

An Integrated Service Delivery Program For the Elderly: Implementing a Community Plan

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I. Background

THE programs of the Council for Jewish Elderly were developed in accordance with guidelines established by a long range planning study. This planning effort was initiated by the Jewish Federation of Metropolitan Chicago in 1968, and was carried out by the Jewish Federation's Gerontological Council. The study and final report was published in the Spring of 1970 under the title: *A Jewish Community Plan for the Elderly*.¹

The Jewish Federation of Chicago, and its affiliated agencies, organized a community gerontological council as a means of confronting some basic problems. The affiliated agencies wanted to develop new programs and construct new facilities. The Federation was faced with mounting costs, multiple requests for capital funds for new facilities, and no way of measuring priorities. The Federation was operating three long-term care facilities (625 beds), and each of these homes for aged had produced a "long range plan" which took little account of the plans of the others.

Within a few months following publication of the Plan, the Gerontological Council Report was ratified unanimously by the governing boards of the agencies and the board of the parent group, the Jewish Federation. In taking this action, this community committed itself to a single plan, to the implementa-

tion of a new service delivery system, and to a new schedule of priorities.

The significance of the community gerontological council emerged only as the "Planning Contract" was developed. The Federation agreed to fund a community program for elderly which was developed jointly by the affiliated agencies. The only condition was that a single community plan be developed and that this plan be endorsed by all of the agencies.

The agencies agreed and the Federation demonstrated its good faith by funding the planning group and committing its top leadership to serve on the council alongside the leadership from the agencies.

II. An Integrated Service Delivery System for the Elderly

"There is general agreement that the present system of providing service and care for the aged can be conceptualized as a straight line leading from the home environment, through a referral system of independent and largely uncoordinated agencies, directly to the nursing home or home for the aged."² Such were the conclusions of the planning study. As a remedy, the planning group called for the creation of a new service delivery system which would be flexible and, by design, compatible with individual needs.

¹ "A Jewish Community Plan for the Elderly." An unpublished report of the Gerontological Council of the Jewish Federation of Metropolitan Chicago, Spring 1970, p. 9.

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In implementing the community plan, the Council for Jewish Elderly of Chicago has made the determination that it would provide a highly diversified service inventory and systems of control which would insure the availability of needed services, the evaluation of need, the development of highly individualized service plans, the speedy and effective delivery of services, and the effective monitoring and follow up on service plans.

The Service Inventory

The services provided by the Council for Jewish Elderly are not in themselves unique. What is unusual is that the broad spectrum of services are delivered under the direction of a single agency.

It is also important to note that the complete service inventory was mobilized simultaneously.

The planners were concerned that, if services were developed in accordance with a so-called "practical" priority schedule, one could not adequately test the impact of the new system, since one or more services were surely to be on the drawing board, marked for future delivery. The planning group stated:

We must take care that we do not initially offer to the community a product which is overdesigned, but we must also be concerned that, in our desire to reduce risk, we do not underdesign the presentation of our product.³

Therefore, it was recommended that the totally conceived program be implemented as a unit. The service inventory was conceived as "Interlocking Service Resources." The notion that these services had to be implemented simultaneously was in keeping with this concept.

In a period of one year, the following services were developed and made operational:

³ *Ibid.*, p. 37.

Casework services
A medical evaluation unit
A home health service team
A housekeeping service
Home delivered meals
A transportation program
A Group Living Residence (Intermediate Housing)
Two housing facilities (Independent Housing)
A comprehensive outreach program
Two drop-in centers ("Coffee Houses")
A "Senior Service Corps" (Employment for the Elderly)
A legal counseling service
A data bank service
Liaisons with long-term care facilities

The implementation of the total network in such a short period of time was made possible by:

A. The availability of a comprehensive plan and the community support generated through the planning process;

B. The early availability of a skilled management team;

C. The effective utilization of knowledgeable consultants in systems;

D. A commitment by the Jewish Federation to fund the program in a flexible manner.

The implementation task was also realizable since the model was to be developed in a defined geographical area which was limited in size and densely populated.

