Anti-Addiction Services (*Administración de Servicios Mentales y contra la Adicción/ASSMCA*) in the Department of Health and fuses the former Department of Anti-Addiction Services and the Auxiliary Office of Mental Health. Its responsibility is to provide services and rehabilitation to those affected with mental health problems, alcoholism, and drug-addiction. It bestows this agency with the power to license, supervise, and maintain a registry of all institutions, organizations, and facilities that provide services to this population.

Act Number 13 of July 24, 1985: This ruling lays the ground for the investigation and determination of cause and circumstances of any death that occurs in any type of residence, whether private or public. It is also known as the Law of the Institute of Forensic Sciences of Puerto Rico. It was amended in 1995 (Bill 192 of August 12) to make mandatory that the District Attorney General be notified when a person dies in a residential long-term care establishment, and when necessary, an autopsy be performed.

Act Number 69 of July 11, 1998: This decree grants the Secretary for Consumer Affairs the power to establish and regulate the prices set up by private establishments, including long-term care.

Act Number 194 of August 25, 2000: This regulation establishes the Bill of Rights and Responsibilities of the Patient. It determines the rights and responsibilities of patients and clients as well as those of service providers and health insurance corporations. It defines terms, establishes grievance procedures, and imposes penalties.

Act Number 11 of April 11, 2001: This edict creates the Office and the position of Ombudsperson for the patients that are beneficiaries of the Health Reform of Puerto Rico. Its objective is that the principles established in the Bill of Rights and Responsibilities of the Patient are carried out, specifically in the case of the medically indigent.

Bill of Law Number 1763 of October 17, 2001: This edict aims to establish the "Law for the Establishment of *Assisted-Living* Projects for Older Adults in Puerto Rico". It has not been approved yet.

V. B. Types of long-term care establishments for elderly adults

Although the term “institution” is commonly used for the establishments that cater to the long term care residential needs of the aged person, the Act Number 94 of 1977 establishes different terms and modes; below is a direct translation of the definitions that are established under this bill:

- 1) **Institution:** Any asylum, residential institution, lodging-house, annex, enter, home, mission or refuge that is dedicated to the care of seven (7) or more elderly, for 24 hours, profit or non-profit
- 2) **Day care home:** A family household that is dedicated to provide day care for profit on a regular basis to a maximum of six (6) adults not related by blood ties to the family owning the residence.
- 3) **Foster home or substitute home:** A family household that looks after no more than six (6) elderly on a twenty-four-hours basis, profit or non-profit
- 4) **Adult day facility/Senior day center:** an establishment, no matter its specific name, that offers care to adults for a period under twenty fours a day, profit or non-profit
- 5) **Establishment:** all institutions, day center, foster home, day care home, as defined

In addition, Act Number 121 of 1986 (Bill of Rights of the Older Person, Article 2, subheadings b and c) establishes the following definitions for institutions caring for the elderly individual based on the criterion of the service being offered on a twenty-four hour basis or less.

- 1) **Establishment for care:** all institutions, day or night care centers, foster home, day care home as defined by Bill of Law 94 of 1977 that offers care to the elderly person outside his/her home during the whole day or during part of the day
- 2) **Residential establishment:** all homes or institutions as defined in the Bill of Law Number of 1977 that offer long-term care for 24 hours a day

In 1997, the *DFPR* introduced another concept for facilities offering services to the elderly adult: camps for the older adult (*DFPR* 1997). A camp was defined as a permanent or temporary establishment that organizes and carries out an activity program for older adults, mostly outdoor activities. These activities will be designed with the purpose of leisure or recreation and may be provided for twenty-four hours or less.

VI. Long-Term Care Residential Establishments (LTCREs)

VI. A. Overview and cost

The long-term care (LTC) sector in Puerto Rico consists largely of board and care facilities. Neither Medicaid nor Medicare covers institutionalization in LTCEs in Puerto Rico. No LTC residential establishment (LTCRE) in Puerto Rico is certified by Medicare, with the exception of seven skilled nursing facilities.

As established by law, most of the LTCREs in Puerto Rico offer the following services: medical and nursing services 24 hours a day (not necessarily at the facility but on call), once-a-week visitation by physician, administration of medicines as prescribed by a physician, laboratory services, meals, and laundering services. Recreational services and social celebrations are also provided. The establishment will make the necessary arrangements for various therapies if required and if the resident has some type of either private or governmental health insurance that covers it. Some establishments provide soap, disposable diapers, moist cleansing towelettes, bedding items, and towels but those who do not may ask relatives of the resident to provide them. In most cases, the family is responsible for medicines not covered by health insurance, special nutritional supplements, clothes, and grooming articles and accessories. Most of these establishments accept persons with different physical and mental health needs. Rarely does an establishment limit acceptance to one condition, with the exception of Alzheimer's. Each residential facility conducts a physical evaluation of the older or disabled person at the moment of admission. This evaluation is not included in the monthly costs and could vary from \$50 to \$150 (García 2003)..

Cost varies according to location, type of facility, services that are offered, and availability of private/semi-private rooms or wards, among others. Monthly payments for LTCREs generally fluctuate between \$675 and \$1,200 yet in some cases it may be as low as \$450 or as high as \$3,000. The *DFPR* is the primary governmental agency disbursing payments to LTCEs in Puerto Rico. The average monthly expenditure per beneficiary by the *DFPR* in 2003 fluctuates between \$675 and \$800 or as needed based on an evaluation of economic means and each individual's classification in terms of care necessities (García 2003, *DFPR ADFAN* 2003). An individual is classified as independent when s/he can function by herself. A second category in terms of care necessity pertains to need for assistance with personal grooming and with feeding, and the last one has to do with aspects such as incontinency, bed-ridden, dementia or loss of awareness of self and surroundings. The establishment can also establish a contract with the resident's family for other expenses, but this is not the norm (Cabrera 2003, Crispín 2003).

During fiscal year 2001-2002, the *DFPR* spent \$13,182,010.25 in payments to long-term-care residential facilities (*DFPR ADFAN* 2003). The number of adults 60 years of age and older placed by the *DFPR* in foster homes and institutions for the same time period was 2,196. The average annual LTCRE spending per beneficiary by the *DFPR* for 2001-2002 was \$6,002.74; \$500.29 per month. From fiscal year 2001-2002 to April 30, 2003 there was a very small increase in the number of older adults placed in LTCEs by the *DFPR*. According to LTC expenditures fluctuations by the *DFPR* for 2003 (monthly expenditure: \$675 to \$800), it is projected that by the end of the fiscal year 2002-2003 the Department will have disbursed between \$17,852,400.00 and \$21,158,400.00 in LTC payments. The Table that follows compares annual and monthly expenditures per older person placed by *DFPR* in a LTC residential setting.

**PUERTO RICO
EXPENDITURES PER OLDER PERSON PLACED BY DFPR FOR LTC**

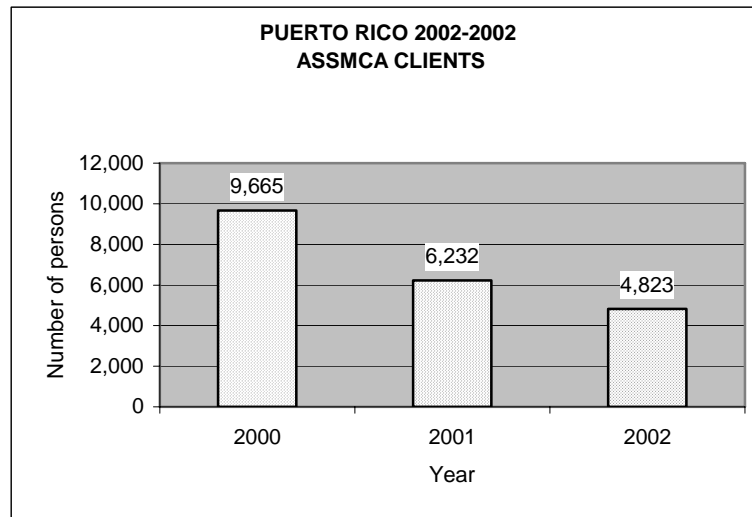
DFPR Adults 60 and over	2001-2002	April 2003 (Projection)
Placed in LTC	2,196	2,204
Average annual expenditure per client in LTC	\$6,002.74	\$8,850
Average monthly expenditure per client in LTC	\$500.29	\$737.50

Source: Department of the Family of the Commonwealth of Puerto Rico, ADFAN, May 2003

The *DFPR* has 70 LTC supervisors throughout the Island; eight of them are for the area of San Juan. The only educational requirement established is that the person has a Bachelor's degree in any field.

Another government agency that covers long-term care residential expenses in Puerto Rico is the *Administración de Servicios de Salud Mental y Contra la Adicción (ASSMCA; Administration of Mental Health and Anti-Addiction Services)* of the Department of Health. *ASSMCA* clients are adults with mental or addiction problems. At present, *ASSMCA* covers expenses for 1,218 adults in these board and care institutions (Negrón 2003). The agency places its clients in facilities classified as substitute, group or prolonged-care homes. Older clients are placed in board and care establishments that are referred to as "geriatric homes" and younger ones in what is referred to as rehabilitation homes. Older adults comprise 24.71 percent (365) of all LTCRE residents whose care is being currently paid *ASSMCA*. Fifty-two percent of the adults 60 years of age and older placed in residential settings by *ASSMCA* are women (159). The monthly LTCRE spending per beneficiary by *ASSMCA* ranges from \$1,500 to \$1,900; an annual range between \$18,000 and \$22,800. These expenses are higher than those of *DFPR* because they cover rehabilitation services as individuals cared for by *ASSMCA* are expected to move to lesser restrictive environments as time progresses and finally return to their community.

