DEVELOPMENT OF A COMMUNITY PROGRAM FOR SERVING THE JEWISH AGED *

by HERMAN L. KAPLOW

Jewish Federation,
St. Louis, Mo.

ALTHOUGH a community plan for services to the aged recently developed in St. Louis is the subject of this paper, its object is not solely to convey the details of that plan but rather to distill from the specific experience principles and attitudes that might have applicability in settings other than St. Louis.

The needs of the St. Louis aged, as we sensed them some two years ago when we started our study, were not regarded as being significantly different in kind from those of older people in many cities. Our early impressions were confirmed the more we dug into pertinent literature and the more we learned of the needs being manifested in other localities.

The significant differences, it seems, lie primarily in the interpretation given available facts and by whom that interpretation is made, the level of understanding and acceptance of the needs of older people as people, and the degree of responsibility accepted for their well-being and by whom this responsibility is acknowledged. Underlying all of these factors, however, and of great importance, is the concept utilized in viewing the requirements of older people. Is the approach fragmented or unified? Is the older person viewed as someone in need of casework services, *or* medical care, *or* institutional care, *or* recreation, *or* any other one service; or is he regarded as one person with many needs? The nature of the concept used predetermines, to a great extent, what is to be done in the community to serve the aged.

In the development of social services there are few, if any, that can function effectively like islands unto themselves if their focus is to be on the well-being of the individual and not on the convenience of the agency. This is particularly so in caring for the aged. If we look at the aged person as an individual, we recognize that he has needs not only for maintenance but for casework, recreation, employment, medical care of many kinds, institutional care, religious services, and companionship. In short he is a person with basically the same material and emotional needs as others. Because of his age he is frequently unable to meet these needs through his own resources and is therefore more dependent on the community for their fulfillment.

If we are interested in the older individual as a whole person then we have to plan, organize and coordinate our services so that, to the maximum degree possible, our agencies function as a whole service rather than as individual agen-

* Presented at the Annual Meeting of The National Conference of Jewish Communal Service, Chicago, Illinois, May 18, 1958.

cies, each concerned solely with its own piece of work. The question then arises as to who in a community can and should assume responsibility for the stimulation that is necessary to start getting things done in the first place. The pat answer that is often given to such a question is that the central planning body and the functional agencies share this responsibility, but initiative cannot be shared. It must be exerted from one point, and responsibility for its existence must be lodged in one source. If we are concerned with planning for a community and with coordinating services around a focal point then responsibility for the necessary initiative must be borne by the central planning agency. In saying that the central planning agency has to assume this responsibility I am not by any means implying that the functional agencies sit back and wait for things to happen. The central agency cannot get very far without the active involvement of the agencies that are closest to the needs of the people to be served and upon whom the community must ultimately depend for the actual provision of services.

The functional agencies are in a unique position. They are among the first to be approached by people seeking help. Such direct contact provides the critical data required to identify the kinds of needs people have and to relate them to existing resources; to determine trends in needs and their implications for present and future facilities, services and financial requirements. There are, of course, many other very important values to be derived from the data that can best be made available through the functional agency.

These facts have great significance not only from the point of view of the individual direct service agency but from that of the central planning agency as well. This is particularly true with respect to areas of service, such as care of the aged, in which several agencies can be concurrently involved in providing a total program of service. Somewhere there has to be a vantage point from which the area of service can be seen as a totality—a totality as it exists and as it ought to be. A vantage point from which all of the moving parts, so to speak, can be seen in operation at the same time, from which missing sections are more readily discernible, and from which realignments of parts to make a more effective whole can more readily be accomplished.

This vantage point is provided by the central planning agency and is shared with the direct service agencies who must also see and understand the totality of which they are a part and in the development of which they have a major role to play. The direct service agency and the planning body each has its contribution to make, the functional agency through its knowledge and competence in a particular service area and the central planning agency through its knowledge and competence in coordinated planning and financing on a community-wide basis.

In short, if the ultimate objective is to be service to the aged individual as a whole person and if it is agreed that to do so requires the combined efforts of several individual agencies on an ongoing basis, then planning must be centralized and implementation and financing must be coordinated. Furthermore, with the cooperation of the functional agencies, the central agency has responsibility for providing the information, stimulation, community understanding and acceptance which are so essential to the implementation of whatever plans are ultimately developed.

Our recent study in St. Louis of the aged and aged chronic sick really had at least some of its roots in a community-wide study of our health services that was completed in 1950. Out of that effort developed a community health plan that

provided for the creation of a medical center through merger of our Jewish Hospital, sanatorium for the chronic sick, convalescent-rehabilitation hospital, and medical social service bureau. The hospital was enlarged from a 300 bed to a 500 bed institution and includes, among others, divisions on chronic disease, physical rehabilitation, child and adult psychiatry, a medical social service department and a home care program. Ancillary services, the medical education program and services in general were upgraded significantly. The hospital is regarded, and regards itself, as the Jewish community's medical center and sees its responsibilities as extending beyond its four walls.