The implementation plan called for the development of a program consisting of all the proposed program elements, but the program was to be realistically scaled in size. The miniaturization of the total program would enable the delivery of enough service to test the program design, while allowing for flexibility to expand or change the emphasis of the program, when this was appropriate and feasible.

The Target Community

The target community covers a relatively small geographical area. The area is mainly residential with a low and middle class mixed population totaling approximately 61,000. As of 1970, 13,300 or 22 percent of the total population were 60 years of age and older. Of the total elderly population in this community, approximately 7,000 are Jewish.

Organization of Services Around a Number of System Models

Although systems specialists can provide a definition of what differentiates an integrated system from a non-integrated system, a practical and meaningful explanation of this concept, as it relates to the pilot program, is that all programs and services are organized in such a way as to make these resources readily available to the elderly. This means the system is organized around a concept of how best to meet a variety of needs.

Since the Council's service system relies heavily on outreach and reaching the elderly, rather than the adult children or relatives, an intake system needed to be devised which was easily maneuvered by the elderly. This meant that intake *could not* be restricted to a central location. Secondly, if one seeks to be highly responsive to needs, changes in needs, and new problems as they arise in the community, one must develop a means by which those staff workers, who are closest to the elderly and the community, can communicate information to the policy makers and the more centralized service staff. Under these circumstances, policies and supporting systems must be strong enough to counterbalance the sometimes overwhelming influence of the centralized staff, which tends to be the highly trained professionals. The focus is not on castrating the profes-

sional, but rather in equalizing the influence of various staff groups on program development.

Thirdly, provision must be made so that the older person is not overwhelmed by the availability of a variety of services. The older person must be buffered from the natural tendency of staff to sell a specific service.

The older person must be given the opportunity to secure a highly individualized service plan.

The older person must be given assurances that he will not be lost or misled after he has received a service. Follow up provision must be structured.

And finally, the older person must be given the opportunity to pull out when service is no longer required or when service needs have been reduced.

Agency policy has provided a flexible framework within which the older person can request and receive services. Systems have been applied to guide practice. Requests for service may be made through a number of entry points. The broad spectrum of services are available to the older person no matter at what point he enters the system (i.e. via the outreach worker, via the Area Service Center, via the Transportation Program, or via the Central Intake Service). Service delivery may be provided at the same location or setting in which the service is requested. Service delivery may be provided by the same staff worker, or staff team, which received the request for service. All of this is achieved, while still maintaining control over service resources.

Maintaining the Older Person in the Community

The Planning Study concluded that the new program should focus on maintaining the older person in the community, as a *functioning* and *participating member* of that community, for as long as

possible. The issue of maintaining an older person in the community is intrinsically bound to the concept of service through selective intervention. A mechanism must be developed which allows for the development of highly individualized service plans. If the agency, by policy, seeks to support independent functioning, a checks and balance system must be developed which insures that *only that service which is required is delivered*.

In the case of the CJE program, this is accomplished through an operation which relies on the assessment of the request for service by a multi-disciplinary team, and a procedure which demands that final authorization of the service plan must be made by the older person himself.

The Interlocking of Outreach With the Delivery of Concrete Services

Outreach, as a program function, has assumed an increasingly important role in the delivery of services to the elderly.

If outreach is to be an effective element of the service delivery system, it must become a part of that system and must have the capacity and the authority to initiate the delivery of a service.

In order to achieve this type of program, a number of steps must be taken:

1. Operational policies must link outreach to the intake system;
2. Outreach staff must be assigned the responsibility and given the authority to initiate a service directly;
3. Outreach staff must be integrated into the service delivery team so as to insure their involvement in the evaluation process, the delivery of the service, and the follow up.

Outreach is not an end in itself. In the integrated service delivery system, outreach is a pathway for service, an entry point.

