Innovative Outreach Approaches in Services to the Elderly*

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. . . Of 105 respondents (nurse-assistants in nursing homes) to the question, "What do you do when a patient wants to talk to you about death?" 97 reported that they changed the subject or in some other way avoided the topic. Clearly, these are motivated persons who, with training, can improve the services they are delivering.

This article will discuss some specific innovative approaches that have been taken in the community service programs of the Miami Jewish Home and Hospital for the Aged at Douglas Gardens, a 376-bed, JCAH accredited, nursing home-hospital which has developed a variety of services aimed at forestalling institutionalization. Parenthetically, I do not believe there are alternatives to institutionalization. When one needs an institution, one needs an institution. However, I do believe there are various forestallers to early institutionalization that can effectively improve the quality of life for the elderly person in the community. In pursuit of this goal, the Board of Directors of the Miami Home has established a number of service programs in South Florida, among which are: two outpatient mental health centers for the elderly; a comprehensive community mental health center; two day-care centers; a senior employment project; and ambulatory medical program, and a variety of research and training efforts.

One of these research efforts provides us with data which have significant implications for the development of innovative approaches in service delivery. For the past year the Home has been conducting a research study under contract to the State of Florida, Department of Health and Rehabilitation Services. In this study, we are looking at 400 elderly persons who were recently discharged from acute care hospitals. 200 of these individuals were placed in nursing homes. 200 were placed in the community. Four communities were selected based on the following criteria:

> One represented the community with a good intergenerational family structure and good community services; one represented a community with a good family structure and poor community services. Two communities had poor intergenerational family structures: one with good community services and one with poor community services.

The research methods will be reported elsewhere, but the findings merit reporting here. *First,* mental capacities and activities of daily living are the key variables in determining whether an individual is placed in a nursing home. *Second,* people are placed in nursing homes on the same rate regardless of economic circumstances. *Third,* the availability of the family becomes a major factor in preventing nursing home placement. *Fourth,* and most disturbing, community services availability has no significant impact on nursing home placement. This last point tells us that the availability of community services without local family intervention is insufficient to forestall institutionalization. It demonstrates the need for innovation and creativity in the delivery of services to assure a surrogate family system.

As a true believer in the golden role, "He who has the gold makes the rules," I am dismayed by the pigeonholing effect of present funding sources. We know the elderly suffer from a variety of problems which have a combined social and health genesis. Yet, the usual service delivery system is basically either on a social track or a health track, often a function of the nature of funding sources. In the development of effective delivery systems

one must always be cognizant of the need to integrate the social and health aspects of the delivery system.

One such attempt toward integration is the "SWAT" team of the Miami Jewish Home and Hospital for the Aged. "SWAT," standing for Service Workers for Aged in Trouble, is a 3-year demonstration project funded by the United States Administration on Aging. It was based on the model of the police SWAT team (Special Weapons and Tactics) using two of the basic concepts therein. First, modern technology, as in the police SWAT teams, serves as the nucleus of service delivery. Second, a set of mind is created. Just as the police SWAT team attempts to create a sense of hopelessness in the perpetrator through the use of uniforms, equipment, etc., our SWAT team uses the same techniques to create a sense of hope, hope for continued independence within the community.

SWAT has two primary methods of procedure. First, it is a case management approach aimed at a target area in which everyone in an eight-building target population is defined as a SWAT client. Persons receive services based upon an individually determined need plan. Second, the role of SWAT is one of filling gaps. SWAT is not intended to replace primary health care, home health care, traditional social services, or any other existing service system. It is merely intended to fill the gaps of those systems and coordinate their delivery. If someone is eligible for Medicare benefits for home health-care, we would encourage the physician or primary health provider to order these services, as normally would be done. If the client, however, requires such services following the exhaustion of all Medicare benefits, and eleemosynary home health services are not available at that time, the SWAT team will provide the service until the United Way's home health program could intervene. If the client can't afford proprietary home health services, the case manager, a social worker, would assist the client in obtaining this service. In the course of the three years of the life of this project, the emphasis will be on examining the effect and the costs in this delivery system.

It is worth noting that some dilemmas are encountered in initiating new programs like SWAT. For example, the name of the program, Service Workers to Aged in Trouble, was not well received by potential clients on initial outreach attempts. They expressed a firm conviction that they were not "in trouble." As a result, all communications with clients simply state the name of the program as SWAT, avoiding the problem behind the acronym. Presently, the team is reviewing the advantages and disadvantages of the influence of the uniform on the mind-set. While we are aware of a great deal of literature relating to the value of uniforms in creating a sense of security for the impaired elderly, we are equally aware that we do not want to deepen dependency feelings in a population that sees itself as "sick."

