NATIONAL INSURANCE INSTITUTE
Research and Planning Adminstration

The Role of Elderly Volunteers in Helping to Identify Elderly at Risk

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Jerusalem, December 1994

Discussion Paper 10
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Introduction

Towards the end of this decade, there will be approximately 462 thousand elderly people in Israel, about 200,000 of them age 75 or older. The increase in the very old population (age 75 and up) is primarily a result of the rapid increase of the 80-plus age group, which will reach 37% (Be'er and Factor, 1989). The number of disabled dependent persons in the elderly population as a whole will be as high as 41% in 1995, and will rise to 42% in the next century. The group of elderly whose only limitation is in taking care of their housekeeping chores will reach 184,900 by the end of the decade (Factor and Primak, 1991). These projections do not take into account demographic changes in the wake of the recent mass immigration to Israel and advances in medical technology which are likely to prolong the lives of many elderly persons.

These demographic projections indicate an increase in the scope of support and services that the elderly will require. As a result, this population will be increasingly dependent on society. Factor and Primak (1991) project that by 1995 it will be necessary to increase services to the elderly by 15%. We can assume that in the near future we will not have the resources to develop and provide the full range of services that the limited and dependent elderly will require (Morginstin, 1990). For economic and social reasons, the support network of the welfare state has become increasingly eroded (Katan, 1989). Informal support networks and the family will continue to bear the burden of responsibility for prolonged treatment for the dependent elderly living in the community. This reality is manifested by the fact that many elderly "fall between the cracks" and do not receive the services they require. The Long-Term Care Insurance Law (LTCI) was designed to assist with some of the needs of the dependent elderly and to lighten the burden of the family members who care for them. Many of the elderly who were found ineligible for LTCI benefits do not receive

the services they require.

Moreover, when a relative is responsible for the prolonged care of a dependent parent, the care becomes a mental, physical and financial burden to the relative. As the condition of the dependent elderly deteriorates, the family member becomes less and less able to care for him/her. (Morginstin, 1992). These conditions can produce intense hostility, acute tensions, and unwillingness to help out. In extreme cases, injury, neglect, or physical or mental abuse of the dependent elderly person may take place (Katan, 1989). In other words, even the elderly who receive assistance and nursing services from formal and informal organizations can fall into a situation of hardship or risk.

In light of these developments - the demographic projections, the inability of the establishment to provide services to the entire dependent elderly population living in the community, the decreasing ability of family members to cope - there is a concern that many elderly will face hardship and risk and will not receive appropriate care. There is, however, recognition that society has responsibilities and obligations towards these elderly and cannot neglect them (Morginstin, 1990; Lowenstein, 1991). Other assistance networks, mainly voluntary organizations, will have to locate and identify the elderly at risk, in order to guarantee that the limited resources will indeed reach the most needy sector of the population.

In the past several years, the Counselling Services for the Elderly and Pensioners of the National Insurance Institute (NII), together with the Research and Planning Administration, have invested a great deal of effort in the initial home visits conducted by volunteers of the Institute to the homes of the elderly, in order that these visits may provide relevant and reliable information which can help identify those elderly who are not receiving adequate care.

This paper aims at presenting an innovative process which integrates the special qualities volunteers bring, i.e. an informal, supportive, and direct approach to the client, into the organizational/bureaucratic functions of identification, follow-up and supervision. This integrative approach is based on the assumption that the informal aspects of volunteer work can help in achieving the goals that the organization is interested in achieving. For this reason, the volunteers had to be equipped with an instrument which would provide more objective data, rather than relying on their general impression of the situation.

This innovation, of course, raises the question of the limits of volunteerism and the definition of the volunteer's role. We will deal with these issues later.

The paper focuses on the home visits conducted by volunteers and the development of an instrument to identify elderly persons at risk. It addresses topics such as: What is *an elderly person at risk*? How can we identify this person? What is the appropriate instrument for identifying elderly *at risk*? The results of the research evaluation[1] of volunteers' home visits illustrate the types of information volunteers are able to gather, and how this information can be used to help the elderly.

