Information and Referral Services for the Chronically Ill and Aged

EILEEN E. LESTER, M.S.W., ETHER B. SMITH, M.S.W., DORA M. DEPAOLI, M.P.H., and JOE BALES GRABER, M.P.H.

IN JUNE 1966 the Public Health Service awarded the first of 16 community health project grants to support a unified approach to chronic disease control programing (*1*). Previously, grants had been made for programing in a single disease category only, such as heart, cancer, stroke, or diabetes, and Service personnel were restricted to working within the single disease category to which they were assigned.

The project officer for the 16 new grants, Mrs. Graber, identified a variety of action-oriented activities which could take advantage of the expertise of persons employed in these categorical programs. For example, nine of the projects stated intentions to develop or expand information and referral services (IRS)—"a professionally staffed community service . . . to match needs of professionals as well as the general public against known resources" (*2–4*).

Since IRS's often include social workers and public health nurses on their staffs, members of these two disciplines who were working as consultants at headquarters in Washington, D.C., and in the field for the Division of Chronic Diseases (now the National Center for Chronic Disease Control) were asked to participate in the development of the nine projects. Because of the variety of experiences of these consultants, a consensus was needed about the kind of consultation to be given to project staffs. After discussions with a number of the consultants, the project officer decided that a series of site visits to established information and referral services would provide a "laboratory" setting in which to explore the individual thinking of the consultants and of the operators of the services. Topics for discussion were to cover the establishment, management, and expansion of the services.

Miss Lester, an experienced consultant in information and referral services, was invited to assist in the final selection of sites and in a briefing session at the outset and a summarizing session at the conclusion of the visits. Her thoughts, as expressed during these two occasions, are presented in the "Discussion" section of this paper.

The services to be visited were selected on the basis of high quality and individuality of leadership, contribution to the immediate community, and national contribution to basic investigations in information and referral serv-

---

The authors are with the Public Health Service. Miss Lester is medical social consultant in the Home Health and Related Services Branch of the Division of Medical Care Administration, Bureau of Health Services. Mrs. Smith, medical social work consultant for the heart disease control program, Miss DePaoli, health education consultant for the cancer control program, and Mrs. Graber, special assistant to the director of the Bureau, are with the Bureau of Disease Prevention and Environmental Control. Other members of the site visit group who prepared the reports upon which this article is based are Elizabeth G. Sullivan, R.N., M.P.H., Boston, Mass.; Agnes M. Newall, R.N., M.P.H., and Roger W. Turenne, M.S.W., Atlanta, Ga.; Sophia B. May, M.A., Dallas, Tex.; and James J. Gwaltney, M.S.W., Denver, Colo.

ices. The variations among the services provided an excellent stimulus for the exchange of information and also yielded information about new findings not yet widely publicized. As the visitors moved from one location to another, the project officer helped identify common denominators which merit special attention in providing consultation on information and referral services. A number of these—objectives, functions, target groups, and so forth—are discussed in detail in this paper.

Following the site visits, the participants formed two-member teams for the preparation of extensive reports on each service visited. Draft reports were returned to the director of each service for verification. Much credit is due each director and staff of the four information and referral services visited for their substantial contributions at the time of the visits and during the reporting period afterwards.

The Services Visited

The four information and referral services visited were Counseling and Consultation Service of Mansfield Memorial Homes, Inc., Mansfield, Ohio; Health Resource Center, Denver, Colo.; State Information and Referral Service, Oklahoma City, Okla.; and Referral, Kansas City, Mo. Table 1 presents an administrative profile of these services; some of the distinguishing features of each are highlighted. The most nearly consistent administrative feature was the funding mechanism which served either to stimulate the establishment of the service or to maintain it. Though not noted in table 1, staffing for each of the four centers included at least one medical social worker, an administrative secretary, and a clerical staff of one or two persons. Referral in Kansas City had a full-time public health nurse as part of the permanent staff, plus the part-time services of a public health educator provided by the sponsoring agency. In addition, Referral had an associate director for research. All of the services began operating between November 1961 and October 1963.