By making sure that the elderly know of the various services offered in the

community, and by providing easy access to the needed services, the outreach program seeks to offer ongoing support to the older person so as to prevent serious crises from occurring. This is accomplished, in part, through the operation of "Drop-In" Centers.

Area Service Center facilities serve as "Drop-In" Centers or "Coffee Houses" for the elderly. The openness of the "Coffee House," plus its visibility in the neighborhood, allows it to function most successfully as a visible entry point to the service system. Elderly can drop in and use the facility and the unstructured programs on their own terms.

As already noted, outreach workers may act as intake workers. Outreach workers can initiate the service by reporting directly to the service team, contributing to the preliminary evaluation, and making recommendations regarding the nature of the service to be delivered.

A concrete service may be given by the outreach worker as part of the outreach effort. Letter writing, friendly visiting, assistance in filling out forms, advocacy and a host of other basic services may be provided by the outreach worker as part of the outreach function.

Application of the Selective Intervention Concept

"If we assume that it is possible to take any individual and, through a process of evaluation, place him at a precise point in terms of his particular medical, social and psychological dependency needs, and if we can assume that we have the wisdom to put together whatever is necessary to meet those needs precisely, then we have the basis for *selective intervention*. It is possible, and indeed essential, to determine precisely the social needs and environmental needs of individuals as well as their medical or psychiatric needs. If we can do so then

we must conclude that for each individual in need there is a 'treatment of choice.' We can determine what that treatment of choice is that will best meet those individual needs. In addition, we must take a prospective view of the person and seek a prognosis against which we can formulate goals and measure effectiveness of any prescribed program of treatment."⁴

We assume that people who have lived as part of a community for at least 65 years want to maintain themselves as individuals in that community for as long as possible. Our service is aimed at intervening in their lives with the kind of help that will be just enough to best support this continuance of a decent independent life as defined jointly by the agency and the client. This means providing service that will produce a dependency of the clients on the agency — put another way — to provide service to enhance their independence. This also means that the agency must enter into a contract that allows for the client to be involved in assessing and determining his own needs.

It has been observed that elderly tend to request concrete services first. The agency will provide the requested service even though that service, by our assessment, may serve a minimum of the person's total needs. We know that in the course of an elderly person's life any and all of our services could be appropriate to some degree. The issue is to provide appropriate service when it is most needed. Who could argue that transportation is a problem for most elderly, or nutrition, or loneliness, or decent housing at a reasonable cost, etc. Our goal is to provide the transportation, or any other service, where and when it helps each individual person to achieve on his own.

⁴ Elias S. Cohen, "Selective Intervention: An Approach to Serving the Aging." Presented at the Annual Meeting of the Illinois Association of Homes For The Aged in Chicago, Illinois, May 1, 1970.

Our newness has the advantage of not categorizing service into fixed definitions. We encourage and support new ways if the traditional model does not fit. Since this includes many different aspects of service and crosses professions, we have developed, as a core unit, multi-discipline teams that make these decisions. This kind of team concept in community social service agencies is relatively unique, but is necessary if we are to provide appropriate service.

Each case comes to the team, and an individual client plan is devised. The client plan is the key to the coordination of the work as it asks what services are to be provided, for how long, by whom, and why. It assigns specific tasks to certain team members who, by their presence in the discussion, know the needs of the person to be served. It further asks the team when it thinks these services should be re-evaluated. Each client is assigned a principal worker, although several staff may be providing service. The principal worker is usually the worker who has the most effective relationship with the older person and, again, may be any team member. By re-evaluating on a planned basis, we can determine when to decrease, increase, or add additional service, as a person's problems develop or diminish. An additional function of the team is to provide some degree of training. A medical, social work, and psychiatric consultant sit in on appropriate case presentations and point out in the discussion some general principles relating to client's need. This is done in addition to a formal in-service training program. This is an important function as the newness of the agency and its staff requires a conscious effort in staff development.

