EAST HARLEM LIVING-AT-HOME PROGRAM
Progress Report-the First Nine Months

EXECUTIVE SUMMARY

The East Harlem Living-At-Home Program (EHLAHP) is a consortium of 14 health and social service providers, represented by a coordinating office. EHLAHP staff perform outreach, case finding, and care coordination for frail East Harlem elderly residents in order to improve their well-being and diminish their chance of institutionalization. The EHLAHP received a smaller grant than expected and staff hiring proceeded slowly. Despite these initial problems, the consortium operated with enthusiasm, an excellent and well-qualified staff was hired, and now, after nine months of operation, 25 clients have been enrolled (with a first year target of 50 enrolled clients). The EHLAHP is one of the very few inter-institutional, collaborative programs to address an East Harlem problem, and the community has welcomed its arrival.

INTRODUCTION

This report details the progress of the EHLAHP from the beginning of operations in April 1987 to the present. The EHLAHP is a coordinating office for a consortium of 14 health and social service providers, under the direction of the lead agency, the East Harlem Council for Human Services. The EHLAHP coordinates these services through a case manager for the most frail elderly East Harlem residents, in order to improve their well-being, to strengthen their capacity to live independently in their own homes and community, and to prevent or postpone their institutionalization. This progress report addresses the problems encountered as well as the achievements attained in the progress toward the program's goals.

OBJECTIVES

The following specific 3-year objectives were laid out in the original proposal: (1) To create and formalize a consortium of health and social service providers; (2) to create the coordinating agency for the consortium; (3) to enroll and provide case management services for 50 elderly persons in the first year, 100 persons in the second year, and 150 persons in the third year; (4) to identify gaps in East Harlem services and to promote the development of new needed programs; (5) to develop a volunteer services project as an adjunct to the program; (6) to elicit further funding from the private sector; and (7) beginning in the second program year, to explore the feasibility of developing a Social/Health Maintenance Organization. As the following narrative indicates, some of the original objectives have been met, while others have been deferred.

THE CONSORTIUM AND THE COORDINATING OFFICE

Ten health and social service providers who care for East Harlem older people were brought together in 1985 by Dr. Robert N. Butler, Chairman of the Ritter Department of Geriatrics and Adult Development at Mount Sinai, and formed the original coalition which created the EHLAHP. The participants viewed the collaboration as an exciting venture because of the unique opportunity it presented to address an East Harlem problem as a collaborative effort. In the interim between the proposal submission in April 1986 and the receipt of the first check in April 1987, the consortium formed an advisory council of representatives from each of the agencies. The Advisory Council was very active during this year and developed a workplan and the model of the case management service (attached).

The Project Director, Pedro de Cuba (resume attached), was hired in April 1987 after an extensive search. He has served to strengthen the consortium by enlisting four new

consortium members (see Appendix for list of consortium members, services available to enrolled clients and interagency agreements). He has also formalized the activities of the advisory council, enlisted the services of a gerontology intern from the State University of New York at Old Westbury, and established working subcommittees (Program Evaluation, Functional Assessment Instrument, Bylaws, Interagency Agreements, and Finance) of consortium members in order to take advantage of individual expertise and interest. The Case Manager (now called the Care Coordinator), Margarita Rivera (resume attached), began on September 22, 1987. She spent her first month meeting consortium members, visiting East Harlem health and social service providers, and consolidating the lists of frail elderly persons offered by consortium members and friends of the program. Screening and enrollment of clients began in October 1987.

ENROLLED CLIENTS

The target population for the care coordination service is East Harlem residents over the age of 65 years who are at risk for institutionalization because of frailty. Since October 1987, 25 such people have been enrolled and have received a functional assessment by the care coordinator. To date all of the enrolled clients have been referred to one or more of the consortium member service agencies. In addition nine individuals either have referrals pending or need further assessment. Therefore we are currently working with a total of 34 older persons. The frailty of the enrolled clients is documented by the attachment in the Appendix. One client died several weeks after enrollment. The 25 clients were referred to 8 health and social service resources, among them four geriatric medical providers, a nursing home, a meals-on-wheels program, a day care program, a psychiatric hospital, a social network program, and a housing program. Details of the number and types of

referrals are enclosed in the Appendix. We hope to exceed the first year goal of 50 enrolled clients by the end of the first operational year (April 1988).