Objectives. The broad objectives for each service were similar. They included (*a*) developing an information, referral, and consultation service, (*b*) identifying and eliminating gaps

Table 1. Administrative features of 4 selected information and referral services

Title and location	Population served	Type of community	Auspices	Funding
Counseling and Consultation Service of Mansfield Memorial Homes, Inc., Mansfield, Ohio (Mansfield Memorial Building).	About 170,000	⅔ urban and ⅓ rural (city-county).	Mansfield Memorial Homes, Inc. (philanthropic foundation for services to the aged).	Initial: Public Health Service contract and the foundation. Present: Mansfield Memorial Homes, Inc.
Health Resource Center, Denver, Colo. (Denver Medical Society Building).	About 1 million	Major metropolitan area covering 4 counties.	Autonomous agency (voluntary).	Initial: Contributions from voluntary health agencies and State health department. Present: same.
State Information and Referral Service, Oklahoma City, Okla. (renovated residence near university medical center leased by State department of health).	About 2½ million served statewide; 25 percent served at local level by 23 information and referral services.	Statewide, primarily agricultural rural.	Oklahoma State Department of Health (official agency).	Initial: Public Health Service grant; State department of health. Present: same.
Referral, Kansas City, Mo. (downtown Kansas City, adjoining offices of Regional Health and Welfare Council).	About 1¼ million	6-county area in 2 States, including a metropolitan area.	Regional Health and Welfare Council, Kansas City (voluntary agency).	Initial: Public Health Service grant; Regional Health and Welfare Council. Present: same.

in community services for the chronically ill and aged, (*c*) developing a coordinating function to strengthen continuity of services for the chronically ill and aged, and (*d*) influencing community planning toward better services for the chronically ill and aged.

Differences in these four objectives became apparent, however, as they were implemented. Each one was greatly influenced by the community's existing resources and its health needs as defined by the key project planners. Also, because community plans focused on local problems and resources, each used a different administrative framework and emphasized different operational methods to attain objectives. The latter pertains to target groups, staffing, advisory groups, committees, records, and reports.

Functions. Similar selectivity was demonstrated by each service in establishing priorities in relation to functions to be performed. The following describe the usual functions of an information and referral service.

Information. Collect information about all health and welfare resources in the community which may be brought into play in the interest of persons with health and related social problems. Maintain a central file of current information so that it is readily available for use by physicians, nurses, social workers, dentists, and other professionals, as well as by agencies, institutions, and organizations in the provision of services and in the extension and coordination of health and welfare services. Disseminate the information to appropriate health and social agencies, institutions, and other health-related groups for their use in planning and developing services to provide for unmet needs of the chronically ill and aged.

Referral. Make referrals to appropriate agencies or professionals for specific problems, such as medical care and financial assistance not provided by the IRS or accept referrals from professionals and agencies and from individuals and their families for counseling and consultation by the IRS staff.

Counseling. Provide individual counseling to help families and individuals solve their problems, which includes locating and matching their needs to the best community resources available.

Consultation. Provide professional consultation to physicians, nurses, dentists, physical therapists, social workers, and others providing direct services to the chronically ill and aged and to local communities, groups, and individuals concerned about gaps in services for the chronically ill and aged to assist in the development of new services and in the extension or change of existing services to more nearly meet the needs.

Coordination. Provide a coordinating mechanism for groups and agencies at the local, county, and State levels providing services to the same clientele or having common problems in the provision of services. Develop guidelines or tools which can be used by official planning groups and others responsible for developing policy and establishing programs to fill gaps or to strengthen community services and facilities.

Planning. Make data resulting from documented unmet needs available to communities for planning and have staff serve as members of community planning groups.

Training. Participate in both academic and inservice multidisciplinary training programs. Sponsor institutes designed to increase understanding of the needs of the chronically ill and aged for medical, paramedical, and welfare personnel. Provide orientation and training in the mechanics of planning, setting up, and implementing a program which may provide information, referral, counseling, and consultation.

Research. Build into the program a statistically sound research plan for purposes of program development and evaluation.

Interpretation. Provide publicity and continuous public relations efforts to reach health professionals, selected groups, and the general public through the use of public media, including newspapers, television and radio, meetings, newsletters, displays, and brochures.

