Integrating Services For the Elderly

Collaboration Improves Long-Term Care Providers' Ability to Care for the Elderly

As the nation inches toward healthcare reform, long-term care providers and others who care for the elderly are finding collaboration essential to continue serving their constituents. Although these collaborative arrangements may not be as well-integrated or comprehensive as the integrated delivery network model proposed by the Catholic Health Association, they do represent a first step toward broader involvement with the community and other providers.

INTEGRATED DELIVERY NETWORKS

Information Network

A collaborative information and referral program in Battle Creek, MI, is one of the most promising and comprehensive of such ventures. Senior Information & Services (SIS) is a network of healthcare providers and agencies that serve the area's elderly. Although it is just getting off the ground, eventually the network could encompass 150 organizations, linked through an information system that will enable them to share appropriate patient data.

SIS's goals are to facilitate the elderly's access to a continuum of services, prevent them from falling through the cracks, and identify gaps in services, explained Jennifer Link, director of Burnham Brook Center, which will house the SIS office. The center, currently under construction, "will be a focal point for the county so seniors know where to locate services," Link told an audience at the American Society on Aging's annual meeting last March. The multipurpose facility will include a swimming pool and offer activities for the elderly. In addition, satellite locations around the county will provide services to those unable or unwilling to travel to the large complex.

In the two-year process that led to the network's development, initiators unearthed complaints from area providers that they were "fighting to stay even at best" and "treating problems in isolation, with limited communication and coordination," Link reported. Seniors, on the other hand, were unaware of available services, thought they were ineligible for services, and were confused by the variety of information sources. "Most dropped out rather than going through the maze," Link said.

Surveys conducted by the project's initiators showed that older adults prefer to obtain services simply, through one phone call, one intake form, and one centralized location. To meet these needs efficiently, they planned an electronic system to link service providers. "But without collaboration, the electronic system would be virtually useless," said one of the project's leaders, Frank Crookes, vice president of community services at Kellogg Community College, Battle Creek. He spearheaded the effort to bring community providers together to form the information network.

The Collaborative Process

The collaborative process evolves in four phases, said Crookes, noting that SIS is currently in phase 3 (see **Box**). The phases run on a continuum, he explained, from nonagreement to broad agreement; separateness to integrated thinking; defensiveness to sharing; and pieces to gestalt, or wholeness.

He added that the biggest challenge in collabo-

ration is "the group has to be instilled with the idea they really can do it."

At initial meetings of interested area providers, Crookes noted, the group agreed on a definition of collaboration: "a mutually beneficial and well-defined partnership, entered into by two or more organizations to obtain common goals" (from Paul W. Mattessich and Barbara R. Monsey, *Collaboration: What Makes It Work*).

Next, group leaders asked various questions to show the value of collaboration, such as, Is there enough work for all of us to do? The answer—that even by working together, they could not meet all the needs—sparked joint thinking about collaboration, Crookes said.

To initiate the process, Crookes arranged for a nationally known gerontologist to interview providers and recipients. Based on his recommendations, the committee members settled on a community services model of collaboration that stressed coordination by the center; community-based services; negotiations and coordination between providers; and the need for agreement on cost, service population, and other fundamentals.

Without wasting any time, Crookes then invited area service agencies and providers to a series of meetings on senior services. Forty persons attended the first meeting—the first time they had all gotten together. Since then, the group has expanded to 150 organizations.

At the first meeting, Crookes and other leaders answered their questions, addressed any feelings of threat, and defined collaboration. The half-day meeting resulted in a tacit agreement to move ahead with a consumer-driven model, in which clients would determine the healthcare and social services to be provided.

At a second meeting a few weeks later the group set ground rules for accountability, attendance, and record keeping. Then the group as a whole elected a steering committee of 16 organizational representatives (chaired by Crookes) to discuss who would participate in the network and how, goals, technology needed, and funding and then to report back to the group as a whole.

Crookes stressed that the process in forming a collaborative network is as important as the network itself. "You need to spend time so people get a vision of themselves as collaborators," he said. "If you don't go through that process, it doesn't matter what system you have. It'll sit there like scum on the water—it just won't be integrated."

