The Family Agency as a Community Base for Long-Term Care*

SANDRA KING
Associate Executive Director, Jewish Family Service of Los Angeles

The long-range goal of the Multipurpose Senior Services Project (in the family agency), if the data support the concept of cost-effective in-home care, is the provision of such services to all "frail" elderly. Medicare and medicaid would need to be revised, . . . government agencies . . . restructured, . . . case management programs . . . developed.

LONG-TERM care, to most health and social work professionals and policymakers, has traditionally been synonymous with nursing home care and institutionalization. What have recently emerged from the experiences of workers in the field of aging are a new look at the needs of the ever increasing group of frail elderly and a redefinition of the approach to satisfying these needs. The concept of long-term care, as a result, now refers to the network of health and social services provided to the frail elderly either within their homes, in community settings, or in residential care homes, as well as in institutions. Indeed, with more and more increasing frequency, the term refers to services which have as their goal the avoidance of premature institutionalization.

This article describes a major State of California research and demonstration project in long-term care, the Multipurpose Senior Services Project (MSSP), its goals, its research and operational design, and the planning, implementation, current status and future implications of the program. With eight MSSP sites throughout the State of California, this paper will focus specifically on the experiences of the Jewish Family Service site and will highlight some of the issues, problems and new perspectives the program has introduced to the agency. As a multi-million dollar project (over $30 million statewide and over $4 million to JFS during the 3-year period, the coming of the MSSP has brought with it expansion in size and scope of staff, innovations in service delivery, research-related demands, and new types of organizational directives and fiscal management requirements. This paper will discuss some questions an agency such as Jewish Family Service might ask as it considers sponsorship of a program such as the MSSP.

MSSP—Goals and Purposes

The Multipurpose Senior Services Project is designed to test the thesis that frail elderly persons can be helped to avoid institutionalization by being given services in their homes, and that this can be done at a cost no greater than that required for convalescent hospital care. This thesis is also the focus of a number of other long-term care demonstration projects throughout the country. Because of the size and scope of the MSSP, however, it is hoped that the research data collected will be particularly effective in influencing legislation in the direction of generalized out-of-hospital long-term care for the frail elderly. While it is recognized that institutions play a vital role in the provision of a continuum of care and that convalescent hospitals will always be necessary for some elderly patients, the goal is the

* Presented at The Annual Meeting of the National Conference of Jewish Communal Service, New York, June, 1981.

provision of options. With alternatives, the appropriate level of care could be chosen, and older people would be provided with services which would help them to maintain their independence as long and as completely as possible.

The choice of sites by the State MSSP indicates the concern for a broad spectrum of population and a variety of service delivery styles. Sites include: The San Diego Area Agency on Aging, the City of Oakland, Mt. Zion Hospital in San Francisco, the County of Santa Cruz, the Ukiah Senior Citizens Center, the East Los Angeles Health Task Force, and Jewish Family Service of Los Angeles.

Client Selection

Nineteen hundred clients statewide (300 of those at the Jewish Family Service site) during the three-year life of the Project are being compared with a control group which receives only the normal mix of services provided to seniors generally in each of the eight communities. Both experimental and control groups are Medicaid recipients. MSSP clients were chosen at each site according to criteria designed to target, for research purposes, those elderly who were thought to be the most "at risk" of becoming institutionalized, and if they were 75 or above, or, under certain conditions, between 65 and 75. Eligibility for the 65 to 75 year group included: the loss of a spouse or home within the last year, recent hospitalization, serious physical illness or disorientation. Additionally, the first twenty-five percent of the clients selected at each site were required to be community referrals. The next forty percent were randomly selected from the census list of acute hospitals in the area. Ten percent then were randomly chosen from Medicaid Field Office lists of patients referred for admission to skilled nursing facilities in the area. The final twenty-five percent were chosen to fill in the gaps for research purposes, so that the Project, statewide, would have a full range of "at risk" elderly—from the more independent, well functioning, who still fall within the definition of "frail," to those most disabled and in need of service.

Operational Design: The Case Management Team Model

The MSSP operational plan incorporates the principles of single access to services (to as great an extent as possible, given problems of bureaucratic "turf"), the combining of health and social services, the involvement of family and friends when possible to provide a network of support, and the inclusion of the client in planning and arranging for services.