While each of the services visited reported some activity related to all these functions, emphasis varied considerably. In addition, each service appeared to have a distinct function which received a high priority. For example, the IRS in Mansfield serves as the admitting service for all other programs and services of the Mansfield Memorial Homes, Inc. (*5–7*). This includes its geriatrics center, home for the aged, senior citizens' center, and meals-on-wheels program. In Denver, the IRS provides medical social services in hospitals, extended care facilities, nursing homes, and home health agencies through a contractual mechanism (*8*, *9*). The latter is an outgrowth of the Health Resource Center's response to a community need not available through any other resource. For this activity, four clinical social workers and a social work aide were added to the staff. Statewide information and consultation services are provided to professionals and health and health-related agencies in the Oklahoma IRS; concurrently, this IRS is developing a network of local programs to provide direct counseling services to patients and families. High priority was given by the Kansas City regional IRS to the con-

291–983—68——3

struction of a research design to document unmet needs for use in community planning for the chronically ill and aged in a six-county area.

Target group. In the process of matching needs of recipients with providers of services, all projects shared a concern that certain services were not available to meet the special needs of the chronically ill and aged. In establishing contact with the two major target groups, the community resources group and the patient-client group, each service concentrated on a different approach. For example, in Mansfield there was a high degree of involvement and participation by the medical community; in Denver, emphasis was given to reaching individual patients and families; in Oklahoma, the State-level program primarily served professional staffs; while in Kansas City, there was a balanced effort to provide services to professionals and agencies and to individuals and families.

Staffing. Staffing patterns did not vary significantly in the four services. Usually, the overall direction of the program was the responsibility of the medical social worker with some staff services being provided by other health professionals, such as public health nurses and public health educators. The qualifications for the director of an information and referral service most often identified were leadership, commitment to a philosophy of the service as described in the "Discussion" section of this paper, variety of professional skills, and capacity for maintaining close working relationships with key agencies. In addition, each agency used an administrative secretary and other clerical help. The administrative secretary frequently acted as a receptionist, answering less-complicated questions concerning the location of a service or facility and referring persons requiring professional attention to the medical social work staff.

Advisory groups. Each service recognized the importance of an advisory group in the development, implementation, and evaluation of its program. These advisory groups included repre-

Table 2. Methods used by each service to collect information on community resources

Location	Initial		Updating	Kinds of records and reports
	Method and type of information	Collectors		
Mansfield, Ohio	Collected detailed information on available services.	Project director and medical social worker.	Working experience and constant use of resources.	Index card, case record, daily worksheets, monthly reports, final project report (*10*).
Denver, Colo	Reviewed and compiled all available information on community services and facilities.	Executive director of the service.	Making use of new directories of local services, working experience, and constant use of resources.	Revolving file for information on community services, master index file on all patients served, master index card, annual report (narrative and statistical).
Oklahoma State	Survey of all community resources in all 77 counties.	6 graduate social work students and 1 volunteer, with orientation and supervision by project director.	Communication sheet left at time of interview to report changes, letter to agencies asking for validation of their material, newsletter, personal contact.	County profile, vertical visible record on all known health and welfare resources, reference file, local IRS's provided with identical file of county resources, final project report (*11*).
Kansas City, Mo.	Interviewed agencies and nursing home personnel to evaluate services for chronically ill and aged.	Medical social worker and public health nurse, separately and jointly.	Letters and revisits to selected agencies.	Master resource file, visible card system, case inquiry forms, daily tally sheet, quarterly reports (*12*), annual report (*13*), final project report (*14*), chronological log of administrative activities, simple card system showing individuals requesting or offering service.

sentatives from key community agencies and from the general public. Advisory groups were instrumental in creating a public awareness of the need for the IRS and in stimulating use of the services offered.

Committees. The following list shows the variety in structure and function of the committees used by the four services. Most frequently, the membership was chosen strictly for technical competency related to the purpose of the committee.

Mansfield, Ohio
Medical Advisory Committee with representation of professional societies to provide professional guidance and interpret counseling and consultation service to their respective professional groups.