ASSMCA has experimented a reduction in clientele since 2000. Its officials state that the reduction in clients since 2000 has been the result of the ambulatory services offered under the *Reforma* (Negrón 2003). However, administrators indicated that it was their understanding that the number of geriatric homes in Puerto Rico are not sufficient to cover the needs of the population that they serve (Morales 2003, Negrón 2003).



Source: ASSMCA, Rehabilitation Division, 2003.

VI. B. Institutionalization : Requirements and procedures

In order for a low-income older person to apply to the *DFPR* to be eligible for admission in a LTC residential setting or be granted home-aide services and receive government subvention, he/she must meet some of the following criteria: (García 2003):

- Low-income
- Have 60 years of age or more
- Poor health
- No income to pay for at-home care giving services
- Not married (single, divorced, widow/er) or has no family willing to take care of him/her
- Inadequate nutritional status
- Inadequate housing or living conditions

The *DFPR* does not classify clients according to health condition or incapacity.

ASSMCA also requires that a person be 60 or older for placement in a geriatric home. Other requirements related to *ASSMCA*'s placements of adult individuals in LTCREs are:

- Mental problem diagnosis (slight, moderate or severe)
- Requires supervision and assistance in activities of daily living
- May hallucinate or show aggressive behavior occasionally but the condition is manageable
- May be bed-ridden but his/her physical deterioration is not severe
- Can live by herself in the residential establishment even though may need an escort when going out of the residence

ASSMCA's geriatric and residential establishments must have twenty-four-hour nursing services and an absence of potential suicide or homicide risks. ASSMCA also specifies that clients will be offered the alternative of residential rehabilitation and be moved from a more restrictive environment to a less restrictive one until the person can be reinstated in the community. An interdisciplinary behavioral evaluation is supposed to be carried out every four months to determine the steps to follow in terms of lesser restrictive alternatives.

Both *DFPR* and *ASSMCA* require a social and economic study of the potential beneficiary prior to residential placement. A pre-placement interview with the administrator of the residential facility is also carried out in order to corroborate that the establishment can meet the needs of the client. *ASSMCA* also identifies two areas of behavior per client that must be paid special attention to by the person in charge of the facility in order to prevent a potential crisis and establishes a plan for crisis management (Morales 2003, Negrón 2003).

A client without an income is considered insolvent and the agencies and other collaborating government departments assume the costs for residential placement. If the person receives Social Security or any other retirement benefit, the earnings are used as follows:

- 75 % for payment of the residential facility
- 15% for personal expenditures
- 10 % for savings

If he or she has other income sources such as inheritance, savings account, and/or checking account, half of these assets will be used to pay the facility and personal expenses and the other half will be placed in an account. If a client with sufficient economic means has been declared not legally competent and a tutor has been selected, the tutor has the responsibility for paying for the facility and opening a joint savings account and deposit of 10% of the client's earnings or income. Personal incomes are evaluated annually.

If the client has relatives with economic means, payments will be determined after a social and economic study of his/her family⁶. If the family is identified as a potential benefactor, the family contribution is determined in the following way:

- If 20% of the family monthly income is equal or higher than the cost of the residential facility, the family will be responsible for covering the entire cost
- If 20% of the family monthly income is less than the cost of the residential facility, a recommendation for a joint payment between the family and the government will be issued, and it cannot be less than 10% of the family earnings

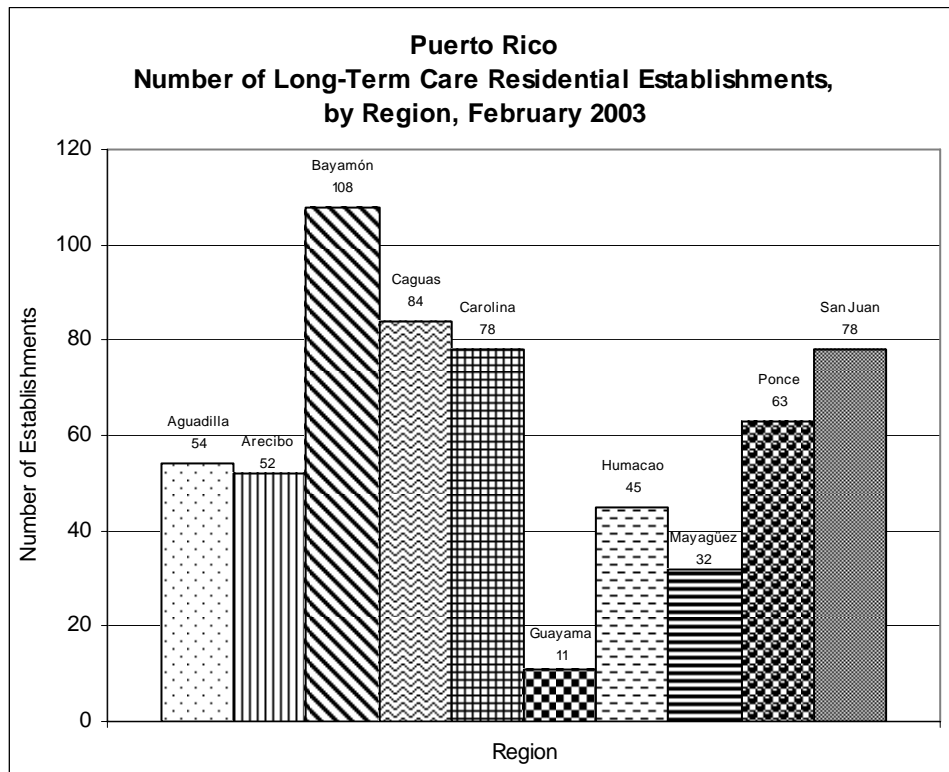
Some nursing-home-care providers have begun to stipulate that prior to institutionalization, the relatives of the potential client, sign an agreement that stipulates that they will acquire the responsibility for specific personal care items or services that the person needs. This modality has been endorsed by the Association of Providers of

⁶ Established by direct lineage (not collateral kinship) or by spousal responsibility under the laws of the Commonwealth of Puerto Rico.

Nursing Home Care in Puerto Rico, a recently formed organization catering to the interests, needs, and responsibilities of the owners of residential facilities (Cabrera 2003).

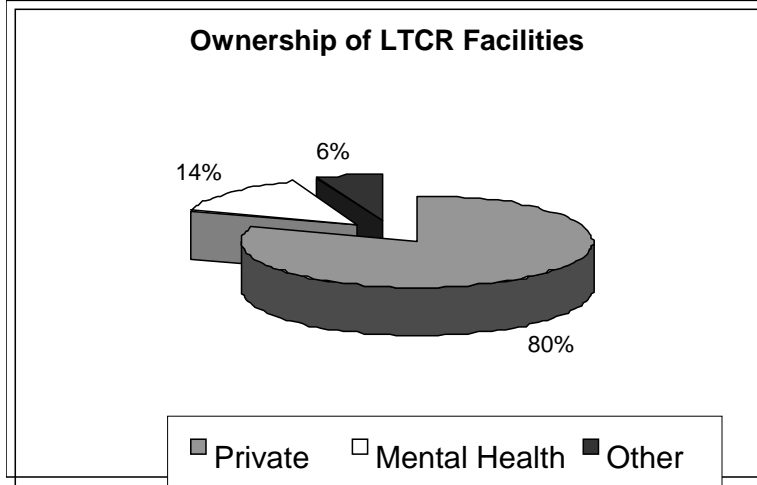
VI. C. Statistical data on long-term care residential establishments (LTCREs)

Information provided by The Department of the Family of the Commonwealth of Puerto Rico indicates that there were 605 long-term care residential establishments (LTCREs) in Puerto Rico in February 2003 and the majority were privately owned. Accordingly to the definitions in the previous section, 21.65 percent (131) were foster or substitute homes that cared after a maximum of six persons and 78.35 percent (474) were institutions that provided care to seven persons or more. In 2002, one assisted care facility was established. The total number of establishments by region (defined by existence of a subsidiary office of the Department of the Family) as of February 2003 is depicted in the following graph.



Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, February 2003

Most of the 605 establishments are privately owned (80%). ASSMCA's geriatric and rehabilitation homes comprise 14 percent of all LTCREs and the ownership of the remaining six percent is made up by religious groups and the governmental administration of certain municipalities (Luquillo, Vega Baja, Isabela, Camuy, Ponce, Humacao, and Yabucoa).



Source: OGAVE 2003

Licensed establishments comprised 82.31 percent of existent LTCREs (498 of 605). Of those whose license was in good standing, 21.28 percent (106) were foster homes and 78.72 percent (392) were institutions.

**PUERTO RICO 2003
LICENSING STATUS OF LONG-TERM CARE RESIDENTIAL ESTABLISHMENTS,
FEBRUARY 2003**

<i>LTCE</i>	<i>Licensed</i>		<i>License tardy*</i>		<i>No License</i>			
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	TOTAL	%
Foster Homes	106	80.92	17	12.98	8	6.11	131	100
Institutions	392	82.70	41	8.65	41	8.65	474	100
Total	498		58		49		605	

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, February 2003

*These LTCE were tardy in re-applying for a license but used to have one; many were in the process of complying with the requirements.