There are several outreach programs of Douglas Gardens. In opening an outpatient mental health center to serve the elderly, we discovered, not surprisingly, that mental health remains of concern to this population. One must be mindful that the elderly were born about the time that Freud was just beginning his work. They are much more familiar with electroconvulsive therapy, insulin therapy, and foam padded rooms than with psychotherapy and psychotropic medication. Therefore, we felt it important to "demythify" mental health for this population. Several approaches were utilized. First, almost everyone is aware of the "Peanuts" cartoon's Lucy Booth in which Lucy provides psychiatric help for five cents. With the aid of the maintenance department of the Home, a Lucy Booth was constructed in which a display read in three languages, English, Yiddish and Spanish, that help was available to people with problems. This booth is positioned in a number of sites where seniors gather. On a typical half-day, (assignments were for half-days because of a "burn-out" potential for the psychiatric caseworker who could tolerate only a limited number of hours in such a booth) 50 persons

approached the Lucy Booth. Of these, 41 were interested in issues like location of the ladies room, the nearest delicatessen, or other such important information and referral matters. Nine persons came to the Booth to discuss mental health-related issues. These nine ultimately wound up in a formal mental health setting.

Another such attempt at outreach was prompted by an experience while having lunch at a South Beach delicatessen, where a waitress tenderly expressed concern for the lack of appetite of an elderly patron. It brought to mind that professionals occasionally omit personal concern as a necessary ingredient in care. The mental health centers initiated a program of training hotel managers, merchants, and other non-professional intervention agents in the symptomatology of deficiency or problem in mental health. With this training, these persons were better able to recognize problems in their older patrons and to gently make a referral to the care system.

Now to turn to discussing the process most aptly termed "inreach." This refers to attempts to reach *into* nursing homes and congregate living facilities to provide services. Too often agencies such as Jewish family service and other community-based services define their client population as only those living in the community. Yet, we are very much aware of the flaws in the quality of life in many institutions. The average standard of work done at Jewish homes for the aged in communities around the country is high, but these are not typical facilities. Most facilities do not have the resources to provide such a high level of care. Reaching into such facilities can often make a significant difference to those older people for whom they are home. Presently, tnere are several Douglas Gardens programs that attempt to do this. The mental health centers are providing "reality orientation" services in a number of nursing homes throughout Dade County. This service, which is professionally supervised but administered by para-professionals, is funded through Title V of the Older Americans Act, a senior

community service employment project. Family adjustment problems exist in most nursing homes placements. The professional staff of the outpatient mental health center provides a formal program in nursing homes to assist families in the adjustment of the placement of an older member. Finally, perhaps most important, through a special project funded under the Nurse Training Act, the Home is able to place nurse-training staff in each of the 37 nursing homes throughout the county. This staff provides training for the nurse assistants and the licensed practical nurses. It is important to note that these are the persons having physical and direct personal contact with the older patient. Their attitude, skills, and knowledge have the most significant effect on the quality of life of the nursing home resident.

Among the interesting findings in the first year of operation was one that the majority of these personnel actually chose to work with the elderly, and they are concerned with the quality of their efforts. Yet, they lack the necessary skills. Of 105 respondents to the question, "What do you do when a patient wants to talk to you about death?" 97 reported that they changed the subject or in some other way avoided the topic. Clearly, these are motivated persons who, with training, can improve the services they are delivering.

I should note that evaluation efforts must accompany any innovative program. The days in which simply providing "good" services was sufficient are over. We must be accountable, and, if we wish tc seek positive change, we must be more than accountable—we must be able to verify objectively and document the effect of the services we deliver.

I close with three issues that are significant in attempting to develop innovative approaches creatively. First, is that of board education. One role of the executive is to provide board training so that a board of directors understands the services an agency offers. For example, having been taught the values held by a counselling agency, a board

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may. firmly believe that a client's motivation through voluntary attempts to seek help is a prerequisite to receive an agency's services. A competent executive may have taught the board this fact. When the same executive comes to the board and says, "We want to begin an outreach program in which we seek out service recipients," inevitably the board will ask whether this is in contradiction of the accustomed value system.

The second issue relates to turf. Every senior center in the country under the auspices of a community center provides some degree of counselling to their clients. Where is the line that keeps this counselling from duplicating the counselling offered at the local family service agency? When does a Federation information and referral program cross over into the turf of the functional agencies? What is the effect of homes for the aged getting involved in the variety of community services that they now do? Turf is a real issue in the development of new services, one not to be denied. We must be sure not to let it interfere with the development and provision of meaningful service alternatives for our elderly population. Finally, there is a need for a psychological set of staff as well. Staff, board and the community must look at the problems of the elderly with positive thoughts of possibilities for their solution. We all must encourage the generation and evolution of ideas, regardless of how far out they may seem at the moment. We sit on a demographic time bomb with regard to the increasing number of aged requiring care over our professional lifetime. We *must* look toward new delivery systems. In these delivery systems, we must look for creativity and innovation to meet the challenges ahead.