Denver, Colo.
Committees composed of board members. Committee functions indicated by title of four specific committees: executive, finance, personnel, public relations.

Oklahoma
Technical Advisory Committee formed at inception and used in the developmental, implementation, and evaluation stages. The Council of Cooperating Agencies assisted the staff in implementing the service and enhanced interaction between member agencies.

Kansas City, Mo.
Committee on Aging and Chronic Illness of the Health and Welfare Regional Planning Council was active in the establishment of the service and serves as the basic management committee.

Consultants. Each IRS recognized the importance of consultants, particularly during the organizational and developmental phases of the program. Consultants of different professional backgrounds have, among other things, assisted in designing interview schedules and served as public relations and information specialists. In addition, the services used the consultative services of physical, speech, and occupational therapists; dietitians; and other professionals.

Data collection. The methods employed in each service to collect information on community resources at the start of the program and periodically thereafter and the kinds of records and reports used by each service are shown in table 2. The use of social work students and others to collect the initial information used in establishing the Oklahoma service is noteworthy. This was accomplished through a 3-month survey covering all 77 counties and 308 communities. The interview schedules used for the Oklahoma survey are included in a published report (*11*).

Discussion

Philosophy. Information and referral services were developed in response to an increasing awareness and concern by groups throughout the country, including the Public Health Service, of the growing impact of society on older persons and of older persons on society, particularly those persons with disability related to chronic disease. It was recognized that typical patterns of care—medical, hospital, and rehabilitation services—could not solve the multiple problems of large numbers of middle-aged and older persons in our communities. The interrelationships of social, economic, and other factors with the health problem required that consideration be given to all needs of the individual in working out care plans. This meant that a variety of services were needed and should be provided to the patient whether he was in a care facility or in his own home. Also, accurate information about available resources should be accessible to professional persons, such as physicians, lawyers, and clergy, in order to help them arrange appropriate plans for continuing care.

The array of independent and fragmented services available in almost every community made it difficult to identify the most appropriate services to meet specific health and social needs. Thus, the information and referral services described earlier evolved from the need for a focal point—ideally in every community—for the identification of resources, professional services, and facilities. This was not visualized as a new service to supplant the information, referral, and counseling activities engaged in by the professional staffs of established agencies but as a service to strengthen, coordinate, and use as effectively as possible available community services and resources.

Persons responsible for developing the early demonstration models were aware of and built upon the contributions of existing, organized information and referral activities—publication of directories of social agencies, provision of telephone answering services to identify the location of community resources, and the social

service exchange to provide information to agencies serving the same clientele. They were concerned, however, that these activities did not really provide the kind of information needed to meet the multiple needs of a large segment of the population. The need to identify all types of services to meet the multiple problems of the chronically ill and aged led to the planning of the first Public Health Service demonstration project.

Demonstration project. The Public Health Service project was designed to demonstrate the following new approaches.

1. Testing the feasibility of providing assistance through a centrally located, professionally staffed IRS to patients and their families; to third-party groups—physicians, lawyers, and clergy; and to providers of services in need of accurate information or of other services appropriate to the respective consumer's needs, or both.

2. Assessing the ability of an IRS to meet the unique and multiple needs of the clientele to be served, and simultaneously collecting information in depth about resources which would establish a base for the cooperation of these agencies with the IRS.

3. Providing four levels of service: (*a*) accurate up-to-date information about available resources to anyone requesting it in order to help him work out care plans for himself or for relatives, patients, or clients, (*b*) referrals to selected agencies for persons who needed assistance in finding appropriate resources, (*c*) counseling to persons who needed considerable assistance and skilled medical-social evaluation of their needs before they could effectively use community resources, and (*d*) consultation to agencies accepting referrals so that the individual's health problem and its implications for a variety of services would be understood and so that coordinated care plans could be worked out if more than one agency were involved.

4. Assessing available community resources in relation to the needs of the chronically ill and aged and identifying duplications or gaps in services as well as any agency policies or procedures which might prevent the most effective use of the service.

5. Documenting unmet or inadequately met needs and channeling this information to appropriate planning groups so that they could effect the necessary changes in the community.