The largest metropolitan areas in Puerto Rico (Bayamón, Caguas, Carolina, and Ponce) have the highest proportion of licensed LTCEs with the exception of San Juan, the capital city. All LTCREs in the region of Ponce were licensed. The distribution of those that were licensed as of February 2003, by region, was as follows:

PUERTO RICO 2003
LICENSING STATUS OF LONG-TERM CARE RESIDENTIAL ESTABLISHMENTS,
FEBRUARY 2003

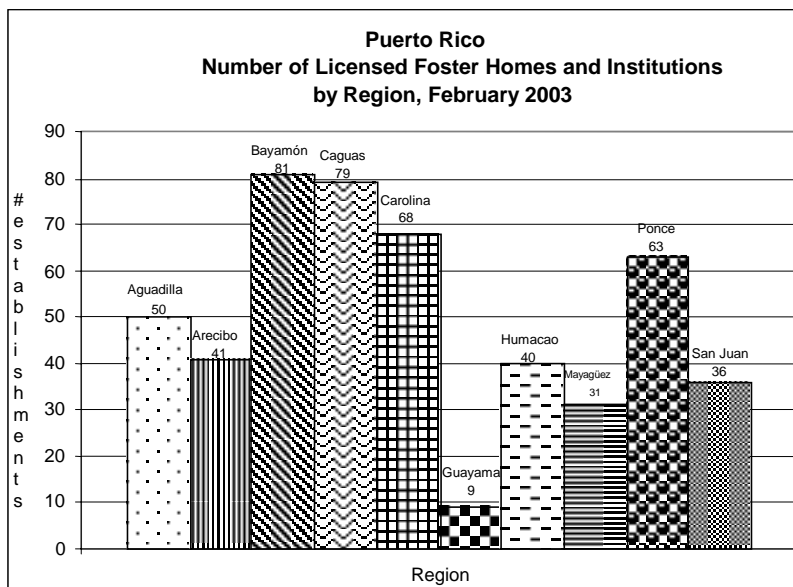
Region	LTCRE				Total
	Licensed		Non-Licensed		
	N	%	N	%	
Aguadilla	50	10.04	04	03.74	54
Arecibo	41	08.23	11	10.28	52
Bayamón	81	16.26	27	25.23	108
Caguas	79	15.86	05	04.67	84
Carolina	68	13.66	10	09.35	78
Guayama	9	01.82	02	01.87	11
Humacao	40	08.03	05	04.67	45
Mayagüez	31	06.22	01	0.94	32
Ponce	63	12.65	00	0.00	63
San Juan	36	07.23	42	39.25	78
Total	498	100.00	107	100.00	605

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003

PUERTO RICO 2003
LICENSING STATUS OF LONG-TERM CARE RESIDENTIAL ESTABLISHMENTS,
FEBRUARY 2003

Region	LTCRE				Total	
	Licensed		Non-Licensed		N	%
	N	%	N	%		
Aguadilla	50	92.59	04	07.41	54	100.00
Arecibo	41	78.85	11	21.15	52	100.00
Bayamón	81	75.00	27	25.00	108	100.00
Caguas	79	94.05	05	05.95	84	100.00
Carolina	68	87.18	10	12.82	78	100.00
Guayama	09	81.82	02	18.18	11	100.00
Humacao	40	88.89	05	11.11	45	100.00
Mayagüez	31	96.88	01	03.12	32	100.00
Ponce	63	100.00	00	100.00	63	100.00
San Juan	36	46.15	42	53.85	78	100.00
Total	498		107		605	

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003



Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003

Although San Juan is the main metropolitan area in Puerto Rico, it is interesting to observe that the area possesses less licensed LTCR institutions than nearby metropolitan areas such as Caguas, Carolina, and Bayamón. This could be a factor related to insufficient supervisors and tardiness in licensing procedures. San Juan has eight *DFPR* supervisors (Ortiz 2003).

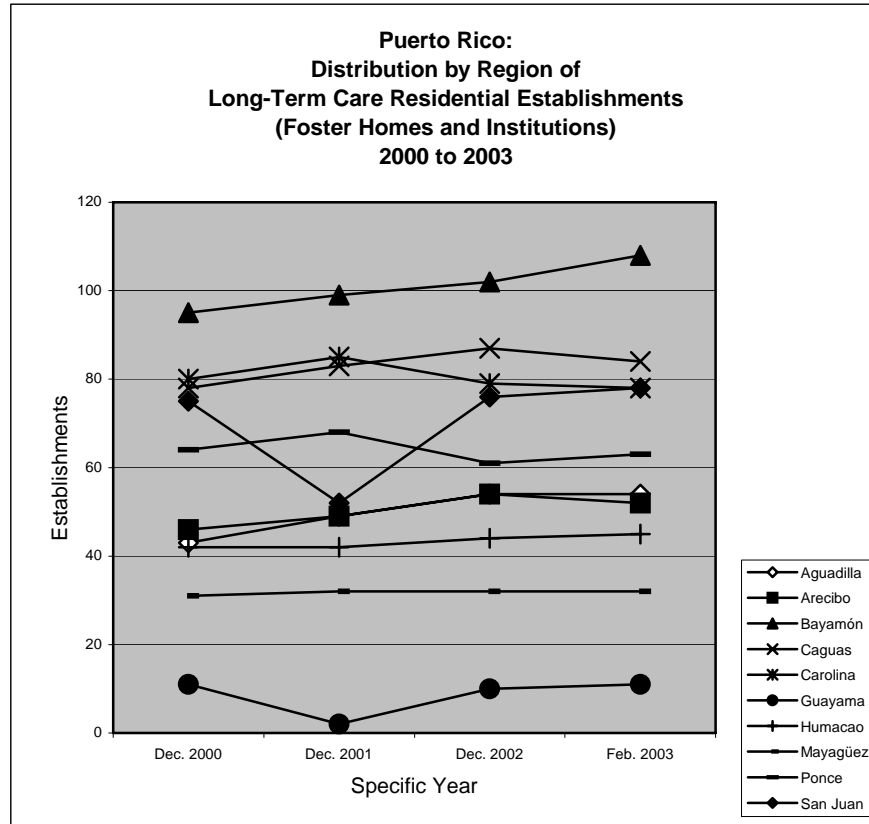
The *DFPR*-clients occupancy rate for licensed LTCREs in Puerto Rico for March 2003 was 75.84 percent. The Regions with the highest occupancy rates are Ponce (93.39%) and Guayama (91.53%) that are located in the southern area of Puerto Rico. The table below summarizes *DFPR*-clients occupancy rates for licensed LTCREs.

**PUERTO RICO, MARCH 25 2003
LICENSED LONG-TERM CARE RESIDENTIAL ESTABLISHMENTS
BY REGION AND ENROLLMENT**

<i>Region</i>	<i>Capacity</i>	<i>Enrollment</i>	<i>% Occupation</i>
Aguadilla	561	310	55.26 %
Arecibo	568	461	81.16 %
Bayamón	934	624	66.81 %
Caguas	831	633	76.17 %
Carolina	1,170	819	70.00 %
Guayama	59	54	91.53 %
Humacao	561	416	74.15 %
Mayagüez	733	673	91.81 %
Ponce	1,316	1,229	93.39 %
San Juan	597	340	56.95 %
Total	7,330	5,559	75.84 %

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 25, 2003

When we compare data from 2000 to 2003, it can be observed that there has been a growth in LTCEs (licensed and non-licensed) for most of the regions. This trend is observed in the Graph and Table that appear below.



Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, Dec. 2000, Dec. 2001, Dec. 2002, February 2003

**PUERTO RICO
DISTRIBUTION OF LONG-TERM CARE RESIDENTIAL ESTABLISHMENTS BY REGION,
2000 TO 2003**

REGION	December 2000	December 2001	December 2002	February 2003
Aguadilla	43	49	54	54
Arecibo	46	49	54	52
Bayamón	95	99	102	108
Caguas	78	83	87	84
Carolina	80	85	79	78
Guayama	11	2	10	11
Humacao	42	42	44	45
Mayagüez	31	32	32	32
Ponce	64	68	61	63
San Juan	75	52	76	78
Total	565	561	599	605

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, Dec. 2000, Dec. 2001, Dec. 2002, February 2003

According to *OGAVE* (2003), most of the long-term care residents are in the seventy years of age category (2003). Although the Census of 2000 indicated that long-term care residents constituted a minority of the elderly in Puerto Rico (1.45%), over a ten-year period there has been a numerical increase in the number of adults 65 years of age and older who live in LTC facilities although not necessarily a proportional one (*OGAVE* 2003).

VI. C. Skilled nursing facilities

There are seven skilled nursing facilities and all are certified by Medicare and licensed by the Department of Health of the Commonwealth of Puerto Rico (*OGAVE* 2003). These facilities admit patients of different ages, mostly older adults, who have been discharged from a hospital and need further medical attention and rehabilitation. They are located in or near large and medium size metropolitan areas (*OGAVE* 2003). Four of the seven skilled nursing establishments throughout the island are in the metropolitan area of San Juan and the others are in medium size metropolitan areas. The agency responsible for licensing or certification is the Department of Health of the Commonwealth of Puerto Rico. The names of these facilities and their location appear in the Table that follows:

**PUERTO RICO 2003
SKILLED NURSING FACILITIES, BY LOCATION**

<i>Name of SNF</i>	<i>Location</i>
Auxilio Mutuo Hospital	San Juan
San Gerardo Hospital	San Juan
Mimiya	San Juan
Centro Médico Antillas	San Juan
Ryder Memorial Hospital	Humacao
Damas Hospital	Ponce
Wilma Vázquez Hospital	Vega Baja

Source: *OGAVE*, April 2003

All the facilities accept Medicare and private plans. Medicare pays for all expenses for a specific number of days. Private plans require a pre-certification of need and reimbursement is determined according to each patient's condition, needed services, and length of stay. The Table below sums up number of beds certified by Medicare, occupancy and estimated cost per stay and day as offered by each facility. Total enrollment in Medicare certified beds in all skilled nursing facilities considered jointly is hardly half of the total capacity (56.49%). Daily costs per patient range from \$200 to \$480.

