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Coordinated-Care Teams: Improving Health and Social Care for Older Israelis

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Abstract

Throughout the world, those serving the elderly face two fundamental challenges: coping with the increasing number of disabled elderly by developing services that will help this population maintain its quality of life despite functional disabilities; and establishing a cost-effective, efficient system of qualitative services appropriate to the needs of this population.

In Israel, the impetus to improve the organizational structure of the system of services for the elderly led to the formation of an inter-organizational task force, comprising representatives of agencies responsible for providing services to this population. The model ultimately developed by the task force was that of coordinated-care teams, comprising a nurse and social worker, which manage care at the neighborhood level. The teams assess needs, formulate and implement care plans, mobilize available community resources, and conduct follow-up. This model capitalizes on the strong points of the Israeli service system, which include universal health coverage, a low proportion of institutionalization, and a well-developed infrastructure of health and social services at the neighborhood level.

The coordinated-care team model enables professionals to care for the elderly according to their own perceptions of good professional practice, which include comprehensiveness and continuity of care. This, in turn, encourages cooperation between team members, capitalizing on the benfits of teamwork. The coordinated-care team model integrates care and case-management functions, enabling team members to achieve their individual and joint professional goals. In addition, by helping define the boundaries of responsibility of each organization serving the elderly, the model minimizes unmet needs and precludes duplication of services.

Coordinated-Care Teams: Improving Health and Social Care for Older Israelis

by Jenny Brodsky and Esther Sobol

Israel responds to its growing numbers of disabled elderly and their needs for comprehensive services with nurse/social worker teams who share responsibilities and reap professional benefits.

Israel's program for coordinated, comprehensive care of the disabled elderly has two, parallel goals that reflect the fundamental challenges facing service systems throughout the world: to cope with the increasing number of disabled elderly by developing services that will help this population maintain its quality of life despite functional disabilities; and to establish a system of qualitative services appropriate to the needs of this population that is cost-effective and makes maximum use of existing resources.

Israel's Unique Demography

In trying to meet these goals, Israel has had first to overcome at least some of the problems faced by its system of care for the elderly. Israel occupies a unique place on the aging map. The absolute number of aged in Israel has increased tenfold since its establishment in 1948, and the proportion of the aged among the total population has increased threefold, reaching approximately 9% in 1990. While life expectancy in Israel matches peak levels in western Europe, birth rates in Israel are much higher; and while the mean age of Israel's population is considerably lower than those of most western European countries, its elderly population is quite old.

More importantly, the number of functionally disabled elderly in Israel has grown rapidly during the past two decades and is expected to continue to grow during the coming decade. Nine percent of the elderly who are not institutionalized suffer some form of functional disability. The percentage of disabled increases with age, reaching nearly 20% among those aged 80 and over. In Israel, the rate of disability is higher for women than for men and is twice as high among elderly originating from Asian and African countries as it is among elderly of Western origin.

One of the factors contributing to the increase in disability rates is the increase in the number of those aged 75 and over. This population increased by a remarkable 90% between 1970 and 1990—an unparalleled rate compared with Western countries. Moreover, the number of elderly over 85 increased by almost 100% during the 1980s and is expected to continue to increase during the 1990s. Also expected to contribute to an increase in disability rates is the anticipated rise in the percentage of women and individuals of Asian-African origin among the elderly.[1]

This increase in the number of elderly—particularly disabled elderly—has made more urgent the need to develop new services, as well as to expand and better utilize existing ones. Before discussing the contribution of the coordinated care program to meeting this need, let us examine the long-term care services currently available.

Major Agencies and Service Providers

In Israel, as in many other countries, the responsibility for care of the elderly is divided among a multiplicity of providers, each with its own funding source, eligibility criteria and basket of services. Responsibility for the elderly is shared by numerous governmental, public, voluntary and, increasingly, private agencies. While some care is provided within the context of services for the general population, much is provided through services designated specifically for the elderly.

These latter services were developed recently in response to the specific needs of this population. Nevertheless, the nature of services for the elderly is still largely determined by the principles that govern the structure of health and welfare services for the general population.

The Ministry of Labor and Social Affairs, the Ministry of Health, and the National Insurance Institute (social security) are the main government agencies involved in the care of the elderly. They either directly administer services or support services administered by local authorities. The Ministry of Labor and Social Affairs plans services and participates in their organization and financing. Services under its aegis include homes for the the aged, clubs, day-care centers, meals-on-wheels, semi-professional home care for the frail elderly and housekeeping. These are implemented by social service bureaus, which are responsible for the establishment and provision of social services to the general population at the local level.