The demonstration verified several hypotheses concerning these services. For example, all three groups for whom the services were designed—users (patients and their families), professional persons trying to plan for patients, and providers of services—were willing to be involved in and to work with the information, referral, and counseling service. It proved that this kind of centrally located, highly visible service could match patient needs with available resources and thus achieve better utilization. The demonstration also validated the hypothesis that many individuals required an evaluation of their needs before referral to the most appropriate resources could be made or before alternate plans for care could be developed. Frequently, counseling services were needed before an individual could use the available services.

Sponsorship. The demonstration revealed that a number of different types of organizations can sponsor an IRS, provided that the sponsoring group has a high degree of neutrality. If an existing agency providing direct services is chosen to develop an IRS, for example, special attention must be given to interpreting the new services to the community and separating it completely from the primary service functions of the parent agency. Whatever the decision, the IRS cannot have a conflict of interest, and it must be acceptable to the three groups it serves. The latter is particularly significant in relation to the information and referral service's function of coordinating and strengthening community resources, which includes preventing fragmentation. Additionally, it must be able to match needs to resources and supply information about gaps and other inadequacies in the community resource picture to planning groups.

In a smaller community with fewer resources, a local health or welfare department might be considered an appropriate sponsor if it is acceptable to the medical community and to all other agencies in the community. Further, in this instance, the IRS should be set up within the official agency as a separate entity and should not be part of a program in progress. This is essential to give the IRS visibility and to encourage all segments of the community to use its services.

Staffing. A great deal more experimentation in staffing patterns is needed in order to include persons with a variety of backgrounds. Increasingly, staffing patterns need to provide for well-developed administrative skills, knowledge of operational research methods, ability to communicate and to work with news media, and maintenance of a constant awareness of the service throughout the community.

To date, most information and referral services in health and related fields have been staffed by persons with a social work background, more specifically medical social work. In larger communities where the service is big enough to need more than one person with a professional background, the team of medical social worker and public health nurse is most desirable. All have secretarial and clerical staff as well. Persons having other professional competencies are used as the scope of the service and its budget permit.

If an IRS must start with only one professional staff member, it should hire a social worker with a health background, one who has had progressively responsible experience working in the community. This person should be supported by an adequate budget which permits the use of expert consultants. The consultants could assist in setting up the administrative aspects of the service, in developing a research design to identify and document gaps, and in interpreting the service to the community. This particular pattern of staffing requires close cooperation and good working relationships between the IRS worker and the voluntary or public agency providing public health nursing services, or both.

Budget. Usually, an information and referral service does not have a large capital outlay for space, equipment, business services such as bookkeeping, and housekeeping services, as these are provided by most sponsoring agencies. The budget will be determined in most instances by the scope of the service to be offered. A minimum budget of $25,000 a year is needed, however, to provide for the essential staff required for any information and referral service, namely, a medical social worker and an administrative secretary, and for operating expenses such as telephone service and travel.

Organization and development. Experience has shown that information and referral services have been more successful in serving their constituency when they have developed a way of making the community's resources more visible and accessible to those in need of assistance; this has resulted in the better use of scarce personnel, care facilities, and resources of all kinds. Many different organizational patterns are possible, provided they are adaptable to the community's characteristics and capable of changing as objectives are achieved and new needs or problems are identified.

Four elements of service should be built into the organizational pattern:

• Up-to-date information about many types of community resources.

• Ability to assess an individual's needs and to match them to available resources, using referral and counseling services to assist individuals or professional persons in developing appropriate care plans.

• Documentation of unmet needs and of gaps in community services and a way of transmitting information about these to community planners.

• Working relationships with many different groups in the community—agencies, organizations, public officials, communications media.

After the basic structure is established, however, it is possible to determine a more specific focus. Through periodic evaluation the IRS may broaden its scope of service. Communities should be encouraged not to permit a proliferation of information and referral services to serve separate vested and categorical interests lest they defeat a major purpose—coordination of information to provide one accessible, central focus in the community for matching patient needs to resources.