PUERTO RICO, APRIL 2003
SKILLED NURSING FACILITIES BY ENROLLMENT AND AVERAGE COST

<i>Skilled Nursing Facility</i>	<i>Beds certified by Medicare</i>	<i>Enrollment in beds</i>	<i>Occupation (%)</i>	<i>Average cost per private patient</i>	<i>Average daily cost</i>
Auxilio Mutuo Hospital	42	38	90.48	\$2,800/ 1 week	\$400.00
San Gerardo Hospital	100	32	32.00	\$2,000/10 days	\$200.00
Mimiya	24	19	79.17	\$230/day	\$230.00
Centro Médico Antillas	16	09	56.25	\$480/day	\$480.00
Ryder Memorial Hospital	62	30	48.39	\$200-\$300/day	\$250.00
Damas Hospital	21	19	90.48	\$160/day	\$160.00
Wilma Vázquez Hospital	20	14	70.00	\$300/day	\$300.00
TOTAL	285	161			\$232.43

. Source: Data provided by each private facility, April 2003.

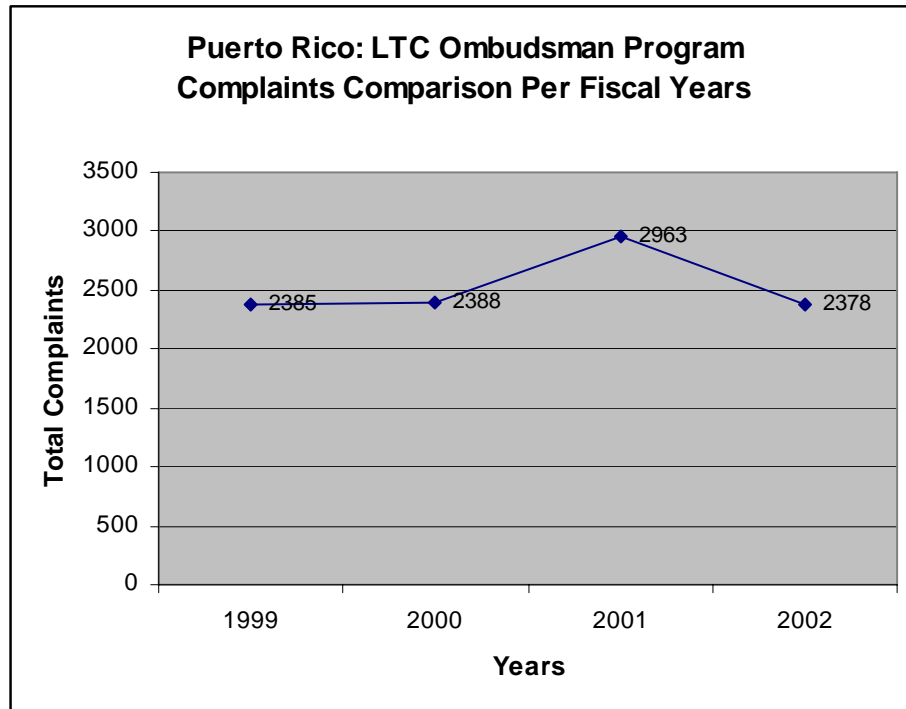
The only assisted living facility in Puerto Rico has 22 clients and is located at Ryder Memorial Hospital Complex in Humacao (Matos 2003). Customer's expenses include the monthly rent and the services rendered. Services vary according to each client's needs. A future facility with 50 residential units will be built in a Rio Piedras high-income residential area (Aponte 2003). Government officials stated that, although the conceptual framework behind assisted living is correct, the reality is that only a few have access to these costly services.

VI. D. Long-Term Care Establishments: Quality of Care Reports

VI. D. 1..Complaints to the LTC Ombudsman

The LTC Ombudsman Program of the Governor's Office for Elderly Affairs (OGAVE) is the program in charge of protecting the rights of the aged who reside in LTCEs. According to the law, this is the Office in charge of investigating complaints made by or on behalf of residents of LTCEs. These services can be used by elderly residents in all types of LTCEs, by their relatives or friends, by the staff of the LTCEs, and by community members or groups who are interested in the well being of a resident. The Ombudsman Program received 2,378 complaints on LTCEs during fiscal year 2002. These complaints, jointly with 2,290 situations not resolved during the year 2001, were investigated. Sixty-two percent of the total 4,668 complaints were satisfactorily resolved (OGAVE 2003).

According to *OGAVE*, the number of complaints made during fiscal year 2002 is eight percent lower than for the previous year. See the Graph below for a comparison of complaints for fiscal years ending in 1999 through 2002.



Source: *OGAVE* 2003

The LTC Ombudsman’s Office indicates that the greatest difficulty faced by the program was recruitment of personnel to cover all the LTC facilities (*OGAVE* 2003). The Office has seven supervisors scattered throughout the Island. The educational requirement for these supervisors is to have a Bachelor’s degree in a discipline related to social work or social/behavioral sciences (Matos 2003). For fiscal year 2002, the San Juan-Carolina area did not have volunteers available to monitor the complaints and it affected coverage in this area (*OGAVE* 2003). *OGAVE* recognizes that this staffing problem could have been accountable for the decrease in reported complaints for fiscal year 2002. According to the classification provided by *OGAVE*, the complaints received during fiscal year 2002 were related, in descending order, to: quality of life, resident care, residents’ rights, and administration. The two Tables that follow show the complaints reported by categories and also a comparison for fiscal years 1999 through 2002.

PUERTO RICO 2002: LONG-TERM CARE ESTABLISHMENTS, COMPLAINTS REPORTED

COMPLAINT CATEGORIES	NUMBER	PERCENT
QUALITY OF LIFE	865	36.37
Activities and social services	75	03.15
Dietary	335	14.09
Environment	455	19.13
RESIDENT CARE	579	24.35
Care	335	14.09
Rehabilitation or maintenance of function	104	04.37
Restraints (chemical/physical)	140	05.89
RESIDENTS' RIGHTS	491	20.65
Abuse, gross neglect, exploitation	44	01.85
Access to information	156	06.56
Admission, transfer, discharge, eviction	13	00.55
Autonomy, choice, exercise of rights, privacy	252	10.60
Financial, property	26	01.09
ADMINISTRATION	443	18.63
Policies, procedures, attitudes, resources	219	09.21
Staffing	186	07.82
System/Others	38	01.60
TOTAL	2,378	100.00

Source: OGAVE, Annual Report "Puerto Rico Long Term Care Ombudsman Program", April 2003.

**PUERTO RICO: LONG-TERM CARE ESTABLISHMENTS, COMPLAINTS REPORTED
COMPARISON FISCAL YEARS 1999 – 2002**

CATEGORY	YEAR			
	1999	2000	2001	2002
QUALITY OF LIFE				
Activities and social services	39	63	156	75
Dietary	292	352	473	335
Environment	701	627	711	455
RESIDENT CARE				
Care	341	306	362	335
Rehabilitation or maintenance of function	59	79	90	104
Restraints (chemical/physical)	94	107	167	140
RESIDENTS' RIGHTS				
Abuse, gross neglect, exploitation	33	36	48	44
Access to information	188	114	202	156
Admission, transfer, discharge, eviction	12	06	17	13
Autonomy, choice, exercise of rights, privacy	168	173	188	252
Financial, property	22	13	18	26
ADMINISTRATION				
Policies, procedures, attitudes, resources	203	266	281	219
Staffing	165	201	225	186
System/Others	68	44	25	38
Complaints in other settings		01		
TOTAL	2,385	2,388	2,963	2,378

Source: OGAVE, Annual Report "Puerto Rico Long Term Care Ombudsman Program", April 2003

The overwhelming majority (72.83%) of the complaints reported in 2002 were filed by the Ombudsman's Program. Complaints received from relatives and friends were a distant second (12.30%). The table that follows presents the number of complaints received by plaintiff and by area.

**PUERTO RICO 2002
LONG-TERM CARE ESTABLISHMENTS, COMPLAINTS RECEIVED BY PLAINTIFFS**

AREA						
	Caguas/ Humacao	Carolina/ San Juan	Arecibo/ Bayamón	Mayagüez/ Aguadilla	Ponce/ Guayama	
PLAINTIFF						N (%)
Resident	13	19	03	10	03	48 (05.13)
Relative/Friend	19	47	17	16	16	115 (12.30)
Non relative/ Legal rep.	0	0	0	0	0	0 (00.0)
Ombudsman	150	190	191	68	82	681 (72.83)
Facility staff	04	09	04	04	03	24 (02.57)
Medical staff	0	03	0	01	01	05 (00.53)
Social worker/ agency rep.	01	07	07	02	0	17 (01.82)
Unknown/ Anonymous	06	13	10	01	06	36 (03.85)
Other	0	08	01	0	0	09 (00.96)
TOTAL	193	296	233	102	111	935 (100.00)

Source: OGAVE, Annual Report "Puerto Rico Long Term Care Ombudsman Program", April 2003