Electronic Referral Network

The steering committee members developed the SIS collaborative model and formed a pilot consortium of 16 organizations, which began handling cases in July. The "glue that's holding the SIS network together" is a custom-designed electronic information referral network, said Carolyn Harvey, communications director at the Battle Creek Volunteer Bureau, which manages the

PHASES FOR COLLABORATION

Phase 1: Environment and Isolation

- Purpose is to further own goals.
- Members have different conceptual frameworks.
- Members maintain protectionist or competitive stance or see other agencies as irrelevant.
- Members rarely work with one another and never meet as a group.

Phase 2: Membership and Networking

- Members have different conceptual frameworks.
- They share information to further own goals.
- Members begin to cooperate, but essentially maintain protectionist or competitive stance.
- They hold informal meetings to discuss recent developments at their agencies and in the community.
- Proposed programs are not yet collaborative.

Phase 3: Process and Structure—Collaboration

- Purpose is to further similar goals developed independently.
- Partners work to merge differing conceptual frameworks.
- Partners maintain cooperative stance to coordinate existing services, but do not share resources or responsibility for programs.
- Partners meet regularly and develop relationships and group identity.
- Partners share information on respective missions and programs, resources, and funding sources.
- Joint projects result from discussions, but there is no systemwide analysis.

Phase 4: Communication, Purpose, and Structure—Collaboration

- Purpose is to further jointly developed goals.
- Partners have common conceptual framework.
- Partners share resources and responsibility for programs.
- They jointly identify priority issues and charge work groups to study them; they begin systemwide analysis.
- They submit joint funding requests with proposed collaborative programs.
- Partners oversee joint implementation of work group recommendations.
- Partners formulate joint policies and operating procedures.

resource data base.

Users can enter the system by contacting any member organization and filling out only one intake form and (if they are willing) one release form for the entire network, Harvey explained. Electronic transfer of information between providers speeds access to services.

The core computer system is based on 486 personal computers (PCs) connected to a 24-port expansion board to support 10 modems to the central station. Each PC hooks up to the master computer, which holds the resource data base. To protect confidentiality, users load their data into the central data base using a standard format.

The cost of developing the system, about $100,000, was subsidized by the W. K. Kellogg Foundation, located in Battle Creek. Individual providers will pay for the hardware they need and will pay a user fee based on the savings to the agency.

SIS provides several levels of assistance, Harvey said: basic information about available services; referrals; short-term coordination of existing community services; and more intensive care management to locate, integrate, and coordinate a variety of services.

STEPS TO SUCCESSFUL COLLABORATION

Frank Crookes, vice president of community services, Kellogg Community College, Battle Creek, MI, offered the following tips for providers looking into community-wide integration:

- Bring in somebody from the outside to initiate the process. An outside expert can point out the need for collaboration more bluntly than members of the community, without being suspected of ulterior motives. He or she can also set a conceptual framework for collaboration.
- Do not let any time elapse between the "kickstart" and the meeting to address the issues. And hire someone to facilitate the meeting, since it can be difficult to obtain tacit agreement from the diverse groups represented.
- During the process of structuring your network, write down every decision made. Keep journals, and get written agreements along the way. This will serve as a document for change and answer questions that arise later. For example, it will help to come back to the purpose and goal of the project when it gets confusing down the road.
- As you develop a collaborative effort, first identify areas of agreement, then move on to areas of nonagreement. For example, if people are worried about confidentiality, start by discussing what they *are* willing to share. They may find they can "bite off bigger pieces" than they initially thought possible.
- Divide the tasks into sections so they are not so overwhelming. "It's like the old joke, 'How do you eat an elephant?'" said Crookes. "One bite at a time."

The SIS network benefits elderly users by enhancing their quality of life and promoting independence and autonomy, according to Harvey. The network offers full and equal access to services, since all providers in the network have agreed to provide services regardless of race, income, or other factors. And the network promotes efficiency and cost-effectiveness in delivering services.

Harvey pointed out that the information system:

- Links client demographics to the resource data base to match clients to needed services
- Tracks clients through the system
- Provides statistical data (which will eventually be used in research on outcomes and unmet needs)
- Flags clients' unmet needs
- Establishes eligibility criteria using standard terminology
- Enables members to refer clients by transferring a call to another provider automatically, making an electronic referral, or giving users the name and number for them to call

All calls to the system and their disposition are logged. This will facilitate more effective service planning, since providers will have a greater awareness of available services and unmet needs. Already they have discovered that transportation is the biggest gap in services for the elderly, Trish Siemers, director of SIS, said in an interview. SIS will be consumer driven, Link noted; if its clients identify needed services that are within the consortium's purview, it will provide those services or work with other care givers to do so.