PROBLEMS

Two major problems have threatened the stability of the EHLAHP during this initial period, one externally imposed and one internal. The external problem was one of funding. Although the consortium applied for a three year grant of $350,000, only $318,000 was awarded. Year One funding, furthermore, was delayed by six months and was reduced by approximately twenty-five percent (from a requested $116,000 to $82,666). Internally, the EHLAHP had a staffing problem during the early months. The recruitment process for a project director was more complicated than expected (he did not begin until the third week of the program). Similarly, because hiring a sufficiently qualified case manager (care coordinator) was more complicated than expected, client enrollment was delayed for 5 months. Because of the current contracted budget, furthermore, staff lines for support personnel had to be diminished or eliminated (see the Appendix for the budget). Despite these problems, and because of the hard work of the program staff, lead agency and advisory council, the program is now operating well and providing services for the frail elderly.

FUNCTIONAL ASSESSMENT

The Project Director and members of the Functional Assessment Subcommittee (of the Advisory Council) developed a screening instrument and a functional assessment instrument (see Appendix). The instruments use many questions from the Older American Resource and Services (OARS) instrument and also contain questions which are pertinent to our particular elderly population of blacks and Hispanics. These instruments are currently being modified to incorporate the recommendations of the Care Coordinator, to integrate

questions from the Patient Assessment Tool for Homecare (PATH) developed by the New York State Office of Aging, and to elicit information needed for program evaluation. Thus the enclosed instruments are not yet finalized.

CARE COORDINATION

Care coordination begins with case finding. The care coordinator has made numerous telephone and personal contacts to collect the names of potential clients. The Appendix contains the brochure, information bulletin for professionals, and information flyer for lay people which were developed for marketing the program's services. Because the EHLAHP intends to enroll elderly who are at high risk for becoming institutionalized soon, the Care Coordinator must seek out people who are the most isolated and least connected to health and social service resource providers. This often takes the form of investigation of "tips" from older clients of the consortium members. The Care Coordinator must also make the assessment that the screened person is eligible for enrollment by the demographic criteria and by the degree of frailty. We have found that the typical enrolled client had a pressing need for services, such as help with impaired vision or hearing, resolution of unsafe conditions in the home, or referral for an untreated active medical condition.

VOLUNTEERS, ADVOCACY FOR NEW EAST HARLEM PROGRAMS, AND RAISING ADDITIONAL FUNDS

Because of the slow start-up of client enrollment, the Director and Advisory Council elected not to focus attention in the first year on the development of a volunteers program, advocacy for East Harlem programs, or raising additional funds from the private sector. Three potential avenues for developing a volunteers program are available to the EHLAHP. The first is the Volunteers for the Elderly at CASABE Program, a collaborative project of CASABE House and

the Department of Community Medicine (Mount Sinai School of Medicine). This program is intended to develop the skills of CASABE House resident volunteers to diminish the social isolation of other CASABE House elderly persons. CASABE House is the residence for the elderly in which the EHLAHP offices are located. Because of the proximity of programs and mutual interest, many of the methods and tools of the Volunteers for the Elderly at CASABE House Program will be made available to the EHLAHP Care Coordinator.

The second potential method for developing a volunteers program is through VISTA (Action/Volunteers in Service to America), which may be a source of volunteers in the program's second year if the Care Coordinator has the time for the program development and supervision. The third potential method for developing a volunteers program is through the New York City Volunteer Corps.

Although the Project Director has not made these activities a top priority, he has discussed additional funding with several elected officials and a consulting firm that specializes in small, not-for-profit health programs. This will become more important in the second program year.

MANAGEMENT INFORMATION SYSTEM

Because of budgetary constraints, a computerized database of screened elderly, enrolled clients and client referrals could not be established in Year One as originally proposed. A manual system has been created and is the basis for a future computerized data management system.

PROGRAM EVALUATION

The Project Director and Program Evaluation Subcommittee developed an evaluation plan that addresses the structure, process and outcome of the program (see Appendix). This

plan is currently being modified to incorporate the data needs of the national evaluation team.

FINANCES

The Appendix contains the original approved budget ($116,000) and actual expenditures for the first nine months and projections for the remainder of the first year. The first year grant was reduced to $82,666, and we project no expenses above this. The Year One expenditure reduction was accomplished through: in-kind contributions from the East Harlem Council for Human Services, the lead organization; small in-kind contributions from the consortium members, such as Mount Sinai; reducing the secretarial line to a half-time position; and eliminating a computerized data management system. The projected budget for Year Two, also included in the Appendix, is similar to the original second year budget. It is important to note that, beginning in 1988, the East Harlem Council for Human Services has imposed indirect cost charges of 10% on all of its programs (see Appendix for memorandum of explanation).