V. D. 2. Evaluation report on ASSMCA's long-term care residential establishments

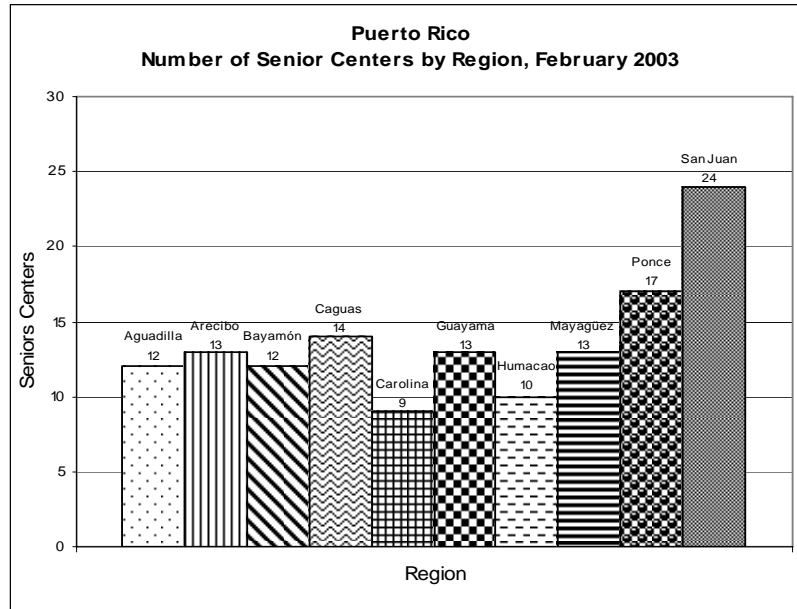
ASSMCA carried out an evaluation process of the quality of services rendered at their LTCR Division (*División de Hogares*) during the period covering July 1 2000 to June 30 2001 (Negrón 2002). Among its more important findings was that the required every four-month evaluations of the services rendered at the residential setting were not being performed. Only 55 percent of the homes in the sample had been evaluated during that time period and only once. The remaining 45 percent had not been evaluated. Similar problems were found in the compulsory resident file. ASSMCA requires that its clients be evaluated periodically since the aim of the agency is rehabilitation. As such, a treatment and rehabilitation evaluation has to be carried out by

an interdisciplinary team (*Plan Individualizado de Tratamiento y Rehabilitación /PITRE*) thirty days after the time of admittance (maximum) and thereon every four months. The findings indicate that some facilities do not have a complete interdisciplinary team for evaluation in the following areas: nursing, social, psychiatric, and occupational and recreational therapies. Only 50 percent of the ASSMCA clients had their initial *PITRE* and 85 percent of these had never been revised. Another important finding relating to the *PITRE* revolved around the fact that only 50 percent of the clients had signed their *PITRE* as required; a detail that created doubt as to whether the remaining half had any knowledge of the existence of the evaluation or had taken part in his/her rehabilitation plan. According to the Report, this is a clear violation of the Bill of Law 408 of October 2 2000 that stipulates that every adult institutionalized by ASSMCA has a right to a *PITRE*, to be informed of its contents, and to consent to the plan. Another associated finding was that no professional recommendations were offered for rehabilitation in 31 percent of the cases having a *PITRE*.

Similar findings arose with the implementation of the daily activities plan for each client (*Plan de Actividades Diarias/PAD*). The purpose of this plan is to incorporate the interdisciplinary team's recommendations in order to meet the rehabilitation objectives. Only 50 percent of the residential facilities had a *PAD* and only 67 percent of these revised the plan on a regular basis. Some of the facilities that had a *PAD* for their clients had a generic plan and not an individual one as required. In the same way, even though ASSMCA aspires to relocate its clients to lesser restrictive environments as time passes, the average time per client in a specific residential facility was five years. What the Report did find that was met in most cases (over 75% in the majority) was the regulation pertaining to the physical facilities, such as: lightning, number of residents per room, locked armoires, twin-size beds without a headboard, parking area, accessible telephone, sign with the date visible to the clients, 80 square feet of green area, dinning area with required furniture, first-aid-kit, and required number of showers and toilets per resident (one for each six residents), among other requirements. All the issues discussed in this section point to a lack of compliance with service-quality criteria that extends beyond regulations pertinent to physical structure, facilities, and furniture.

VII. Adult Day Facilities/Senior Centers

Although not a residential setting, senior centers or adult activity day facilities also provide long-term care services and allow the elderly to remain in the community-at-large. Senior day facilities offer a series of direct services such as social services, nutrition (congregate meals and home-delivered meals), escorts, health, and recreation to improve the conditions of daily living and to prevent social deterioration and isolation. There were 137 senior centers throughout the Island in February 2003. Over three-fourths of the adult day facilities (78.10%) existing in February 2003 were licensed.

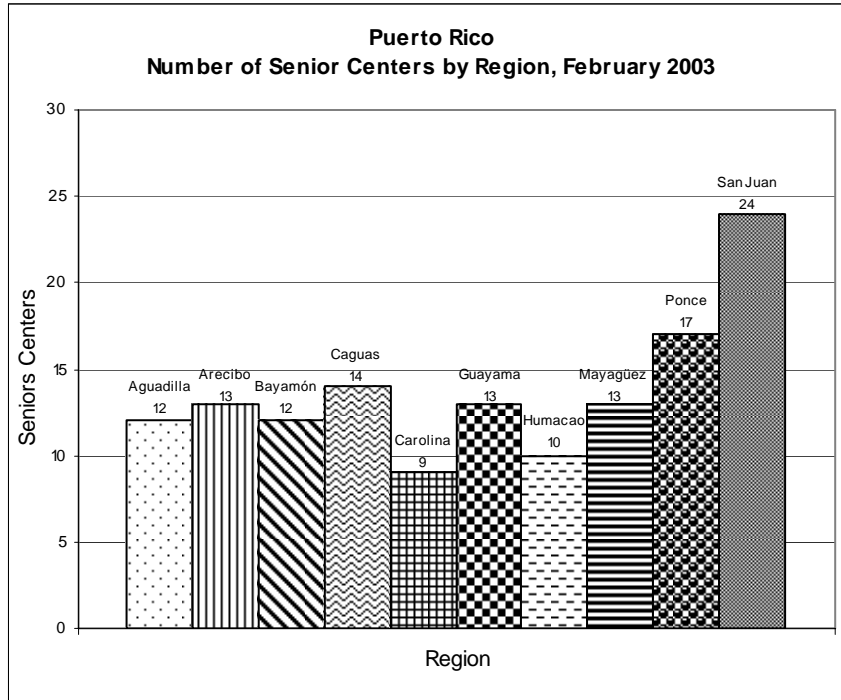


Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003

PUERTO RICO, FEBRUARY 2003
LICENSED SENIOR CENTERS

<i>REGION</i>	<i>LICENSED (N=107)</i>	<i>%</i>
Aguadilla	11	10.28
Arecibo	9	08.41
Bayamón	12	11.21
Caguas	10	09.35
Carolina	9	08.41
Guayama	10	09.35
Humacao	7	06.54
Mayagüez	12	11.21
Ponce	15	14.02
San Juan	12	11.21
TOTAL	107	100.0

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003



Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2003

It seems that older adults are congregating in senior day centers in view of the the occupancy capacity of the centers. Licensed centers have an enrollment of over four-fifths of their capacity; a rate of 87.17 percent. No center has an enrollment of less than 68 percent of its capacity. A total of 5,939 older adults throughout the island of Puerto Rico used the services offered at adult day facilities in March 2003.

**PUERTO RICO, MARCH 25 2003
LICENSED SENIOR DAY CENTERS BY CAPACITY AND ENROLLMENT**

<i>REGION</i>	<i>Capacity</i>	<i>Enrollment</i>	<i>% Occupation</i>
Aguadilla	726	497	68.46
Arecibo	513	443	86.35
Bayamón	1,165	985	84.55
Caguas	590	545	92.37
Carolina	620	455	73.39
Guayama	551	419	76.04
Humacao	255	250	98.04
Mayagüez	724	688	95.03
Ponce	1,099	1,072	97.54
San Juan	570	585	102.63
TOTAL	6,813	5,939	87.17

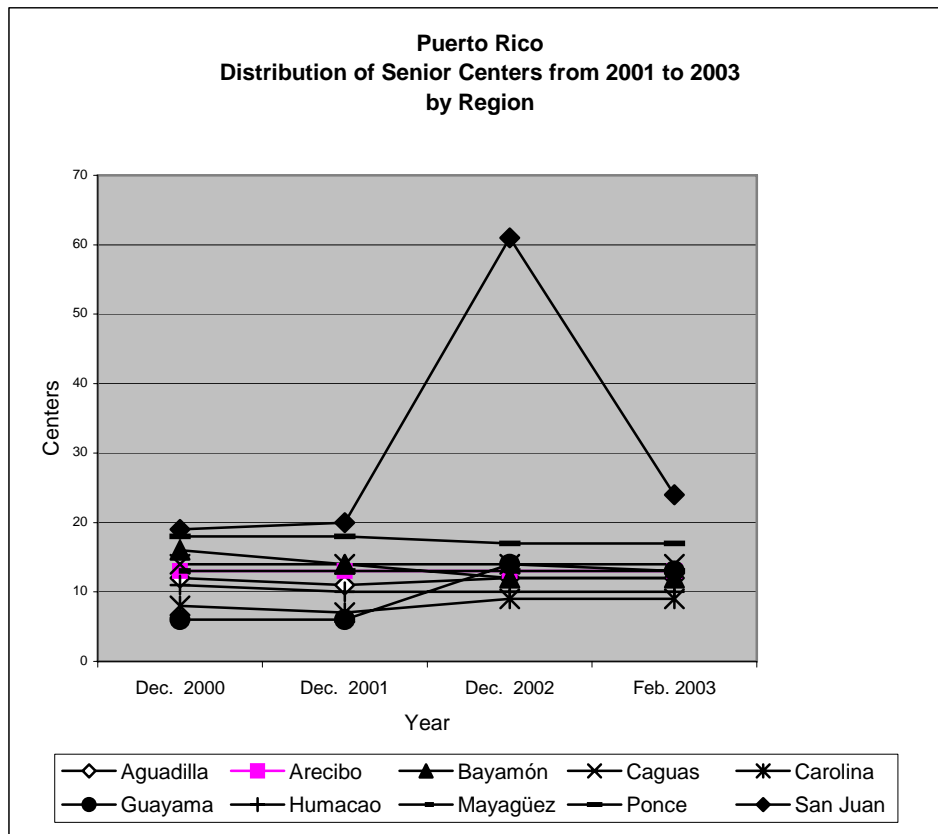
Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 25, 2003

During the last three years, the total number of senior centers has remained fairly stable. It is worth noticing that in San Juan there was a considerable increase from 2001 to 2002 and then in less than two months, 37 centers closed. This is illustrated below.