Home Visits of Volunteers - From the Counselor's Office to Identification in the Community

Counselling centers for the elderly were established in 1972. The centers are based on a principle that resembles self-help - "Elderly to Elderly." The concept underlying

[1] Baich-Moray, S., and Dabush N., *Volunteers Visit the Homes of Elderly Eligible for Long-Term Care Benefits*, Survey No. 78, National Insurance Institute, December 1990.

Baich-Moray, S., *Elderly Volunteers Visit the Elderly in the Community*, Survey No. 89, National Insurance Institute, January 1992.

the service was that adults with life experience in different fields, and themselves experiencing the difficulties which are part of the aging process, are able to help other elderly while, at the same time, benefiting from their volunteer work.

Today, all the local branches of the National Insurance Institute provide this service. In addition, auxiliary centers are located all over Israel. Approximately 3,200 volunteers are involved, the vast majority of whom are over 60 years old. The lion's share of the volunteers are engaged in conducting home visits, and the others work in the centers as counsellors. On average, the volunteers make about 30,000 home visits a month. A staff of seventeen directors and twenty administrators direct and supervise the volunteers. Most of the staff members are social workers (Givoli and Yehuda 1992; Givoli, Oberlander and Berkman, 1989).

During the first stage after the centers were established, the volunteers counselled the elderly at the centers only. Shortly after counselling centers opened, however, it became obvious that the elderly who were most in need of the services were not able to come to the centers. At this point, the decision was made to train volunteers for a home visit program. With the assistance of welfare agencies in the communities, publicity and self-initiative, the centers began an intensive program to locate single or house-bound elderly persons. This program emphasized the importance of forging a personal connection, establishing continuity, providing a limited amount of hands-on help in the elderly person's day-to-day life, and most important, in striving to solve problems by referring the elderly person to the proper agency.

In addition to the on-going visitation program, and in light of the growing demands of the older population, the National Insurance Institute decided to establish a program of one-time home visits intended to locate the elderly at risk. Prior experience and information about the status of the elderly in Israel enabled the

Institute to define the target populations with possible risk factors. These groups include elderly for whom a pension-recipient was appointed, elderly widows and widowers, those over age 75, and elderly who do not deposit their pension money in the bank.

The purpose of the visits is to assess the situation of the elderly, to identify any problems (such as loneliness or improper spending of their money by others), and to pass on the information for intervention and follow-up.

As stated above, these visits are identification visits and are meant to improve the situation of the elderly; they are not a substitute for professional care. Some one-time visits turn into a series of on-going visits.

After the enactment of the Long-Term Care Insurance Law (LTCI), which provides home care for the eligible elderly population, the program to train volunteers to identify special problems entered a new stage. Because the law is so new and innovative, and because of the lack of formal supervision at the early stages of its implementation, it was decided after extensive deliberations that volunteers should conduct the home visits to the eligible elderly. Since the matter was of such importance, it was suggested that the home visits should be conducted in a systematic and clearly-defined manner, and that the volunteers should address specific questions in their visits (Are the services being provided? Are there problems in providing the services? Is the elderly recipient satisfied with the services?) and that they be instructed to evaluate the elderly person's quality of life according to a number of accepted indicators.

In addition to the professional problems of how to devise the instrument (see p. 10), staff members of the National Insurance Institute (NII) also raised professional

objections to volunteers being involved with an evaluation questionnaire. The issue was whether was it is possible to maintain the personal, informal, and supportive atmosphere of the home visit and, at the same time, to gather reliable and uniform information, that could be used to indicate problems and difficulties in order to arrive at the best possible resolution.

Follow-up of the volunteers' visits to the eligible population demonstrated that the elderly volunteers were able to conduct a structured home visit using the evaluation form. The atmosphere of the visit was not marred; on the contrary, the form helped define the purpose of the visit. The fact that volunteers from the National Insurance Institute were conducting the initial home visits gave the community the impression that there was a watch-dog group looking out for the rights of the elderly.