At the time of the health study consideration was given to the medical needs of the chronic sick, including the residents of our home for the aged. At that time we began to see other implications for the future with respect to needs of the aged but we had all we could carry at that time with the health plan that eventually cost $7,000,000 in capital funds and some $600,000 per year in deficit financing.

By the time the health plan was launched and well on its way toward implementation, the needs of the chronic sick aged for nursing or custodial care became more pressing. The chronic division of our hospital was established to provide hospital care for those persons requiring intensive medical and nursing services. The so-called "burned out" cases, for which medicine could do little or nothing, were not regarded as suitable patients for that division. The reasons for this decision were the relatively high costs of care in the hospital as compared to a good nursing institution and the difference in service focus of the two types of agencies.

The Federation took the initiative in making a preliminary exploration of the needs of the aged chronic sick through consultation with the five agencies that were involved in serving older people in one capacity or another. These agencies were the hospital, home for the aged, family agency, community center and employment service. This initial inquiry revealed several things. The home for the aged, for example, was worrying about the increasing need for nursing services for its residents. Although applicants had to be ambulatory in order to be admitted, residents were living to a riper old age and an increasing number of them were becoming afflicted with ailments requiring more nursing and related services. This was a situation with which the home was not properly equipped to cope.

The hospital was concerned about how it was going to prevent its chronic division from becoming a long-term custodial or nursing unit since there were limited facilities in the community to which such patients could be discharged. There were also serious financial implications in this for the hospital because care in the chronic division was relatively expensive and very few, if any, patients or their families, could afford to pay the bill over a protracted period of time.

The family agency was struggling with a variety of needs exhibited by older people including inadequate finances, idleness, loneliness, home management, poor housing, and many others, for which there were few outside resources. The employment and vocational service was striving to secure employment for the employable older person, with some success, but was completely frustrated when it came to the handicapped older individual who was desperately anxious to keep occupied. The community center was operating a Golden Age Club program but was thwarted in its attempts to meet the recreational needs of older people more adequately due to lack of properly located physical facilities.

Our initial inquiry also revealed that

although the agencies had an avowed interest in all of the needs of the aged, in practice they were absorbed in those aspects of care related to their own particular functions and almost to the exclusion of other problems confronting the older person. The relationships of those needs to other agencies and of all the agencies to each other was a relatively unexplored area. It was also obvious that if any improvement was to take place, centralized leadership in tackling the complex of needs, services and relationships would be required.

Added to these observations were two other considerations that played a part in our preliminary thinking about the total situation. One was the body of facts already available from various sources about what was happening to the size and make-up of the older population in general and the implications these had for both the present and the future. Another was the increasing popular understanding and acceptance of the needs of older people in all walks of life that was being generated by numerous groups and organizations, both voluntary and governmental, who were successfully using all types of mass communication media in getting their story before the public.

The latter consideration, although a fortuitous circumstance as far as we were concerned, was creating a positive community climate which could not help but influence the attitudes of those, both lay and professional, who were subsequently involved in the study in whatever capacity. This made the staffs of the Federation and the agencies feel that the time was right not only for a major study in this area but also for the setting of sights and objectives somewhat higher than would have been the case had this pre-study conditioning, so to speak, not existed.

All of these preliminary considerations added up, in our minds, to both a responsibility and an opportunity: a responsibility to view the needs of the aged person in their totality and to plan accordingly, an opportunity to set the community's sights high enough so that it could see not only the present but also reasonably far into the future. It also became clear that directions, in both breadth and depth, had to be determined early in the study and that the kinds of plans ultimately arrived at would depend in great measure upon how well we knew, at the outset, where we were headed. Our experience with other major studies had served to remind us that the setting of sights and directions require professional knowledge, understanding, evaluation and judgment, not only of the facts about the particular area of service, but of the community and how it can be stimulated into action.

Since basic responsibility for community planning is the Federation's, primary responsibility for the professional leadership involved, particularly in the early stages, rested with the Federation's staff. However, the key personnel of the five agencies concerned were actively involved from the start since their specialized knowledge and judgment were vital to the entire study process and to the soundness of the plans ultimately developed as well as to their implementation. This early thinking through of general study directions and objectives had the added values of providing the staffs of the agencies with a better knowledge and understanding of what was going on in areas outside of their immediate concern and of seeing more clearly the totality of needs and their interrelationships on a functional basis. This in turn made it easier for the professional representatives to do a positive job of interpretation to their boards during the study process and to carry out their respective study assignments with unity of objective.