The National Insurance Institute is Israel's major income maintenance agency. It also provides long-term care services to the severely disabled elderly living in the community on the basis of social insurance principles and legal entitlement (the Community Long-term Care Insurance Law).

The Ministry of Health is responsible for the institutional placement of severely disabled and mentally frail elderly, the operation of mental health clinics and the development of preventive public health services in family health clinics. At present, Israel has no compulsory health insurance program. Both health insurance and the full range of health services are provided by nonprofit sick funds (similar to health maintenance organizations), the largest of which is Kupat Holim Clalit (KHC), the sick fund of the General Federation of Labor. KHC insures approximately 95% of the elderly population; it is organized in a national network of neighborhood clinics that employ medical, nursing and paramedical staff. Regional continuing-care units are specifically responsible for supervising and facilitating the care of the chronically ill and disabled elderly.

The Need for Coordination. Because the elderly have a variety of needs, the organization of service provision is necessarily complex. And while anyone needing the services of several agencies would encounter difficulties, the elderly are overwhelmed by the fragmentation of their service system. Their problems are compounded by multiple needs, functional limitations and a relative lack of financial and social support. These problems are exacerbated by the unique characteristics of Israel's elderly population, one of immigrants with poor knowledge of Hebrew, and a relatively low level of education and income.

The need to coordinate services for the elderly and simplify the system is therefore abundantly clear.

Israel's Solution: The Coordinated-Care Team

It is generally agreed that there is no one, universal solution to the problem of coordination among services in the long-term care system. Each country must find its own approach, as dictated by the needs of its elderly population, as well as by existing organizational structures and the actual functioning of service providers.

The number of people aged 75 and older increased by a remarkable 90% between 1970 and 1990.

In Israel, the impetus to improve the organizational structure of the system of services for the elderly led to the formation of an inter-organizational task force, comprising representatives of the major agencies responsible for service provision: the Ministry of Labor and Social Affairs, KHC, the Ministry of Health, the Association for the Planning and Development of Services for the Aged in Israel (ESHEL), and the JDC-Brookdale Institute of Gerontology. The goal of the task force was to develop a workable model of coordinated care; its efforts resulted in a formal agreement for cooperation between the health and social services.

Despite its multifarious problems, the Israeli service system has some strong points. In trying to solve the system's problems, the task force attempted to capitalize on these strong points including: universal health insurance coverage; a low proportion of institutionalization; strong family support for the disabled; provision of home care for the disabled under the relatively new Community Long-term Care Insurance Law of the National Insurance Institute; and a well-developed infrastructure of health and social services at the neighborhood level. The efforts of the

UN Photo by John Isaac

task force were enhanced by the willingness of most agencies to grant professionals broader responsibility and to adopt a comprehensive approach to client assessment. While there had been some cooperation among agencies serving the elderly prior to the establishment of the task force, this had depended on the good will of the professionals involved, who did not always have the means to make this cooperation work effectively.[2]

The model ultimately developed by the task force involved the creation of inter-organizational and interdisciplinary teams. These coordinated-care teams were to become a permanent part of the services provided at the neighborhood level. They comprise two members, a social worker, representing the local social service bureau, and a nurse from the local primary health clinic, representing the medical staff. The teams, which meet weekly at a neighborhood clinic, are responsible for managing care for the elderly in a particular catchment area: comprehensive assessment of needs, formulation and implementation of a care plan, mobilizing all available community resources and follow-up.

The task force chose to base its approach to case management on existing providers of care for the elderly. This required that professionals from separate agencies agree to share responsibility for their clients. Within the framework of shared responsibility, team members were to divide various tasks each according to his/her professional expertise. It was hoped that this basis for cooperation between health and social service workers would resolve previously existing ambiguities and conflicts over responsibility for the care of the elderly.

By ensuring close cooperation among professionals from many organizations, the team approach enhances comprehensive intervention on behalf of the client and increases the effectiveness of service provision. Beneficial to all elderly clients who need both social and health services, this approach is particularly appropriate for those who are physically or mentally disabled or who suffer from complicated problems.

Because Israel's case management model drew on existing care providers, teams were able to take advantage of the infrastructure of the health and welfare systems with which they are familiar. Their extensive ties with the disabled elderly in the community facilitated the implementation of the program.

Another benefit of cooperative case management was the development of tools suited to a comprehensive approach to care for the elderly. The most important of these is the case management record, which is filled out jointly by the nurse and social worker. The case management record enables team members to share data. It also structures the decision-making process to facilitate effective care planning and follow-up.

The approach chosen by the task force meant that professionals from separate agencies had to agree to share responsibility for their clients.

Yet another contribution of this program is that teams have strengthened ties with other components of the system, such as the Ministry of Health for matters concerning institutional care; hospitals for problems concerning discharge; and the framework for financing home care under the new Community Long-term Care Insurance Law.