The form proved to be an effective diagnostic tool, and it was used to locate elderly who were not satisfied with the way that the LTCI was implemented, or who reported problems in receiving services, so that immediate intervention was demanded. This information was passed on to the professional personnel who were now legally responsible for inspection and care.

These results greatly supported the process reported above, i.e. a more extensive use of a formal tool in locating and identifying elderly at risk.

The data gathered during the home visits also helped to define which groups were the most at risk - the oldest and those who live alone. The findings relating to the condition of the eligible population (see below) enabled us to shift the focus of the visits to other populations. It was established that one of the high-risk groups consisted of elderly who submitted a claim for long-term care benefits and their claim was deferred. The decision that these people would be one of the target populations

was based on their functional state (often, their limitations come close to the eligibility threshold) and the fundamental concern that some of these elderly are in effect "falling between the cracks." They are ineligible for long-term care benefits and do not receive help from the other agencies who are supposed to provide the social and environmental services that the law does not.

At this point, the home visits no longer focused on whether or not the elderly person was satisfied with the services, and so the question of how to identify elderly at risk became more pressing. Professionals are trying to find a solution to this complex issue, a matter that is even more complicated in the context of volunteers who have no professional training.

Identifying and Locating Elderly at Risk

The high percentage of elderly receiving assistance who were satisfied with the services they received through long-term care benefits (see p. 13) is surprising and presents pivotal questions. Although there was no doubt that most of the elderly indeed benefited from these services and from their relationship with the care-giver, the significance of the high rate of satisfaction was not clear. Various methodologies and theories were developed to evaluate the satisfaction level of people receiving the services provided by different bureaucratic welfare systems (Hirschmann, 1970; Timms and Maye, 1971). One of the prevalent explanations for the high rate of satisfaction is the dependency created between the service-provider and the service-recipient . Emerson (1962), for example, demonstrates that a client's registration of a complaint about the organization limits the client's ability to extract himself from the circle of relationships he has forged with this organization. As a result, the organization will not listen to his side in a complaint against the service-provider. Administrators, supervisors, and many volunteers have reported that in some

cases, the elderly and the family members are hesitant to complain about the care-giver or the service package lest the agency stop the care or replace the care-giver. Furthermore, many elderly who did not receive any care or attention whatsoever from the establishment before the enactment of the LTCI were delighted when they were provided with on-going care. The force of these arguments led us to look for a different theoretical framework which would enable home visitors to locate and identify elderly living in hardship and at risk, including those who receive long-term care services.

In her attempt to define injury and abuse to the elderly in a clear, comprehensive and accepted fashion, Tanya Johnson, a sociologist , proposed a definition for elder mistreatment (Johnson, 1986). Her definition was based on four elements:

1. Self-injury or self-neglect.
2. Injury or neglect by another (the care-giver).
3. Frequency and intensity of injury.
4. Motive and intent.

Fulmer and O'Malley sought a similar definition, but they posited that a state of neglect and risk was indicated when basic needs were not being provided (Fulmer and O'Malley, 1987). They defined mistreatment or inadequate care as a function of the care-giver responsible for the situation not providing the elderly with basic needs. These basic needs would include proper nutrition, personal hygiene, a clean place to live, a supportive relationship, and health care. In certain cases, the people "responsible" for not providing these needs are the elderly themselves, when for various reasons, they refuse or reject care, or are not capable of taking care of themselves.

There are certain advantages to examining the issue of whether or not proper care has been provided. First of all, satisfaction is not being examined, but rather an

impression of whether or not basic needs are being fulfilled. If they are not, intervention is necessary in order to provide the appropriate care. In addition, it is easier to spot the signs that indicate whether or not appropriate care has been given. Thirdly, examining the needs of the elderly without looking for reasons or a culprit threatens neither the elderly nor the care-giver, and it enables the development of primary trust. Fourthly, when appropriate care is not received - basic needs are not fulfilled - the physical, mental and social welfare of the elderly are endangered (Fulmer and O'Malley, 1987).