THE START-UP

The consortium's leaders will have a lot of work to get agencies ready to use the information system, both in terms of equipment and training, said Harvey. When SIS started handling cases on July 1, much of the paperwork was still being done on hard copies rather than online, Siemers said. By the third week of August, members of the pilot consortium had begun entering information into the resource data base. But a few of the 16 pilot agencies were not yet online, and one had decided to purchase a whole new computer system.

Although the start-up has been difficult at times, Siemers said she expected the network would be "up and doing pretty well" within the next six months. She was enthusiastic about the collaboration that has developed between the agencies, as well as the positive reactions from seniors.

Siemers noted that the pilot group is continuing to hold meetings to refine the software (e.g.,

revising the information requested), and they are planning to start a user's group to discuss how they are using the system.

By 1994 the network plans to expand to 30 agencies in Calhoun County, and then by 1995 to all 150 agencies if they are interested, Harvey said. Network leaders are also exploring the possibility of expanding the network to cover the entire state. And eventually the software will be available for resale to providers in other locations.

> Advantages of the network include contracts with other network members.

Long Beach Service Provider Network

A looser network of adult service providers has been active in Long Beach, CA, for about 20 years—since the Older Americans Act first made money available for such projects.

Already a retirement mecca, Long Beach was serving a growing aging population in the Los Angeles area, explained Patricia A. Glow, coordinator of older adult services at St. Mary Medical Center in Long Beach. In 1973 representatives from the seven community agencies that served the elderly met because they felt the need for peer support and wanted to avoid duplicating services.

As senior services increased, new providers were invited to join the network, and it grew by word of mouth. Today, explained Judith H. Schultz, director of older adult services at Jewish Family and Children's Services in Long Beach, network members include public, private, and not-for-profit agencies, such as hospitals, home health agencies, hospice, senior housing, skilled nursing facilities, county agencies, social service agencies, volunteer programs, ombudsmen, health maintenance organizations, colleges, businesses, and private practitioners.

Schultz noted that the addition of for-profit organizations such as hospitals or skilled nursing facilities to the network was accepted by most members, but they do feel that the for-profits have different goals from others in the network. "They seem to resent the marketing people coming in," she said, referring to homemaking services and home health. But Schultz thinks that everybody should be welcome in this type of network so that providers will become familiar with the organizations they are referring clients to.

An Evolving Structure

The network's structure has evolved over the years. It has an "informal governance structure," Glow said, with no constitution or bylaws. The network comprises two separate groups. The Agencies and Programs on Aging (APA), in which 69 separate organizations participate, focuses on advocacy for funds and plugging gaps in services within the community. Directors and supervisors—the problem solvers—tend to belong to this group, Glow said. The Frail Elderly Task Force (FETF) involves mainly line workers who examine specific cases to deal with difficult clients and offer peer support. According to Schultz, 77 people are in the APA, 71 are in the FETF, and 35 belong to both.

Both groups meet once a month. They have four joint meetings a year and a holiday party twice a year.

The Network's Benefits

Some members devote about 10 hours a month to the network, not including activities related to special projects or committees. What do they get in return? Schultz pointed to formal advantages, such as marketing, referrals, and contracts with other network members. They can also obtain technical assistance, information about requests for proposals, expanded visibility, and a source of new staff or job leads. It also helps network members avoid duplicating services.

"It takes a long time to build and develop trust," she said. "We have to believe we're not competing with each other, trust that other network members have the same goals, and trust the providers we're referring our clients to."

The network's tangible products include a disaster preparedness plan to reach isolated seniors and a memorial fund to benefit social work students in aging. In addition, the network has developed a resource guide for elderly services, a cross-county transportation guide (since the Los Angeles area's transportation system is so fragmented), a housing office, a shopping service, a peer counseling program, a program to provide free Medic-Alert bracelets, earthquake kits on what to do about homebound elderly, and videos targeted to senior audiences.