The case management team approach, which offers each client the on-going relationship of a social worker (MSW or social work assistant) and a nurse (practitioner or clinical specialist) is the basis of the project design. The case management team assesses the psychosocial as well as physical needs of the client, works with the client and family and doctor in care planning, and then arranges for necessary services. The social worker monitors the services, encourages the client to use the services most effectively, and helps to solve problems as they arise. The social worker also maintains on-going relationship with the client, and, along with the nurse, re-assesses the situation at periodic intervals.

Services

An important element in the MSSP operational design is the coordinated approach to the provision of services. After extensive assessment, a care plan-

ning meeting is held and a consensus is reached by the caseworker, nurse and casework supervisor as to services to be prescribed. The client is also consulted and involved in the decision-making.

The effort is made to locate voluntary or already existing services. When those are not available, necessary services can be purchased. Specific categories of services which are regularly purchased include adult day-care, housing repair (and adaptation for special needs), in-home supportive services, legal services, respite care, transportation for non-medical purposes, nutrition services, protective services, specialized communication (including translation), and preventive health care. Provision is also made for creativity in the planning and ordering of services. Individual needs can be met through purchase of special items and by payment to providers for unusual services. In addition to those already named, purchases have included such items as television repair, orthopedic shoes, and emergency clothing, as well as the satisfaction of more specialized needs—for example, ordering a subscription to the large type edition of a magazine for a partially sighted 83 year-old former writer; purchasing yarn and other materials so that an 88 year-old in need of activity could make holiday decorations, and arranging for a badly crippled 78 year-old to have a membership in an arthritis rehabilitation program of swimming and exercise.

Case Example: Mrs. S.

Mrs. S. is an 80 year-old widow who is typical of the MSSP client in that she is in poor physical health, has suffered multiple losses, and has rather severe emotional problems. She has chronic emphysema, is diabetic and is in a weakened condition generally. Coronary insufficiency caused her to be hospitalized in an acute care facility initially. As a recent admission to a convalescent hospital in the area, she became eligible for the MSSP. At the time of her introduction to the program, Mrs. S. was extremely depressed by the thought that she would have to give up her apartment and remain permanently in the convalescent hospital. Her two sons, with whom she had a strained and rather distant relationship, were encouraging her to remain in the hospital. After she met with both the MSSP social worker and nurse practitioner, and her situation and needs were assessed, Mrs. S. agreed to participate in the program. Although she is proud and independent and is often reluctant to accept help, she was desperate for support in her desire to return to her home.

The supportive relationship of the MSSP social worker and nurse practitioner, and the services the program was able to obtain for Mrs. S. have made it possible for her to return to her apartment and to maintain herself there. The MSSP provides personal care by a nurse's aide. Medicare provides for twice weekly visits by a registered nurse to monitor medication and blood pressure. A walker has been ordered and a physical therapist will give instruction and support in its use. Moreover, because they do not feel alone in the responsibility for their mother, the sons have become more involved in their mother's care. One visits regularly to write checks and handle bills and to do the marketing. Unfortunately, the relationship is still strained and rather distant, but it is the hope of the social worker that the family will accept a referral for intergenerational counseling at some point in the future when Mrs. S.' day-to-day care is somewhat more stabilized.

The MSSP social worker calls regularly, and visits at intervals. She monitors the services and arranges for changes in the care plan, discussing sig-

nificant revisions with the nurse practitioner and the casework supervisor. As more common needs arise—transportation to a doctor, a friendly visit from someone with interests similar to those of Mrs. S., occasional meals when the scheduled aide does not appear—the social worker independently arranges for either voluntary or purchased services as available in the community. The worker in such cases offers continuing supportive counseling and crisis counseling, as appropriate.

Funding

As can well be imagined, what has been described of purchased services, administration of program and research costs a great deal. The 1981–82 total statewide MSSP Budget is $17,558,000.

The major portion of the money for the project comes from Title XIX of the Social Security Act (Medicaid). Waivers were granted to the MSSP by the Department of Health and Human Services so that these Medicaid dollars could be used for each of the non-medical, specific services listed above. Other individually designed services are funded by State of California General Fund dollars. State funds also provide the Medicaid match. A smaller amount of money came from Title IIIB of the Older Americans Act.

In fiscal as well as program design, a goal of the MSSP was coordination. Fragmented funding often parallels fragmented service provision. The original hope of the designers of the project was that all funds could be coordinated into a single allocation with one budget per site. Given an allocation per client, each site would, therefore, purchase services according to the policy set by the project.

Unfortunately, this was not possible because of the separate requirements of the various governmental funding sources. Each site, therefore, must prepare, and operate within, three budgets (Title XIX, State General Fund, and Title IIIB). The first two are administered by the State. The last is monitored and funded through the city or county area Agency on Aging.