Our approach to receiving appropriate care was created on the basis of these arguments, as well as on the belief that the home visits in these terms would be more suitable to the character of volunteer work, and would make it easier to locate elderly in distress. It was determined that receiving appropriate care would be based on the following:

The elderly receives one hot meal a day and someone helps him/her to eat it.

The elderly is clean and is dressed in clothes appropriate to the season.

The house is clean and neat.

The elderly is visited regularly.

The elderly receives medical care.

The elderly's general mood is good.

If needs in these categories are not being met, it indicates distress, or that formal and informal bodies have neglected the elderly person, and an additional examination is in order.

Our impression is that today the volunteers and professional staff find it easier to understand that the purpose of the initial home visit is to identify cases where proper care is not being received. They are not coming to "police" the elderly, but rather to identify and help elderly living in hardship and at risk.

Gathering Information - The Instrument and the Method

As stated above, the primary goal of the questionnaire is identification. The questionnaire is an instrument that helps to locate elderly who are in any type of distress, or whose basic needs are not being met. In addition, the questionnaire was designed to be a source of reliable and (as far as possible) complete information. This information will enable the staff to decide whether intervention is necessary, and thereby can prevent the situation from deteriorating any further.

The theoretical framework directed us to choose the same variables which are used to identify unmet needs. We were aware that many risk situations (such as mental or physical abuse) are outside the terms of reference of this type of evaluation, and are the province of professional evaluation alone.

Still, translating the above aims to a questionnaire appropriate to the project's limitations was an extremely complex process that is still going on. The difficulties in designing the instrument were a by-product of our desire to maintain the informal tone of the home visit, which is conducted by non-professionals who have little or no experience and who are often far removed from the world of research and questionnaires. In essence, many volunteers underwent a "socialization" process for this brand-new role, a process that opened doors to new experiences for them.

The solutions we found to these dilemmas and problems were expressed in the *structure of the questionnaire, in the questions themselves, and most significantly, in* the procedures we set.

Structure of the Questionnaire

The questionnaire has three main sections:

1. Personal information about the elderly. This section was filled out before the home visit, using a computer read-out provided by the Old-Age and the Long-Term Care branches of the National Insurance Institute, to the Service for the Elderly and Pensioners.

2. Identifying the situation of the elderly. Most often, the volunteer, alone or together with a professional at the center (generally a social worker), completed this section after the home visit had taken place.

This section includes the indicators of the state of the elderly: personal hygiene, cleanliness of the home, nutritional state, and social situation. In addition, this section lists potentially problematic areas, including the elderly's mood, level of cognition, the condition of the home, security in the home, whether or not services are provided, if the elderly is healthy and family relationships.

This section contains closed questions, and the volunteer has the option of adding comments at the end. The questions which relate to the four indicators are on a scale from worst to best (such as the elderly is clean and neat). In identifying problems, the volunteer indicates whether or not the problem exists.

3. **Decisions and follow-up:** The volunteer and the director of the center fill out this section after the visit. The data is used to determine if intervention is called for, who will perform the intervention (Counselling Services for the Elderly and Pensioners or another community agency) and who at the center will monitor the care.

There is no doubt that this method of filling out the questionnaires raises certain questions. Do the answers reflect the volunteer's general impressions of the situation? Did the volunteer really examine each and every area individually so that the answers depict the true situation? Another issue is how the questions can better be posed and the questionnaires better completed so that the answers will be more reliable.

In order to guarantee maximal uniformity of the process and to improve the reliability of the answers, a set of procedures for all the centers was designed. Volunteers experienced in making home visits were selected. They underwent special training, which emphasized the purpose of the visit, defined the different areas of concern, and taught the way the questionnaire was to be used. A professional (usually a social worker) took part in each stage, from guidance before the visit, to helping the volunteer to fill out the questionnaire when necessary, and then actively participating in making decisions about the outcome of the visit.