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HEALTH POLICY

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At the August 1993 NASHP meeting, Health Care Financing Administration Administrator Bruce Vladeck emphasized his commitment to improving his agency's action on requested waivers. Vladeck, a former New Jersey state health official, spoke of the "need to turn the Medicaid state-federal relationship from a financial one of just writing the checks, to a supportive-assistive, hopefully nonmicromanaged, [relationship] to improve quality and availability of services."

The three states described in this column—Hawaii, Florida, and Washington—represent but the tip of the iceberg in state healthcare reform activity. These three have in common elements of a managed-competition strategy that could provide invaluable insight for the national reform debate, should implementation proceed as envisioned in these states. Other states are pursuing play-or-pay strategies or more incremental reforms, and Vermont is studying a single-payer option. All these efforts will provide us with the critical information required to chart the uneasy course of reform. □

NOTES

1. Allen Dobson, Donald Moran, and Gary Young, "The Role of Federal Waivers in the Health Policy Process," *Health Affairs*, Winter 1992, pp. 72-94.
2. Deane Neubauer, "Hawaii: A Pioneer in Health System Reform," *Health Affairs*, Summer 1993, pp. 31-39.
3. Deborah L. Rogal and W. David Helms, "Tracking States' Efforts to Reform Their Health Systems," *Health Affairs*, Summer 1993, pp. 27-30.
4. Lawrence D. Brown, "Commissions, Clubs, and Consensus: Reform in Florida," *Health Affairs*, Summer 1993, pp. 7-26.
5. Robert A. Crittenden, "Managed Competition and Premium Caps in Washington State," *Health Affairs*, Summer 1993, pp. 82-88.

HEALTHCARE MANAGEMENT ETHICS

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Management of a capitated system calls for innovation and vigilance.

those values. This requires, for instance, measuring the network's quality of care and adopting practice guidelines.

Healthcare managers will need extraordinary leadership skills as they forge new, improved relationships with various care givers to ensure, above all, appropriate, high-quality services. This priority of values will not be realized unless healthcare delivery is understood as primarily a social good, a human service, indeed a ministry, rather than primarily a commercial transaction.

When such an understanding and ordering of priorities prevails, the financial arrangements between and among healthcare professionals and organizations, and the patterns of care that result, will be adjudged satisfactory by communities and individuals to whom healthcare professionals are primarily accountable and by care givers who will be assured they can honor their fiduciary responsibilities to their patients.

Understanding and effecting the right relationship among the values of community and patient well-being, quality, and cost containment are imperative to restore and promote the professional ethos of healthcare. Furthermore, conscientious healthcare managers who succeed in this regard should find their integrity rewarded as their networks are selected by many who recognize that the networks' criterion for decision making is the community's best interests. □

INTEGRATING SERVICES

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THE CHALLENGE OF A NETWORK

Continuing a network of service providers is a challenge, according to Kathleen Wilber, PhD, an assistant professor in the gerontology school at University of Southern California-Los Angeles, because of a "paradox in terms of how we develop services."

"The major problem with coordination of such a network is that we're trying to do two very different sorts of things," Wilber said. "We're trying to develop a systematic approach to service delivery—something that's predictable, that's organized—but we also need services that are adaptable, flexible, responsive. In developing and coordinating a system, we need to encourage diversity and innovation, and we need to have a lot of different kinds of providers."

Wilber said although everyone always talks about the need to eliminate duplication, flexibility and adaptability are more important because of the complex needs of the elderly being served. She advocates a system of "managed chaos" and pointed to the danger of overrationalization. "It's not a jigsaw puzzle," she said. "There will be some gaps, some overlaps."

By establishing a network, Wilber said, providers often assume they can enable the elderly to avoid nursing home placement. She points out, however, that this attitude views the network as a closed system and puts up barriers to ties with nursing home providers. Providers also often think that coordinated services are more efficient. However, the cost of such efficiency is great, she said. And coordinated services will only benefit consumers if they are also flexible.

"People view case management as the magic pixie dust of coordination," Wilber said. But she views fragmentation of services as a reflection of the complexity of the problems faced by the elderly. "We need some glue to bind us together, but not superglue—so that we don't create a system where no one can move independently and the structure creates problems for us." —*Susan K. Hume*