Utilization of Staff in New Roles

Let me describe briefly how the staff structure is organized as this is a critical

factor in how service is delivered. The Community Service Task Force is made up of paraprofessionals and some volunteers who may perform multi-functional activities including friendly visiting, shopping assistance, housekeeping, or basic nursing activities. These geriatric community aides can, therefore, help in providing a tailor-made service to an individual. This staff function is a new one, and provides much flexibility in meeting basic needs of people in a tailor-made, individual fashion. The Medical Department provides basic evaluations and is prepared to offer a wide range of medical service in the home as part of a Home Health Team by training others or by working with the older person's own doctor or hospital. The Social Service Unit may provide basic evaluations, case diagnosis, counseling service and outreach. Its staff consists of MSW's and some BA level people with experience.

The Area Service Staff provides drop-in center activities, plus a major outreach effort and basic answers to concerns that need minimal followup. The Area Service Center also employs elderly to participate in the outreach efforts, to staff the "Drop-In Centers," and at times to provide friendly visiting.

The Volunteer Service has utilized a variety of people, many of whom have a professional background, and may perform tasks with a client as assigned by the Team.

A mention needs also to be made of Housing Services. Apartment buildings within the community are being renovated to provide a housing resource. Placements in the apartments are based on a Team determination of the need for the service by the client. When the older person has a problem related to housing, the agency can intervene and provide: 1) apartment in CJE facilities; 2) help in locating apartments in the community; 3) counseling and assistance in working out problems related to existing housing

conditions; and 4) a Group Living Home which is a communal living situation for people assessed to be not able to live totally independently, but not ill enough to be in a conventional institutional setting. Residents share in cooking and eat together. They carry other responsibilities that are aimed at capitalizing on their resources.

The hallmark of providing needed service effectively is to integrate every service so that the service package is designed or tailor-made to meet the individual's special needs. The interdisciplinary team is the means of achieving this goal, and does this by providing evaluation, control, interaction, planning, and coordination.

Finally, staff performs as advocate for the elderly in the community. Legal service is provided directly to clients. Broader issues of a legal nature (i.e., housing violations) are raised and examined and pursued. The CJE is a community agency, and is responsive to community problems.

One of the results of the team approach has been the development of an attitude among staff that whatever needs to be done to help a person will be done. Traditional roles are shifted or dropped if they are inappropriate in providing a service. The character of intervention is determined in relation to need and staff assignments are related to which staff person can do the best job. Roles and function of workers are defined on the basis of client need. This is a modification of the more traditional approach which tends to provide service in relation to clearly defined professional roles. Although this sounds elementary, it often is not when you consider the wide range of service interventions possible. A client came to our attention because of her inability to get to a doctor for an arm injury. Although it appears logical that a nurse should see the client, which she did, it is a departure from traditional routine to

not have this first visit done by a social worker.

A final point on role development is in the area of inter-agency coordination. The charge to the agency is to become an umbrella on aging services which crosses the lines of other Jewish Federation agencies who have been serving elderly for many years. We have the task of developing models of cooperative service that will lead ultimately to a coordinated comprehensive effort. This effort which is a staff-to-staff and lay board-to-lay board understanding is a subject for another paper. Suffice it to say that working on an inter-agency level is, at times, much more difficult than developing an approach to direct service.

III. Conclusions

The program of the Council for Jewish Elderly of Chicago was established upon a firm planning base.

The Council for Jewish Elderly has

concluded that one cannot adequately test the effectiveness of a comprehensive service program unless all services are implemented as a unit.

The availability of multiple services does not in itself produce an effective program. The older person must be able to utilize the services. This means that systems must be developed that insure the availability of the service, the application of service resources towards meeting highly individualized needs, the monitoring of service delivery so that services match changing needs.

It is possible for one agency to direct all services for the elderly while still preserving the individual's right to receive a tailor-made service.

And finally, it is possible to tie an outreach program effectively to a service delivery system so as to produce a decentralized intake program, and a continuity in service from the point of intake through the actual delivery of the needed service.