Findings - What Can We Learn From The Questionnaires?

The partial findings presented below illustrate the types of information gathered from the questionnaires. This enables us to evaluate what impact this information should have on the work performed in the counselling centers for the elderly.

Data collected from 4272 home visits of eligible elderly (in 1987-88) showed that 84% of this group were satisfied with the services they received. Identifying the elderly who were discontent or who complained about problems in receiving services allowed us to rectify the situation by referring these cases to claims officers. It should be added that other studies on people eligible for nursing services (Shmid and Sabag,

1991) found a similar rate (between 84% and 86%) of satisfaction.

The importance of home visits, then, comes from their contribution to clarifying the situation in the field, i.e. the satisfaction rate, and equally significant, from their ability to locate the eligible who have problems in receiving services. It is likely that without the home visits, the eligible elderly would not have registered their complaints. In addition, the home visits revealed a population seen less often in the counselling centers (people who need more chronic care) and introduced the centers to the group which generally did not go to them. As a result, out of 4,272 home visits, it was decided that the volunteers should visit 1,055 elderly (25%) on a steady and on-going basis.

Table No. 1

Home visitors' impressions of the elderly who receive nursing care

Total home visits	satisfied	not satisfied	received immediate care	satisfied after immediate intervention	still receiving care	on-going visits decided
4,272	3,568	704	506	292	214	1,055

An analysis (Baich-Moray 1992) which compared home visits of five target groups (eligible for nursing services, people whose claim was rejected, elderly widows and widowers, people 75 years old and over, and people referred to counselling centers by a community agencies) by indicators of care received and mental and cognitive state identified the groups where the rate of unmet basic needs was higher than that of other groups.

Table No. 2

Target groups according to care received, mental and cognitive state **

(Percentage)

Indicators	Widow/er	Eligible	Refused benefits	75+	Referred to center	Level of signifi-cancies→
Total in Numbers	114	432	561	162	92	
Percentages						
House clean and neat	83*	86	73	82	82	0.001***
Eats hot meal daily	85	89	76	90	83	0.000***
Clean and neat	80	82	74	86	90	0.001***
Receives visitors	91	94	95	96	92	0.516
Mood good	51	80	63	75	73	0.000***
Logical speech	95	86	93	90	94	0.002***

* The number in each box expresses the percentage of elderly from the target group. For example, it was found that 83% of the widow/ers live in a clean and neat house, as opposed to only 73% of the people whose claim was rejected who live under similar conditions.

** From Baich-Moray, S., *Volunteers Visit the Elderly in the Community*, Survey No. 89, National Insurance Institute, January 1992.

*** The difference between groups is significant at a level of $P < .05$.

Table No. 3

Identifying Problems, By Target Population Groups (Percentage)

Areas where problems were noted*	Total	Widow/er	Eligible	Deferred	75+	Referred	Level of signifi-cancies →
Family relationships	6	11	3	6	2	12	0.000**
Living conditions	3	4	3	2	4	6	0.520
Security in the home	2	6	2	2	1	1	0.041**
Social conditions	10	18	5	10	9	23	0.000**
Health/functioning	43	43	30	54	31	52	0.000**
Problems with services from agencies in the community	4	6	2	5	4	4	0.274
Needs services and is not receiving them	11	12	14	18	6	15	0.000**

* The volunteers were instructed to note in every area whether or not a problem was mentioned. Each box indicates the rate of the problem in each group.

** The difference between groups is significant at a level of $P < .05$.

According to Table No. 2 (page 14), visitors' impressions indicate that the vast majority of the elderly in the different groups live in highly acceptable conditions, and only about 10% were found to have unmet needs. A group-by-group analysis

shows that the elderly who submitted a claim for long-term care benefits and had their claim deferred had more unmet needs. When the populations are compared by the rates of various problems, we can see that widow/ers experience social problems and that people whose claim was deferred and those referred to Counselling Services by community agencies (principally from welfare services) experience a significantly higher rate of not receiving necessary services.