There is, however, a coordinated fiscal approach to the planning and ordering of services, and the MSSP does provide more coordinated, accessible services than are otherwise available to elderly in the State. While the money comes from several sources and must be budgeted and tracked accordingly, the total MSSP service package is coordinated, budgeted, authorized and monitored by one person—the caseworker.

The eventual goal is cost-effectiveness in providing for the long-term care of the elderly. The average limit on dollars which can be spent on a single client was set by adding the administrative costs of the Project (per client), estimated out-of-hospital medical expenses (Medicaid), and living expenses (SSI). The services which can be purchased have a ceiling so that the total of all of costs, is still lower than the estimated cost to Medicaid of convalescent hospital care for that individual.

Short-term, more intensive, services in response to acute need, can be ordered with special approval. If Mrs. S. had needed 24-hour care when she first returned from the hospital, that might have been ordered. At issue is her eventual ability to manage with services which require no more than the budgeted amount. High short-term costs which avoid a chronic need for expensive services are often cost-effective on a long-term basis.

Within the project, cost consciousness is necessary at every level. Not only the site executive administrator, who must approve expenditures over a certain level, but also the social workers who prescribe services, and the casework

supervisors who sign the care plans, must carefully monitor expenditures.

The Planning Phase

The goals of the MSSP, its funding sources, and the operational design of the project were all determined by the time the sites were identified. At that point, however, the sites were actively brought into the planning. From July 1979 to January 1980, two MSSP staff members were selected by each site to participate with State staff in statewide planning sessions.

Planning was begun from the perspective of the MSSP as one statewide project with eight sites. Additionally, as a program of a specific sponsoring agency, each site had certain individual mandates and pressures. Site staff was, therefore, accountable to both the local agency and to the State MSSP. It became the responsibility of the Director of each MSSP site to plan (and later to implement) the program in such a way as to balance the demands of both the State and the sponsoring agency. Conflicts, when they occurred, needed to be resolved so that decisions conformed to both MSSP and the sponsoring agency's policies.

Planning sessions also focused heavily on the research demands of the project. Assessment instruments, forms, and reporting systems were devised to provide the data required by the research design. A lengthy assessment form was compiled, tested and retested at the sites for consistency and applicability. While the program would provide much service, the research priorities were made clear. An analysis was made of tasks to be performed at each staff level. The demands of HHS, as the major funding source, required the outlining of staff members' responsibilities according to percentages of time to be spent on each of three divisions of case management tasks: Assessment, care planning, and service provision.

Policies were set for contracting with provider agencies. Many sites, including JFS, had never entered into formal contracting relationships with other agencies before, and had never purchased services. A number of other sites had never operated service programs for this population.

Fiscal policies were set to conform to the demands and regulations of the California Department of Health and Welfare and to general State fiscal procedures. Fiscal accountability to the State MSSP became the responsibility of the Director of each MSSP site. In many cases (as in the case of JFS), this required an adjustment within the organizational structure of the sponsoring agency.

During the planning period, attention was also paid to the individual needs of specific sites with regard to language and cultural and ethnic issues, restrictions and constraints resulting from varying policies of sponsoring agencies, and demands on the program that were likely to emerge from specific community pressures at certain sites.

Program Implementation

From January to the summer of 1980, space was obtained and equipped, twenty-five MSSP staff at the JFS site were hired and trained, contracts were made with providers of purchased services, formal agreements were written with providers of free or already funded services, and systems were devised for intake, assessment, care planning, and the ordering and monitoring of services. Relationships with health professionals and community agencies, particularly hospital social work staffs and local physicians, were developed and/or strengthened.

Throughout this period, as in the

previous planning phase, some effort was necessary at most sites to resolve situations which arose out of differences in MSSP needs, demands, procedures and styles, and those of the sponsoring agency. In the case of JFS, Federation mandates relating to personnel practices and procedures, planning and budgeting, contracting procedures, etc., introduced another level of often conflicting requirements which needed to be satisfied.

From April to January, 1981, 300 clients were taken on at JFS (1900 statewide). The lengthy assessment procedure, involving social workers and nurse practitioners, was complicated by the need to take clients on in a particular sequence, through random selection of both hospital and convalescent home clients. This period of intense effort at all sites concluded the phase-in stage of the project, and, by February, 1981, the MSSP was in full operation throughout the State.