In determining how broad our study should be there was early agreement among the Federation and the agencies that although it was our original intention to study only the pressing problem of the aged chronic sick, it made more sense to adopt a broader approach and to consider the predominant needs of all aged with which the community should be concerned. This would also help us to see the totality of need and to focus on serving the whole person. Having arrived at this point we then directed our attention to setting down some "ground rules," some basic principles to serve as guides to the total study effort and which would also reflect the general level of services we thought desirable and feasible in St. Louis. These principles were:

1. The older person is an individual and like all other individuals has a right to a life of dignity and independence and to opportunities to satisfy his emotional and material needs.

2. These needs exist among older people of all economic and social backgrounds. The community has an obligation to assist in meeting these needs for all who require such help.

3. Insofar as possible, prevention of deterioration of the older person should be an integral part of the services of all of the agencies concerned.

4. Rehabilitation of older persons, within their individual physical and mental limitations, should also be an integral part of the programs of all agencies serving the aged and should be applied to persons who may become employable as well as to those for whom a higher degree of self-care is the only realistic expectation.

5. Institutional living is as abnormal for an older person as for anyone else. Therefore, institutionalization of a permanent nature should be considered only as a last resort. Every effort should be made to assist him in living as normal a life as possible.

6. The community's regularly established agencies should provide the appropriate services required by the aged and whenever required.

7. The organization, administration and coordination of community services should have as their focus the needs of the individual person and the making of these services as accessible to him as possible.

These principles, as simple as they may sound, nevertheless inhere in a total philosophy or attitude toward aged people, involve concepts of community responsibility, reflect upon the nature and use of facilities and services, and relate to the organization, coordination and focus of a community plan.

The study committee consisted of lay and professional representatives of the agencies, the Federation and the Jewish community at large. The principles were used repeatedly throughout the study process, first *with* the committee to assist its members in developing an understanding of older people and a positive and progressive attitude toward helping them, and second, *by* the committee as a basic guide in arriving at specific recommendations. The study process also included the gathering of a much detailed information about the aged and aged chronic sick. It gave us a pretty good idea of their number, the kinds of problems with which they were confronted, the services currently available and unavailable and, directly or indirectly, the changes and improvements that were required.

Although agencies were feeling the pressure of current demands for service which they had difficulty in providing, particularly in cases requiring nursing care, we constantly kept before the committee the importance of planning for the future as well as the present. Future planning in an area such as this is par-

ticularly difficult since there is not only a clientele growing in actual numbers but recognition and acceptance of their needs is also growing and concepts of service are broadening significantly.

There is no way that I know whereby one can determine many years in advance exactly how many older people will require help from the community, what types and amounts of services will be involved and what they will cost. On the other hand, it is generally accepted that the number of aged and aged chronic sick will undoubtedly increase for the next several years at least, and it would be logical, therefore, to expect an increased demand for community services. If an intelligent job of community planning is to be done, therefore, it is incumbent upon those responsible for such planning to make reasonable provision for the future, at least for 10–15 years. The difficulty in planning for the future arises particularly in connection with the erection or expansion of physical facilities, rather than with non-institutional services. The former, once built, cannot readily be expanded or contracted except at a high cost, whereas the latter are much more flexible in adapting to need.

In spite of the difficulties in projecting into the future it is a responsibility that must be borne by whatever body functions as community planner, with the functional agencies participating in the decision making. As a practical matter, the final decision is usually a synthesis of an educated guess as to what the needs might be many years hence and an estimate by responsible leaders as to how far the community is able and willing to commit itself financially. The point at which this decision is made, first by the study committee and subsequently by approving bodies, is usually the first real test of how well the needs were understood by the professionals involved, how carefully and imaginatively the study was conceived and executed, and how effectively key lay people were educated and inspired to take positive action. All of these considerations are basic to the ultimate implementation of a plan of action. At least that has been our experience in St. Louis.

We completed our basic study and report about a year ago. It has been approved by the boards of the five agencies involved, the Federation board, and our council of social agencies to whom we submit all significant planning projects since many of our agencies receive support from the United Fund. I shall not attempt to describe the detailed findings of our study but it can be of interest to summarize the recommendations:

1. The recommendations flow from the basic principles mentioned above and have as their objectives the achievement of a smoothly operating, well coordinated and effective battery of necessary services to the aged and aged chronic sick. Since the success of each type of service is highly dependent upon the existence and effective functioning of the others, the stated objectives can best be realized only if all of the necessary services are provided for concurrently.