**PUERTO RICO
DISTRIBUTION OF SENIOR DAY CENTERS BY REGION, 2000 TO 2003**

<i>REGION</i>	<i>Dec. 2000</i>	<i>Dec. 2001</i>	<i>Dec. 2002</i>	<i>Feb. 2003</i>
Aguadilla	12	11	12	12
Arecibo	13	13	13	13
Bayamón	16	14	12	12
Caguas	14	14	14	14
Carolina	8	7	9	9
Guayama	6	6	14	13
Humacao	11	10	10	10
Mayagüez	13	13	13	13
Ponce	18	18	17	17
San Juan	19	20	61	24
Total	130	126	175	137

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2000-2003



Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 2000-2003

**PUERTO RICO
LICENSING STATUS OF SENIOR DAY CENTERS, FEBRUARY 2003.**

<i>Establishments</i>	<i>Licensed</i>		<i>License overdue</i>		<i>No License</i>	
	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>
N=137	107	78.10	20	14.60	6	4.38

Source: Department of the Family of the Commonwealth of Puerto Rico, Statistics Division, March 25, 2003

VIII. Home/Family Settings

VIII. A. Home care

Home-maker services

Home-aides (*amas de llave*) are one of the most important services provided by the *DFPR*. This service is offered to older adults and adults with impediments that face difficulties in performing activities of daily living, personal and household chores, and lack relatives who can take care of these needs suitably. This service is provisional and subject to re-evaluation of needs. It allows older adults to remain living in the community and prevents relocation in foster homes or institutions. Requirements to receive the services are: to be 60 years old or to be an adult with disabilities and to have an income at or below poverty level. A socioeconomic case study of the individual is required.

This service is offered solely in the home of the beneficiary. It is not offered in hospitals or in foster homes or other institutional settings. Home-aides receive a salary of \$5.15 per hour (Valentín 2003). Most of them have a low level of schooling. They are required to attend occasional one-hour workshops that address issues such as needs of older adults and role of the home-aide and specific health topics such as Alzheimer's, other dementias, cancer, and HIV, among others.

The home-aides program is administered by the *Corporación de Amas de Llaves de Puerto Rico*. This corporation caters to the service needs of the Department of the Family, The Governor's Office for Elderly Affairs, The Veterans Administration, The Mental Health Services and Anti-Addiction Administration (ASSMCA), and private entities. The maximum hours of service that a person can receive is 20 hours a week, four hours per day for five days a week. The program covers weekends, if needed. The weekly minimum is 12 hours of service and three days of the week. In February 2003, the *Corporación de Amas de Llaves de Puerto Rico* contracted 3,200 homemakers and serviced 3,026 older adults (Valentín 2003). The *DFPR* covered home-aides cost for 2,527 older adults (*DFPR ADFAN* 2003); 85 percent of those serviced by the *Corporación de Amas de Llaves de Puerto Rico*. *DFPR* administrators project that for fiscal year 2002-2003 the Department will spend \$10,827,689.00 in home-aide assistance; an annual average expenditure per beneficiary of \$4,284.80 and monthly expenditure of \$330.00.

OGAVE's beneficiaries for fiscal year 2002 for homemaker services included 3,669 older adults. *OGAVE*'s criteria for eligibility include frailty status and available income after disbursement for medicines (not a criterion considered by the *DFPR*). The

agency used the services provided by the *Corporación de Amas de Llaves de Puerto Rico* and also that of home-aides paid by funds from the Work Investment Act (WIA). These funds are municipal funds managed by each municipal administration for employment and training. Homemakers are trained by *OGAVE*.

Caregivers of Puerto Rico

The number of home-aides provided by *DFPR*, *ASSMCA*, and *OGAVE* is not adequate and priority is given to persons with meager resources. To satisfy the growing need for home assistance, a private profit organization, *Caregivers of Puerto Rico*, was created in 2000. This company offers home care to elderly and handicapped persons. Home-aides undergo a training and must present personal and prior work references when hired. A staff of health professionals is available for supervision and direction. Customary services offered by this organization are: personal hygiene, supervision of consumption of medicines, preparation of meals, light household chores, company and emotional support, escort to medical appointments, running errands or buying necessary items, and daily checking of patients by the telephone. More specialized home-health services include: supervision of mental patients and post-operation rehabilitation assistance. *Caregivers of Puerto Rico* offers its services seven days a week and on a twenty-four-hour schedule. They provide three different types of assistants based on skills and training: companion, certified auxiliary, and licensed nurse.

These home-aide services are not covered by Medicare. The cost of an initial evaluation is \$35 and the customary weekly expenses of services rendered by either a companion or certified auxiliary during the day (not the evening) are:

- 4 hours/day, 3 days: \$107.40 - \$119.40
- 4 hours/day, 5 days: \$179.00 - \$199.00
- 8 hours a day, 3 days: \$214.80 - \$238.80
- 8 hours/day, 5 days: \$358.00 - \$398.00

Home health care

A private non-profit agency known as **Home Care** provides this type of services to homebound elders that are either Medicare or private health insurance recipients. There are 46 home-care-service agencies in Puerto Rico. Service providers must be certified by Medicare and comply with federal, state, and local laws that regulate home care services. Some of the services offered are: certified nurses, health assistants, physical therapy, occupational therapy, speech therapy, medical social workers, dieticians/nutritionists, medical supplies. A medical referral is necessary if any type of insurance is to cover the services. The following services are not covered: round-the-clock nurses, medicines, home cleaning, cleaning, meals, and transportation to medical appointments. This service, when provided by Medicare A, requires that the patient be 65 years of age or older or be disabled, be under the care of a primary physician, have received a certification that the home-care service is needed, and must reside in an area covered by the agency. Residents of nursing homes and rehabilitation facilities are also covered. Expenses are billed by each visit made by the different health professionals. Medical equipment is billed separately. Estimated monthly cost ranges from \$1,200 to \$1,500 per patient. As presented in Section IV.B., Medicare home health agency utilization payments in Puerto Rico for the year 2000 amounted to \$49,722,196.00 (CMS 2003) . A total of 100,286 claims were received and the total of patients served was

29,406. The average reimbursement per patient during the calendar year 2000 was \$1,691.00. The total of home health visits for the same year was 876,409 and the average number of visits per patient was 30.

Private home-caregivers

There are families that pay a caregiver to look after the frail old adult in the home. This service varies from \$800 to \$2,000 a month per caregiver and is available to those who can afford it, mostly upper-income families. These caregivers are neither trained in gerontology or health care nor supervised by a government or private agency. Most of them are low-literate women who provide homemaker services and assume the responsibility for household chores and looking after the frail elder. They may also provide assistance with medications but not wound care or intravenous therapy. These women may or may not reside in the home and their chores may extend to 24 hours or just eight hours a day. Most of them work from Monday to Friday and the family must look for another caregiver during the weekends. Since these services are not registered in any agency, specifications and cost vary according to the needs of each family.

Home hospice

Home hospice services allow chronically ill terminal patients to remain in their homes or the home of a relative until they die. It is a comprehensive home-health service that assists the patient and his/her family to confront death and the process of dying. There are 36 hospice organizations in Puerto Rico. To qualify for home hospice services in Puerto Rico a person must have Medicare Part A or a health plan that includes hospice services or be suffering from terminal condition diagnosed by a primary physician or a specialist. Hospice covers all benefits allowed by Medicare and a nurse and doctor are available on-call 24 hours for 7 days a week. The service is offered by private health entities. As in the U.S., the terminal condition has to be determined by a physician. In Puerto Rico, Medicare pays approximately \$1,300 a month per patient and the patient can receive all services included under Medicare (nurses, physician, medical equipment and supplies, pain-killers, social work services, spiritual counseling, nutritional counseling, different types of therapies, home-aide, etc.). Some of the providers also offer respite for a maximum of five days. Medicare reimbursements for hospice utilization for calendar year 2000 totaled \$21,567,311.00. A total of 4,481 patients received hospice services. The average reimbursement per patient was \$4,813.00 (CMS 2003). The total covered days for calendar year 2000 for hospice utilization was 303,330 and the average number of days per patient was 68 days (CMS 2003). The total of covered procedures was 14,852.

Visiting Nurses

The Association of Visiting Nurses is comprised by different health professionals that offer various home-health services besides nursing. They provide speech, physical, and occupational therapy as well as social services and medical equipment. The nursing services are offered on a twenty-four-hour basis. Other services include: hospice, custodial, prevention and maintenance, nutritional counseling, respiratory therapies, and referrals. Although most services are performed in the home, the health professionals can also visit patients in their offices or schools. The Association also offers services at their facility. Expenditures vary according to type of service rendered, amount of time involved in service-provision and where it is offered. It accepts payments from Medicare or private

health plans subsequent to an official verification of needs and certification. Costs for private patients are as follows:

- Licensed nurse: \$55 per visit
- Physical therapy: \$60 per visit
- Speech therapy: \$90 per visit
- Prevention and maintenance: \$5 and up
-

The Association also seeks donations to provide services for persons without health insurance.