The case management model has been adopted as national policy by the participating agencies and is gradually being introduced nationwide. Simultaneously with national diffusion, five areas, one rural and four urban, were designated as demonstration sites. In these areas, special effort was made to ensure effective implementation. The demonstration program, accompanied by continuous evaluation, contributes to the ongoing process of national implementation.

Implementing case management nationwide has required changing professional and organizational practices without the benefit of additional financial or personnel resources. The task force determined that the professionals involved would have to make significant effort to facilitate implementation without additional resources.

Evaluation Findings

The evaluation that accompanies program implementation has been carried out by the JDC-Brookdale Institute of Gerontology. It is meant to determine both whether what was deemed possible in principle is being implemented in practice, and whether the latter actually improves clients' well-being. This evaluation is being carried out through a longitudinal research study that evaluates the process of implementation and its outcomes in the demonstration areas.

The project was implemented by coordinated-care teams established in all of the five demonstration areas. They met regularly throughout the entire two-year demonstration period and team members determined programs of care together. As a rule, the meetings followed a pre-planned agenda. This enabled both the nurse and social worker to prepare relevant case information on the clients discussed at each meeting. As a result, the teams were able to complete the client's program of care at a single meeting.

By evaluating the implementation, it was possible to learn about the quality of performance and its impact on quality of care. One of the central goals of the program that was successfully achieved was team members' joint responsibility for care of the elderly at all levels of disability. This was reflected in the ease with which team members divided tasks among themselves. The various tasks in the management of care were apportioned according to three criteria: the main problems of the elderly client—medical or social; the workload of each member of the team; and individual preference. Since the member of the coordinated-care teams succeeded in agreeing on the division of roles, the duplications in care provision that had previously existed were reduced. For example, team members decided among themselves who would maintain contact with an elderly client's family, and who would be responsible for conducting home visits—a time-consuming yet necessary part of the follow-up process, especially for a disabled elderly population.

Accepting joint responsibility for care of the elderly also resolved conflicts over which organization should be responsible for elderly persons having varying levels of disability. From interviews conducted with staff prior to implementating the demonstration program, it was learned that nurses and social workers often disagreed about the definition of client's functional status, since that definition determined which organization would be responsible for providing care and financing services. In contrast, following implementation of the program, coordinated-care teams began to see the services provided by KHC and the Ministry of Labor and Social Affairs and by other organizations in the system as part of a central pool of services. The program thus succeeded in getting team members to agree upon provision and financing of care and to coordinate their efforts to the benefit of their clients.

Another positive contribution of the coordinated-care team approach was that it gave both the nurses and social workers the opportunity to share their professional knowledge and expertise. As a result, each team member maximized his/her own professional skills, while learning to make better use of his/her colleague's skills.

Team members divided tasks with ease.

It was also found that the various symbols that accompanied the process of formalizing cooperation between nurses and social workers had importance. For example, the fact that the cooperative framework was called a *coordinated-care team* and the fact that work was structured and recorded on forms specially designed for the purpose made the work seem more professional and respectable in the eyes of both team members and other professionals in the service system. Both the nurses and social workers felt that their participation in the coordinated-care team enhanced their professional prestige, which contributed to their motivation and willingness to implement the program.

There were, however, two main factors that inhibited the progress of the program's implementation. The first of these was the social workers' heavy caseload: On average, each was responsible for between 150 and 300 registered cases. To a certain degree, this did not allow them time or ease of mind to internalize the changes in the work concepts introduced by the program. The second factor was the lack of variety in the services offered. The needs assessments carried out as part of the program revealed that there was a significant gap between needs and the services available in the community to meet them. At times, this caused staff to experience a sense of futility, which decreased their motivation to prepare comprehensive needs assessments.

Implementing Organizational Change. The demonstration program also provided a number of lessons about the implementation of organizational change. Implementing a new project—even when it is generally accepted within a system—always involves more effort than expected. This should be made clear to field workers and managers so that they lower their expectations for rapid change. Failure to do so can result in demoralization during the initial stages of implementation, which may damage chances for the project's success. To cope with this problem, a professional from outside the system was appointed to train staff during the demonstration period. He also helped solve daily problems that arose during implementation of the new procedures. In addition to its obvious practical value, participation in staff training came to be viewed as a status symbol, enhancing motivation. Training both before and during implementation proved invaluable in facilitating teamwork.