Examining the relative conditions of people eligible for LTCI benefits can, in our opinion, demonstrate to what extent meeting basic needs (for example, individual care services) has an impact on quality of life in different spheres.

It is evident from Table No. 3 that not only do the eligible have fewer problems in various areas, they also experienced a lower rate of health/functioning problems, despite the fact that they were eligible for services precisely because of their limited ability to function in day-to-day life.

Examining all the data enabled identification of the elderly who did not receive adequate care. Out of the approximately 1,400 questionnaires which were analyzed in the communal study (Baich-Moray, 1992), it was determined that intervention was necessary in a third of the cases. A group-by-group analysis demonstrated that the need for intervention was 50% among the deferred and 21% among those eligible for long-term care benefits. The total data shows that in addition to individual care for every elderly, examining the questionnaires can help establish priorities and determine how to better allocate manpower at the counselling centers.

The data also illustrated that when intervention was deemed necessary, a third of the cases continued to receive care at the counselling centers (principally when the focus was social), half were referred to welfare services, and the remainder referred to the National Insurance Institute (NII).

Conclusions and Recommendations

The demographic forecast presented above, and the assumption that society will not be able to supply all the services that the limited and community-dependent elderly population will require, produces conditions in which many elderly will not receive adequate care, a situation that will become worse and worse with time. In our opinion, in the near future, we must focus our energies on locating these elderly. Volunteer home visitors, as we have seen, can play an important role in this pursuit.

The National Insurance Institute, through its volunteers, is actively involved in working towards this goal. Research findings and evidence from the field indicate that introducing a formal component (identification) into a voluntary framework improved the identification process. Despite the achievements and the wide scope of the home visits, it is still unclear whether or not we should continue to develop in this direction. How will these steps affect formal services? Will there be an adverse effect on professional efforts to identify elderly at risk and to develop instruments to identify this population?

On the basis of the findings presented above, can we be certain that the form used by the volunteers does indeed evaluate whether or not appropriate care has been given? The answer to this question falls far short of a definitive yes.

There is no doubt that more research is called for and that the form requires certain refinements so that the answers it elicits will be clearer. However, the form's main components indicate that it *is* possible to identify hardship situations, if not to judge

their severity. An additional question is to what extent is the assessment of the home visitors objective. The survey showed that the home visitors focus on those areas in which there is a possibility for improvement and change, for example, in providing a hot meal or house cleaning services. The director of the volunteers wholeheartedly approved of this tendency. On the other hand, the survey reconfirmed that the form is an instrument that enables the professional accompanying the volunteer to diagnose situations that require immediate intervention.

In conclusion, we believe that the evaluation form "teaches" the home visitor to be more observant and to center the visit around the goal of identifying a problematic situation. The form does not "announce" all the needs and difficulties of the elderly, but follow-up research can make the form a more efficient and effective evaluation instrument.

Another question is: Does everything we said about evaluating satisfaction also hold true for evaluating appropriate care? Elderly, when asked whether they are receiving appropriate care, are liable to be concerned that a truthful answer will risk what they receive, and therefore they tend not to be critical. We have no definitive answer to this question, and we must examine it closely.

Conducting initial home visits and evaluating them with a uniform form reinforced the mutual relationship between the counselling centers for the elderly and the various agencies who care for the elderly in the community. We believe that an established community coordination framework can further promote this cooperation and can improve our efforts to locate the population at risk and provide appropriate care. This would involve, *inter alia*, processing information about elderly at risk or groups of elderly at risk, establishing priorities for volunteer visits, in conjunction

with the counselling centers for the elderly, and receiving the results of the visits directly. Many communities have similar frameworks (like local professional committees created to enforce the Long-Term Care Insurance Law, or committees composed of nurses and social workers). Redefining the organizations' procedures and lines of authority is of tremendous importance today, in order to ensure that the Counselling Services for the Elderly's volunteers will make the greatest possible contribution to improving the elderly's quality of life.

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