VIII. B. Other programs for family caregivers and elderly residing in the community

Formal services available to elderly adults in Puerto Rico fall under two categories: universal (all aged) and selective (those that possess or exhibit certain characteristics). The following social services are offered under Title XX of the Social Security Program and are geared to those with meager resources: legal aid, day care centers, recreation, meals, homes for the aged, substitute homes, and home aides. The Older American Act (OAA) offers funds to create universal programs for the aged person. These funds cover programs in the following areas: nutrition, information and referral, counseling, and escort.

The Department of the Family of the Commonwealth of Puerto Rico is the agency in charge of providing social services in Puerto Rico. Most of the services offered to elderly adults are channeled through the Program of Adult Services of the Administration of Families and Children (*ADFAN, Administración de Familias y Niños*). Persons 65 years of age or older and those who meet certain poor health or meager economic resources criteria can benefit. Among the services offered by the *DFPR* are: information and referral, home-aides, substitute or foster homes, case intervention and orientation geared to familial or individual problem-solving, prosthetic and orthopedic equipment for impaired elderly, and senior centers.

Information and Referral: This program offers information and refers older or disabled adults to existing community resources.

Counseling: This program is geared to the well-being of clients and offers individual, group, and family counseling

Protective Services: Consists of social services that are offered with the objective to prevent negligence, abuse, abandonment or financial or sexual exploitation of older and disabled adults

Orthopedic and Prosthetic Services: Provides, in a limited way, prosthesis and orthopedic equipment (walkers, canes, crutches) when another agency in the community does not have them available and according to medical recommendation.

Professional and Consultative Services: Provides psychological and psychiatric services for aims of evaluation and establishment of a plan of services.

The Governor's Office for Elderly Affairs (*OGAVE*, Oficina de la Gobernadora para Asuntos de la Vejez) is the government agency in charge of planning and coordinating with public and private agencies the programs, activities and services geared to attend the needs of the aged. It provides orientation and guidelines in the implementation of programs as well as evaluation procedures. Also among its goals is the organization of conferences, workshops and seminars for service providers and the compilation of empirical data. Another of its tasks is to disseminate information to the elderly on available benefits, programs and services as well as to the population as a whole in order to develop positive attitudes toward the aging process and the aged. Among the various programs geared that may impact long-term care services for the elderly that this agency offers are the ones that follow.

Services against Institutional Abuse (LTC Ombudsman): Its purpose is to investigate complaints of abuse or negligence in all licensed or certified LTC establishments and promote services geared to avoid or to eradicate mistreatment. This program is part of the Governor's Office for Elderly Affairs. The location of the LTC Ombudsman at *OGAVE* and not the *DFPR* responds to possible conflicts of interests. Since the Department of the Family is the agency responsible for licensing, a conflict of interest could arise in the investigation of complaints of abuse and negligence, and therefore the need for a different agency to provide these services.

Nutrition Services: *OGAVE* is the agency that offers the nutritional services established in the OAA. Most of them are offered at licensed or qualified senior centers or Centers for Multiple Activities and Services (*Centros de Actividades y Servicios Múltiples*). The objective of the nutrition services is to promote the health of the old adult with great economic and/or social needs by providing adequate meals. The congregate meals are served at senior centers strategically located where the participants can receive other services. Two snacks and lunch five or more days in the week is provided at congregate meals. The menus are planned by nutritionists. Disabled adults who cannot participate in the activities of the senior centers receive home delivered meals. *OGAVE* delivered 1,349,874 home meals during fiscal year 2002 and reached 6,835 persons. Title III funds for Nutritional Services for fiscal year 2002 amounted to \$1,741,006.00 (Aponte 2003).

Support To Family Caregivers (Programa de Apoyo a Cuidadores de Familiares). Offers assistance to family caregivers of an older adult with a chronic disease or disability. This program entails many services: information on available services, counseling (individual and group), training in basic home health chores, institutional respite and day care provided by home-aides, and supplementary services (nutritional supplements, house repairs, durable medical equipment, and supplies for incontinence). It also has a life-line service and provides support to grandparents raising grandchildren 18 years of age or younger. From October 2002 to March 2003, 4,219 persons had received informational assistance, 930 had received home-aide services, three had received institutional respite, 620 had life-line assistance, and 1,343 had received supplementary services (Aponte 2003).

Older Friends and Companions for Persons with Alzheimer's (Programa Amigos Mayores Acompañantes (PAMA) para Personas con Alzheimer). Allows persons 60 years of age and older to offer voluntary respite care to family caretakers of Alzheimer's patients. Some of the eligibility criteria are: monthly income below \$870; mentally,

physically and emotionally competent to serve the particular needs faced by Alzheimer's patients, not part of the work force, and willing to take care of two patients in one week.

Access to Services for Alzheimer's Patients (ASAP)(Programa de acceso a servicios para personas con Alzheimer). Facilitates access to services for people with Alzheimer's in Puerto Rico. Also provides support in the home.

Other programs or services offered by the above mentioned and other government agencies that may enable a person to stay in the community and may provide a more adequate residential environment for long term care in a family or community setting are:

Retired Citizens Voluntary Program (RSVP): Its intention is to provide opportunities for adults 55 years of age or older to become involved in activities in their communities by promoting voluntary services according to the interests of the participants and the needs of the community.

HOPE: It is a comprehensive services program for people of 60 years of age or more with economic and/or social needs related to: nutrition, home-health delivery, transportation, socialization and voluntary services. Some of the eligibility requirements are: to be 60 years old or more and to have special developmental needs or exceptional needs related to health, well-being and education.

Social Action (Acción Social). A comprehensive services program directed to people 60 years of age or more with economic and/or social needs.

Home Improvement (Programa de Mejoras a Viviendas). Facilitates opportunities for home improvement to older persons who are home owners.

Title 8. Provides rent subsidy for low-income families, older and disabled adults.

Defense and Assistance to Crime Victims (Programa de Defensa y Asistencia a Víctimas del Crimen, PROVIEN). Offers protection and assistance to crime victims who are 60 years of age or older.

Assistance to Crime Victims (Programa de asistencia a víctimas del crimen; PASVIC (Department of Justice). Provides judicial support and orientation to crime victims.

Transportation. The Metropolitan Authority of Transportation (AMA) has a program named "Call and Travel" (*Llame y Viaje*). It provides transportation to the mentally and physically challenged. The service is delivered in the municipality of San Juan and nearby areas: Guaynabo, Bayamón, Cataño, Trujillo Alto, Toa Baja (Levittown) Loíza, and Carolina. Eligible persons are picked up at their home and taken any place within the service area. Service hours are from 5:30 A.M. to 10:00 P.M. The service fee ranges from \$0.50 to \$2.50 per trip. OGAVE has a similar program named *SENDAS* that covers districts outside the *Llame y Viaje's* service area.

IX. Social, Cultural and Political Challenges Surrounding LTC in Puerto Rico

The long-term care industry in Puerto Rico has grown in size and importance as a result of the aging of the population. The elderly population in Puerto Rico is not only growing rapidly and living longer, but is also experiencing high rates of chronic conditions, functional limitations, and impairments. They constitute the age subcategory with the heaviest use of medical services, while at the same time a majority is affected by poverty or low-income status (Dávila and Sánchez-Ayénde 1996). Adults 85 and older comprise the segment of the older population that has increased the fastest in the last ten years and the projections for 2020-2025 (presented in the first part of this report) indicate that this trend will continue. This is the segment of the elderly that is more likely to have functional problems, presents an increase in morbidity, shows more serious effects of chronic diseases, and has serious needs concerning long-term care. Issues pertaining to quality of services and access are likely to grow in magnitude as the demand increases and the supply cannot accommodate to the escalating needs.

The political environment surrounding LTC in Puerto Rico is as complicated as the one in the U.S., perhaps somewhat more due to the political relationship between the U.S. and Puerto Rico as well as to the economic dependence of Puerto Rico to the U.S. This relationship affects not only federal funding but also compliance with federal regulations in a country where Medicare and Medicaid are the primary health insurance providers for the older population and persons with special/developmental needs and where benefits for LTC are lacking behind those in the U.S.