Impact. An appropriately developed and staffed IRS cannot fail to make an impact on better use of available community resources because of its personalized service. Also, the gaps identified by this kind of service make an impact on planners that a survey sometimes will not.

Accomplishments and outgrowths. Each of the four services visited has had such an impact on its community. Each has been continued through community support following the demonstration period. In addition to the large numbers of persons served by the small staffs, there

have been important outgrowths, such as the expansion or refocusing of the service to include new groups of persons or to provide or stimulate the development of a service not available elsewhere in the community. The contracts of the Denver service with private hospitals, extended care facilities, and home health services to provide professional medical social services are good examples. (In 1967, a Public Health Service grant was made to assist in this expansion.) Another illustration is the development of the homemaker and health aide service in Mansfield, Ohio, to make care at home feasible for many older persons.

Conclusions

An appropriately organized information, referral, and counseling service has a potential not yet fully visualized. It should be a centrally located service that provides accurate information on resources, professional services, and facilities to three groups: the users; third-party groups, such as physicians, lawyers, clergy, and trustees who use the services in the interest of their patients and clients; and the providers of community resources. It should be professionally staffed throughout and must enjoy a high degree of neutrality and visibility regardless of sponsorship. Also, an IRS should go through the appropriate steps of planning so that it truly reflects the needs and resources of the community. It must be a product of community readiness.

NOTE: A filmstrip on the development of an information and referral service is available for loan on request to: Division of Medical Care Administration, Bureau of Health Services, Public Health Service, Department of Health, Education, and Welfare, Washington, D.C. 20201.

REFERENCES

(*1*) Goodman, G. E., Gainey, C. D., and Graber, J. B.: Community health planning grants for heart disease, cancer, and stroke. Health, Education, and Welfare Indicators, September 1966, pp. 13–24.

(*2*) Graber, J. B.: Findings and implications of a nationwide program review of the resources available to meet the health needs of the aging and aged. Gerontologist 6: 191–200, December 1966.

(*3*) U.S. Public Health Service: Comprehensive care services in the community. PHS Publication No. 1353. U.S. Government Printing Office, Washington, D.C., 1967, pp. 25–27.

(*4*) U.S. Public Health Service: Guide material on development and operation of an information and referral service. Bureau of Health Services, Division of Medical Care Administration, 1966, Mimeographed.

(*5*) Kaplan, J., Ford, C. J., and Wain, H.: Measuring the impact of a gerontological counseling service on a medical community. J Geront 21: 27–30, January 1966.

(*6*) Kaplan, J., Ford, C. J., and Wain, H.: Measuring the impact of a gerontologist counseling and consultation service. *In* Proceedings of the 7th International Congress of Gerontology, Vienna, Austria, July 1962.

(*7*) Kaplan, J.: Training practitioners: new needs, new potentials and overview. Paper presented at 18th annual meeting of the Gerontological Society, Los Angeles, Nov. 12, 1965.

(*8*) Johnson, M. E.: Community action in long-term care through a health resource center. Paper presented at meeting of American Medical Association, Committee on Chronic Illness and Aging, Chicago, Oct. 15, 1964.

(*9*) Ward, D., and Somers, A. R.: Medicine, money, and manpower—the challenge of professional education. Series III. Increasing personnel. New Eng J Med 276: 1421–1422, June 22, 1967.

(*10*) Mansfield Memorial Homes, Inc., Counseling and consultation service of Mansfield Memorial Homes, Inc.: Report to USPHS, No. 9, 1961–Nov. 9, 1964. Mansfield, Ohio, Jan. 6, 1965, p. 31.

(*11*) Oklahoma State Department of Health: Report of State information and referral service, Mar. 1, 1963–May 31, 1966. Oklahoma City, 1966, p. 85.

(*12*) Regional Health and Welfare Council of Kansas City, Mo.: Trial run. First Quarterly Report, December 1964, p. 47.

(*13*) Regional Health and Welfare Council of Kansas City, Mo.: 5400 inquiries and those who made them. Annual report, December 1965, p. 100.

(*14*) Regional Health and Welfare Council of Kansas City, Mo.: Report on the aging and chronic illness project (Referral). Final report, June 1967, p. 180.