The initial premise that involving field workers in the planning stages of the demonstration program would be essential to success proved to be only partly true. Only after the program had begun operation did staff members understand its implications for their work. In retrospect, it seems that involving field workers too early did not enable them to truly respond to the principles of the program or to influence its implementation. Nevertheless, it became abundantly clear that staff should be part of the evolution of a working model. While it may be difficult for staff to contribute effectively before testing a model, there is no question that they should contribute their experience during the demonstration period. This illustrates the importance of built-in flexibility during the evolution of a demonstration program.

Another key lesson of the demonstration program was that successful coordination among field workers from different organizations depends heavily on coordination among organizations at the local and national levels. The situation in each region was unique making it necessary for managers to adapt the program model to the region. Modifying the model to better correspond to reality, guiding teams during the initial stages of implementation, and providing immediate solutions to immediate problems proved essential to efficient team functioning. In addition, the quality of the coordination at the managerial level proved a concrete expression of a manager's commitment to the program. This had great influence on the significance field workers ascribed to the program, and on their commitment to its implementation.

Conclusion

Despite the difficulties, professionals involved in the demonstration program at all levels were convinced that this was indeed the most appropriate way to coordinate care within the Israeli system. A decisive majority of field workers participating in the demonstration program were satisfied with the work of the coordinated-care team and felt that teamwork vastly improved the quality of care for the elderly.

It seems that the model of inter-organizational and interdisciplinary teams provides the structural conditions that enable professionals to care for the elderly according to their own perceptions of good professional practices. These naturally include comprehensiveness and continuity of care, which enable them to assume more responsibility for all the elderly's needs. Because the program was based on existing providers of care, it was not difficult to integrate care and case management functions, thereby enabling the teams to reach their professional goals. Acceptance on the part of professionals of shared responsibility capitalized on the advantages of teamwork. This proved to be effective in overcoming previous conflicts among the organizations and helped to structure more clearly the boundaries of responsibility of each team member and each organization.

Jenny Brodsky, whose background is in sociology, is a researcher at the JDC-Brookdale Institute of Gerontology and Human Development in Israel. In conjunction with Esther Sobol, she conducts research on the evaluation of the quality of long-term care services, case management, and health promotion for the elderly. She is also researching the impact of home care in Israel on the well-being of the elderly, their families, and the service provision system.

Esther Sobol, whose background is in social work, is also a researcher at the JDC-Brookdale Institute of Gerontology and Human Development. In addition to her work with Ms. Brodsky on evaluating the quality of long-term care services, case management, and health promotion for the elderly. Ms. Sobol is examining the elderly's patterns of service utilization, particularly in the area of social care.

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תקציר

שני אתגרים בסיסיים עומדים בפני האנשים המספקים שירותים לקשישים ברחבי העולם כולו: טיפול במספרי קשישים מוגבלים ההולכים וגדלים, על-ידי פיתוח שירותים שיסייעו לאוכלוסייה זו לשמור על איכות חייה למרות מגבלותיה התפקודיות; ובניית מערכת שירותים איכותיים שתהיה יעילה וחסכונית, אשר תתאים לצרכים של אוכלוסייה זו.

בישראל הביאה השאיפה לשיפור המבנה הארגוני של מערכת השירותים לקשישים ליצירת כוח משימה בין-ארגוני, שהורכב מנציגים של הגורמים האחראים למתן שירותים לאוכלוסייה זו. המודל שפותח בסופו של דבר על-ידי כוח המשימה היה זה של צוותי תיאום טיפול, המורכבים מאחות ועובד סוציאלי, והאחראים על ניהול הטיפול ברמת השכונה. הצוותים מבצעים הערכה של הצרכים, בונים תכניות טיפול ומיישמים אותן, מגייסים משאבים קהילתיים זמינים, ומנהלים מעקב. מודל זה מנצל את הנקודות החזקות של מערכת השירותים הישראלית, הכוללת ביטוח בריאות כמעט אוניברסלי, שיעור מיסוד נמוך, ותשתית מפותחת היטב של שירותי בריאות ורווחה ברמת השכונה.

המודל של צוותי תיאום טיפול מאפשר לאנשי המקצוע לטפל בקשישים על-פי תפיסתם-הם את הדרך המקצועית והטובה לספק טיפול, תפיסה המדגישה הן את כוללניות הטיפול והן את המשכיותו. הדבר מעודד שיתוף פעולה בין חברי הצוות, ומנצל את היתרונות שבעבודת צוות. מודל צוותי תיאום טיפול משלב פונקציות של טיפול וניהול, ומאפשר לחברי הצוות להשיג את מטרותיהם המקצועיות הן כיחידים והן כצוות. בנוסף, המודל מסייע להגדיר את גבולות האחריות של כל ארגון המספק שירותים לקשישים, ובכך הוא מצמצם את הצרכים הלא-מסופקים ומונע כפילויות בין השירותים השונים.