The cross-sectional panorama presented in this report identifies a group of agencies in the LTC arena that either develop or implement public policy and programs, implement state/federal regulations or impose penalties. These key players are:

- 1) The Department of the Family
- 2) The Administration of Mental Health and Anti-Addiction Services of The Department of Health of the Commonwealth of Puerto Rico (*Administración de Servicios de Salud Mental y Contra la Adicción/ ASSMCA*)
- 3) The Governor's Office for Elderly Affairs
- 4) Long Term Care Ombudsman
- 5) Medicare
- 6) Medicaid
- 7) The Puerto Rico Health Insurance Administration (*Administración de Seguros de Salud de Puerto Rico /ASES*) and the *Reforma*

A major group of individuals, agencies, and organizations, and one that generally conforms to the laws, regulations, and requisites set up by the aforesaid agencies, is formed by:

- 1) The Association of Providers of Nursing Home Care in Puerto Rico
- 2) Providers of nursing home care not members of the Association of Providers of Nursing Home Care in Puerto Rico
- 3) Agencies providing home-maker/home-care, and home-health services
- 4) Adult day care facilities/senior centers
- 5) Older adults, mentally and physically challenged persons, and their families

Some of the aforementioned agencies and other agencies or organizations (public and private) are part of the LTC background and provide supportive services that are shaped by the regulatory efforts and the kinds of settings in which care is provided. These agencies/organizations are mainly involved in the delivery of services related to:

- 1) Information and referral
- 2) Residential and day care settings
- 3) Respite/Programs for family caregivers
- 4) Counseling and other professional/consultative services
- 5) Protective services
- 6) Programs for special populations

- HOPE
- Alzheimer's patients
- Home-delivered meals
- Crime victims
- Transportation

One of the primary LTC key issues of concern regarding Puerto Rico, according to our interpretation of the data provided by various agencies and also the opinion of the persons who were interviewed for this report (Cabrera 2003, Crispín 2003, García 2003, González 2003, López 2003, Matos 2003, Valentín 2003), is long-term care residential facilities; or in the majority of the cases in Puerto Rico, board and care facilities. This has been a concern also in the U.S. for many years. In 1986, the Institute of Medicine's Study on Nursing Home regulation indicated quality of care-problems in many nursing homes and recommended strengthening of federal regulations (IOM 1986). Despite significant changes due to Medicaid and Medicare, certain dilemmas still remain. Although federal Medicaid and Medicare standards do not apply to LTCREs in Puerto Rico, the Legislature of Puerto Rico and the *DFPR* have provided an ample set of regulations aimed at quality of care at long-term care residential establishments. Puerto Rico has a set of laws that are well oriented and well intended in terms of efforts to improve quality of care and protect residents from abuse. However, both the Licensing Office of the *DFPR* as well as the Office of the LTC Ombudsman are understaffed and were among the first to recognize the need for more staffing for supervision. Likewise, lack of staff for the required socioeconomic and health/rehabilitation evaluations of the potential and actual residents (Negrón 2002, *OGAVE/PAHO* 2003) may affect quality of service as well as supply of needed services.

Another issue that was important to the government officials that were interviewed was the scarcity of homemaker services. The demand for homemakers or home-aides has exceeded by far the supply of the *Corporación de Amas de Llave de Puerto Rico*, particularly for those who are poor and cannot pay for private services offered by Caregivers of Puerto Rico, Home Care, Visiting Nurses, and other profit organizations or non-trained individuals who provide homemaker services for a fee. Homemakers and home health care services facilitate that the elderly and the physically or mentally challenged remain in a familial setting and in the community. Research has indicated that most persons with LTC needs prefer to remain in their homes and receive services there (A.A.R.P. 2001). However, the poor exceed the offer of the *Corporación de Amas de Llave de Puerto Rico* and direct private payments for this long-term care service is available to a few who are in the upper economic echelons. More home-aides and more time assigned for homemaker services to poor older adults and individuals

with mental or physical challenges is a vital consideration. Closely related to this is the issue of institutional respite programs for familial caregivers as a vital component of LTC. These programs are virtually non-existent in Puerto Rico. Likely, adult day care facilities could assist in solving other LTC issues as well as add to the quality of life of the clients they serve. More adult day centers are needed and enrollment figures indicate that the customers and their families are open to this alternative.

The quality of care provided in the nursing home and homemaker/home-aide industry is a major challenge to LTC in Puerto Rico. Most of the residential facilities are board and care establishments and not really nursing homes. Regulatory efforts, although required, are not sufficient to improve the overall quality of nursing home care and home health and social care (Wilson 2003). Current regulatory efforts are mainly directed at architectural barriers and structural features of the residential facilities but not at quality of services. Identification of factors related to poor quality of care in Puerto Rico --and elsewhere-- are (Harrington 1991):

- 1) increased demand
- 2) increased complexity of care
- 3) constrained supply
- 4) high costs
- 5) ownership (in the case of LTCREs)
- 6) staffing and labor issues
- 7) public information
- 8) regulatory approaches

Although conscious of the costs associated with regulation in an effort to improve quality of care and protect the abuse of elderly individuals and mentally or physically challenged persons, specific areas of concern both for homebound care provided by paid caregivers and LTCREs care are:

- 1) training issues and inadequate number of staff/homemakers
- 2) inadequate provision of health and individual care
- 3) sanitary conditions
- 4) nutrition issues
- 5) unenforcement of safety regulations

The development of quality criteria regarding all types of LTC (*OGAVE/PAHO 2003*) in Puerto Rico is a major challenge. Outcome based indicators need to be developed as measurements of quality in the following areas:

- 1) Clinical medical
- 2) Functional
- 3) Resident satisfaction and family satisfaction

Indicators may also provide input for LTCRE staff and home-aides performance (Wilson 2003).

The compilation of adequate data is a main problem with quality control. Government officials as well as private providers aided by health evaluators, consumers and their families, and community organizations need to agree on indicators and specific definitions and measurements. There is a need in Puerto Rico to arrive at clear

definitions in order to obtain valid results both in terms of services rendered and quality indicators. For instance, *OGAVE* and the *DFPR* use different area coverage for service delivery and this difference does not facilitate data comparison. Establishment of similar service and evaluation criteria and names for LTCR facilities by *ASSMCA* and the *DFPR* would also help in data collection and analysis. Issues related to costs pertaining to data collection and implementation of data collection must be clearly established.

Clientele requiring nursing home/board and care services need to have information on which to base their decisions about the best or more suitable facilities for their needs and personal situation. Clients and their families are vulnerable and usually rely on social workers or physicians to make their plans regarding placement in residential facilities and not so much on public disclosure of rating systems. Public disclosure of ratings on quality of services could motivate nursing homes to improve their services (Harrington 1991).

Closely related to the issue of quality criteria is the need to develop a system to assure compliance with minimum standards that are different from licensing criteria requirements for LTCREs (*OGAVE/PAHO 2003*, Wilson 2003). These standards should focus on problem areas such as twenty-four hour real availability of medical services and nursing staff, training of all staff (professional and non-professional) in care issues of the older adult and persons with special needs, architectural barriers, rehabilitation services, and privacy issues for residents, as well as adequate recreational areas and appropriate recreational and socialization activities, among others.

It is also important that definitions of the various LTC settings are clearly defined. Despite efforts, there is confusion regarding services generally offered during the day (camps, day care homes, adult day facilities) and the names for the different residential settings based on the services that they offer and the training of their staff.

Another area that must be emphasized is the adequate preparation and availability of skilled personnel (nursing homes and homecare) both at public and private realms and at managerial and non-managerial levels. Despite efforts, many service providers lack knowledge in terms of the aging process and the aged as well as of populations that are mentally or physically challenged (Cabrerá 2003, López 2003, Valentín 2003). Myths and stereotypes of old age and the mentally or physically challenged are prevalent among LTC service providers at all levels. Yet, most of the formal education or training programs in gerontology, geriatrics, social services, and the developmentally challenged are oriented toward professionals and university students. Home aides, escorts, and non-managerial personnel at LTCREs and homebound services need to be adequately educated in terms of the realities of the populations that they serve and in a manner that is meaningful to them. Likewise, training should also address the needs of the staff in LTCEs, a step recently taken by *OGAVE* (López 2003). Educational communication strategies must be geared to those with low educational attainment and not only to persons with an university degree. The need for better prepared personnel, knowledgeable in gerontology and areas related to the physically and mentally challenged, must be stressed. However, one must be aware that a major barrier to improved staffing is the cost to LTCREs, which, in turn, would mean raising LTCRE rates (Cabrerá 2003, López 2003, Harrington 1991).

Another dilemma relates to staffing demands. An *OGAVE/PAHO* workshop on LTC in Puerto Rico (2003) pinpointed to the high turnover of non-professional staff at

LTCREs. Wages and benefits for LTCRF employees are low and working conditions are not always pleasant. There are times when non-nursing staff are doing nurse related tasks (OGAVE/PAHO 2003). Current regulations, though not willingly, at times allow for overworked employees (Cabrera 2003).

Interagency coordination is a must in Puerto Rico. It is necessary to lay the foundations between agencies and organizations that will bring forth a more organized, encompassing and effective LTC service delivery system. An adequate coordination will help to eliminate the principal problems in service delivery to the aged and the mentally or physically challenged: fragmentation, duplication, unmet needs, and inaccessibility. It will also help many adults to remain relatively independent and assume responsibility for their health and social needs. Some of the gaps in the present governmental health system have been the lack of communication, accessibility, and cooperation between the Department of Health, the Department of the Family, and The Puerto Rico Health Insurance Administration or ASES (González 2003, García 2003, López 2003, OGAVE/PAHO 2003). This interagency coordination should encompass the centralization of statistics for LTC residential and senior centers settings, LTC expenditures, and LTC services at one agency.

The analysis of LTC services in Puerto Rico must be based on an understanding of the present problems and obstacles. The problems encountered with Medicare and Medicaid funding rise to an extent from the inability to control the costs and from the limited objectives of LTC for both programs in Puerto Rico. Other problems in LTC in Puerto Rico pertain to the value system that underlies the delivery of services and the determinants of quality. LTC in Puerto Rico is subsumed under the old notion of the asylums as the last refuge for those in need (e.g., elderly, mentally ill, mentally and physically challenged, impoverished, homeless, without a family) and does not initiate from an evolving perspective that aspires to guarantee the individuals the maximum autonomy possible to manage their own care (OGAVE/PAHO 2003). This paradigm remains to be changed and its transformation must be embrace all parts of the system; from the policy makers to the service providers (both professionals and non-professionals) as well as the clients and their families. The development of a social policy on LTC in Puerto Rico requires the comprehension of the current system and how it operates and of the values or premises from which it stems as well as the adequate compilation of data on LTC clients and an examination of economic considerations for the array of LTC services that are and could be offered. LTC should include a range of medical, health, and social services in various settings and available in a diversity of situations, both in residential settings and in the community. It should never lose sight that it is a changing process, a dynamic one that needs continuous review and monitoring of needs and services (OGAVE/PAHO 2003).

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