Current Status

The focus of MSSP activity is now on service to clients, and on the reporting and compilation of data, which assess and describe the client, the staff, and the system. Case management in the Project is currently being studied by independent researchers. The installation of computer terminals which is now under way at each site, will facilitate data collection and retrieval.

When appropriate resources do not exist, the MSSP works with individuals and agencies to help develop needed services. The neighborhood Jewish community center is currently being helped to begin a Social Day-Care Center for Seniors with MSSP support. Classes and groups are being organized to meet the needs of MSSP clients. The involvement of more frail elderly in the Jewish Vocational Service Sheltered Workshop is presently a joint goal of both MSSP and JVS.

The Project has also helped to facilitate changes in existing programs, so that they can more closely meet the needs of the frail elderly clients. This was the case, for example, with both the Aides to the Elderly program, sponsored by JFS, and a private homemaker referral agency. In both instances, the agencies had been acting as employment referral services. Both changed to become the employers of the aides and have become, as a result, more effective. The JFS transportation program has also become more responsive to the needs of the more frail elderly as a result of the MSSP. These changes, while currently helpful to MSSP clients, should also prove to be of benefit to the community generally, both during the life of the program and in future years.

Observations

It is not yet known if the data will, in fact, definitively demonstrate the cost-effectiveness of in-home care. Some early observations can be made, however. The MSSP is already seeing very many extremely frail elderly managing at home because of the services the program provides, and, at this point, an average of less than $175 per client per month is being spent at the JFS site. This figure is considerably less than even the $325 which was budgeted to insure a savings over convalescent hospital care.

There is some feeling that the eligibility criteria regarding age might have been set somewhat differently. The average age at the JFS site is 82. The average age statewide is 79. As more complete data is examined, it may well indicate that 75, rather than 65, is a more appropriate age at which eligibility should begin for this type of program.

The supportive worker-client re-

lationship may prove to be a most significant contribution of the program to the well-being of the client. But it is also clear that invaluable benefits are to be gained as a result of the ability to obtain for the client services which must be purchased. Also, coming as no surprise, is the fact that, while it is sometimes a simple, relatively inexpensive service which may be the most significant in allowing a person to continue independent living, at other times, in-home care does prove to be prohibitively costly. High quality convalescent home care, therefore, will always be needed. Links should be made and support for such facilities must be incorporated into a community's long-term care planning. At the JFS-MSSP site, the links with the Jewish homes for the aged and with proprietary nursing homes (through the JFS "Project Caring") have been strengthened with this goal in mind.

The JFS Perspective

Understandably, a project the size and scope of the MSSP has considerable impact upon a sponsoring agency. While Jewish Family Service of Los Angeles has sponsored a number of grants for senior programs, none has been nearly so large as the MSSP in terms of funding (of a 1981–82 total JFS budget of $6,500,000, the MSSP portion is approximately $2,000,000). Nor has any grant program been as complex in terms of organizational structure, budgeting, fiscal and statistical reporting, formal and informal contracting with other agencies, and multi-disciplinary staff and community issues resulting from the introduction of health services. The task, then, has been not only phasing in and operating so large and complex a project, but also dealing with its effect on the rest of the agency.

As the focus of legislative and professional concern, the MSSP has brought to JFS a heightened sensitivity to the need for realistic planning, clinical competence, and administrative efficiency. The project has expanded JFS contacts with other disciplines, other agencies, other aspects of service, and other issues in aging. The agency has had the opportunity both to learn new approaches and to teach others. The research aspect of the project has introduced a new dimension of agency activity. The increased visibility has produced new links to resources for all JFS clients.

In some areas of Jewish Family Service, however, the excitement generated by the selection of the agency as an MSSP site and the attention directed toward the growth in that and other senior programs led to the desire for a more balanced perspective. Concern was expressed that the agency's core counseling program might be jeopardized by the over-emphasis on senior programs, that "the tail might wag the dog". Thus, the leadership of the agency has had to deal with a most difficult dilemma, the need to balance support for basic on-going programs for clients of all ages against emphasis on innovative time-limited senior programs which satisfy special needs.