2. The home for the aged had been admitting primarily the so-called well aged. It was recommended that its future role be primarily the provision of care for nursing or custodial care. The latter are defined as those aged persons who are ambulatory but are unable to cope with problems of daily living because of mild senility, strong dependency patterns, need for help with personal care, and the like. The bed capacity of the home is to be increased from 130 to about 235 to provide for about 165 nursing patients and 70 protective type cases. Architecturally, the rooms are to be so arranged as to permit flexibility in their use for either type of case. Ancillary medical and social services are to be increased commensurate with the increase in number of beds and change in focus

of service. It is also recommended that consideration be given to the home's purchasing one or more residences in its immediate vicinity for use as rooming and/or boarding homes by persons for whom this type of care is suitable and who also need the ancillary medical and social services of the home.

3. Our Hospital Medical Center, which now supervises the medical program at the home, is to continue to do so under the expanded program and is to continue to provide the services of specialists as required. The free flow of patients between the home and the hospital is to continue as required in individual cases. The hospital's Home Medical Care program is to be made available to all persons for whom such service is medically and socially feasible. Clinic care is also to continue for those medically and economically eligible. The regular use of the hospital's Chronic Division is to be restricted to those chronic sick persons who require intensive medical care that can properly be given only in a general hospital.

4. Our family agency will continue with its current casework services to older persons and their families; will provide financial aid when necessary, particularly where lack of funds is the chief reason for a request to be admitted to an institution. The agency will also continue to make available help with household tasks for as long as it is required and as long as it is desirable that the aged person remain in his own or a relative's home. The family agency is also to serve as a central source of information and referral for persons seeking help and advice with problems of aging and chronic illness. It will maintain a current roster of appropriate resources, including acceptable private nursing homes. It is to study all applications for protective and nursing care (except discharges from the hospital) to determine the necessity and feasibility of institutional care versus other types. Furthermore the family agency is to establish and maintain a system of foster and boarding home care for older people. In cooperation with the community center, which operates a Golden Age Program, it is to establish and maintain a friendly visiting program.

5. The employment and vocational service was urged to intensify its efforts to place employable older persons in full or part-time employment which it has done, using volunteers from the Federation's Women's Division. It was also recommended that a sheltered workshop be established by this agency for the benefit of those aged persons for whom there is no likelihood of employment in private industry. Such a shop was opened in 1957.

6. The community center was urged to expand its Golden Age Program and to open a lounge for older persons in one of the concentrated areas of Jewish population. Discussions are currently being held with a women's organization that is considering involving itself in such a project.

Obviously, if the agencies are to provide a closely knit, smoothly operated battery of services, a good deal of ongoing coordination will be required. Accordingly, the study also provides for the establishment of a Central Committee on Services to the Aged and Aged Chronic Sick. The committee consists of lay and professional representatives of the five agencies, the Federation and the Jewish community at large. Its responsibilities include coordination of the services of the agencies; clarification of their responsibilities; collection and analysis of pertinent data on needs of the aged; periodic examination of programs; recommendations for revisions in services; setting of program priorities; and research and study on how services can be improved. Currently it is involved in developing detailed plans for the im-

plementation of the general recommendations in the study report.

Much detailed planning remains to be done before the approved recommendations are translated into actual services, and some $1,500,000 in capital funds has to be raised as well. We will also be confronted, ultimately, with the need for some $200,000, or more, in operating funds. Before we became involved in the details of the study, we knew that the capital and operating costs would be large even though we had not yet worked up an estimate. However, no advance financial guarantees of any kind were sought or given for the simple reason that there are no such things. The closest one can come to a guarantee of support is an informed community with a strong conviction as to the importance of the services.

We understand, of course, that there are many factors which can seriously affect the realization of any plans and over which the community has no control. Economic conditions are a key one. However, we do know from experience that there is no such thing as "holding the line" with community services for any extended period of time. We either move ahead or regress. To hold the line is to stagnate, to cast aside new knowledge and techniques and to deprive people of the benefits they could make possible. The least we can do, therefore, is to try to move forward, seeking no guarantees of any kind but rather opportunities of demonstrating and putting to work the knowledge and skills we now possess, of learning new knowledge and developing more skills and putting them to work. If we don't succeed the first time then we must come back again and again until we do. By "we" I mean the professional personnel of the Federation and the direct service agencies because upon them rests the primary responsibility for stimulating and initiating those activities without which there can be no real progress in programs for the aged or any other field of service.

In St. Louis we have accepted that responsibility and so far the lay leadership has responded to the directions and levels of services we have pointed out. Some recommendations have already been put into effect, the fate of others remains to be seen. The future is never certain, but of one thing I am sure, if we don't succeed the first time, we shall go back.