The MSSP presents Jewish Family Service with another area where balance is needed, i.e., the balance between requirements for conformity and the need for autonomy. As one program with eight sites, the MSSP requires very close linkage between the site staff and the State staff. This has introduced dual lines of organization and authority within JFS. The structure set by the State mandates that the MSSP staff at each site be a self-contained body, reporting to the State MSSP Director, yet responsible also to the sponsoring agency. Operationally, the questions of structure have not interfered with the management of the JFS-MSSP. This has been primarily due to the recognition by

the Executive Director of JFS that, if it is to function successfully, the non-traditional nature of the MSSP precludes its conforming to a good many general agency practices and systems. Interpreting and defining this "inconsistent" position to other JFS staff at various levels has required some effort. As well, there has been the need to require conformity to JFS systems in the special instances when that was necessary. It has also been necessary for JFS executive staff to orient Federation staff and board to the special needs which the MSSP grant program imposes upon the system.

Other areas of concern specific to the JFS-MSSP site have been community related. Programs for seniors at the Freda Mohr Multiservice Center for Seniors and the Valley Storefront, the areas which the MSSP serves, regularly tend to be oversubscribed. Additionally, the MSSP was structured so that intake was to be open, within the strictures of the research design, to all "frail" elderly within the catchment area. There was a good deal of concern that resentment would be generated when potential clients were refused admission to the program. An MSSP Selection Criteria Sub-Committee of the Advisory Council was formed to act as a lay group which could interpret selection requirements to anyone experiencing interest or registering a complaint. Despite early concerns, there were fewer problems in this regard than were anticipated. The community seemed to accept both admission limitations and other restrictions mandated by the research design.

The introduction of new types of staff and the revision of the job descriptions for the caseworker position were also issues with which the program had to deal. The multi-disciplinary team approach, requiring cooperation of nurse practitioners and social workers, needed definition, but then evolved with very little difficulty. What was problematic was the setting of salary ranges and criteria that were appropriate to the nursing profession and also consistent with JFS personnel practices.

A good deal of effort was necessary to strengthen already existing relationships and develop others with community health professionals. It was necessary to gain the approval of doctors if their patients were to participate in the program. Social work and nursing staff of hospitals needed to be enlisted as allies in the effort to select eligible seniors at the point of discharge. While relationships with the medical community were a major concern before the program began, these fears were not realized in practice.

When the concept of the MSSP was introduced, the interest of JFS was aroused because of the agency's commitment to the provision of service to the elderly. That commitment continues. It is that commitment which motivates the day-to-day efforts to resolve the kinds of problems the program brings. With the program goal of improved service for the elderly, the efforts of JFS are certainly appropriately focused at the present. Based on what is being learned from the MSSP experience, JFS will be more able to plan adequately and approach realistically future programs which support its goals.

Implications for the Future

The long-range goal of the MSSP, if the data support the concept of cost-effective in-home care, is the provision of such services to all "frail" elderly. Medicaid and Medicare regulations would need to be revised. Legislators are clearly eager for data which they could use to support such revisions. Government agencies would need to be restructured to allow for the im-

plementation of such changes. The State of California, for example, has already begun to explore the establishment of a Department of Long-Term Care which would coordinate a number of programs now allocated to the Departments of Aging, Health and Social Services. Case management programs would need to be developed in whatever form is appropriate within particular communities.

The role which family service agencies might take in the provision of long-term care for the aged is still uncertain. More specifically, Jewish family service agencies need to look carefully at their goals and priorities, and make decisions as to the arenas in which they wish to be involved. Service to the aged is clearly a mandate. The best form in which such service should be delivered needs to be determined individually as each agency explores available options and resources.

Bibliography

Austin, David et al, *Case Management Research Project.* School of Social Work, Austin Texas: University of Texas (1980).

Butler, Robert, *Why Survive? Growing Old in America.* New York: Harper and Row (1978).

Carter, Genevieve W. et al, *Case Coordination with the Elderly: The Experiences of Front-Line Practitioners.* Los Angeles: Andrus Gerontology Center (1979).

Eggert, Gerald and Bowlyow, J. E., *Preliminary Findings—The Access Model.* Monroe County Long Term Care Program, Inc., New York, (1979).

Hodgson, Joseph H. and Quinn, Joan, "The Impact of the Triage Health Care Delivery System on Client Morale, Independent Living and the Cost of Care, *The Gerontologist* (1980), p. 20, 364–371.

Kane, R. L. and Kane, R. A., *Alternatives to Institutional Care of the Elderly: Beyond the Dichotomy.* The Rand Paper Series, Santa Monica (1979).

U.S. Department of Health, Education & Welfare, *Long Term Care: An Overview.* Wash. D.C.: National Center for Health Statistics, DHEW Pub. No. PHS 78–1232 (1978).

Western Gerontological Society, *Generations: Long Term Care,* Vol. V. No. 3 (Spring 1981).