The Role of the Community Center in Meeting the Health Needs of the Aged: An Overview*

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New directions in health maintenance for the aged may be useful in preventing or delaying their submission to custodial care. A description of present and projected prevention health programs in community centers is presented, including suggested changes in staffing patterns. Such programs are far less costly than nursing home care and can preserve the happiness and dignity of the Jewish aged.

"Do not cast us out upon the time of old age; when our strength fails, do not forsake us."

Aging is a process which presents social, psychological, physical and financial problems. Each year the proportion of aged in the general population increases. In New York City the number of persons over 65 years of age represents twelve percent of the total population. The percentage of aged among Jews is probably greater, since their lower birthrate leaves a greater percentage of elderly in the community. Furthermore, it has been estimated that the proportion of Jewish aged who are over 65 will continue to grow. In 1991, it is expected that they will be in excess of 15 percent of the total Jewish population."[1]

Poverty is more prevalent among the elderly. The statistics for Jews are particularly revealing. Jewish households headed by an individual over 65 years of age (1/5 of all Jewish families) have average incomes of less that $5000 a year. 72 percent of all Jewish households with incomes under $4000 a year are 65 years of age or older.[2]

Of greater concern to health and welfare agencies is the need for adequate resources to meet the complex needs of the elderly, and to make their lives more dignified, comfortable and rewarding. Programs must be designed to help the individual attain an optimal level of mental, social and physical well-being; in essence, life enhancing programs, rather than life sustaining programs.

Health Problems of the Aged

Of the various problems which the aged encounter, those concerned with health are generally of paramount importance to them and to those who help them, i.e., their families, physicians, social agencies, hospitals and others. The monetary cost of poor health care are extremely high. "The Social Security Administration reports that the average health care bill for a person 65 or older was $1360 in the year 1975, almost three times that of people aged 19 to 65."[3] Aging is accompanied by an increase in chronic, degenerative and communicable diseases. The older person is less able to adjust to, or recover from, the debilitating illnesses that beset him. The aged, especially those living in urban poverty areas, frequently have poor access to adequate hospitals. They cannot afford the fees of highly qualified physicians, and often resort to inferior "Medicaid mills" or hospital outpatient departments, where physicians may speak little or no English, and have great difficulty communicating with patients. The trip to the hospital may be a long and tiring one. "A study of 1,552 older persons in selected inner city areas of New York indicated that the elderly suffer from poorer health status and higher incidence of functional incapacity than

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1 Celia B. Weisman, *The Future Is Now,* National Jewish Welfare Board, p. 3.

2 *Ibid.*, p. 161-162.

3 "Health Care Costs for Elderly Rise in 1975," *Aging*, April, 1977, p. 31.

their citywide or national peers."[4] Nationwide, "in 1972, 25.9 million elderly persons were limited to some degree because of chronic disease impairment, and in 1970, 7.3 million of these were confined to the house except in an emergency."[5]

The aged, especially those on fixed incomes, may seek care only when a crisis occurs, at a time when therapeutic intervention may no longer be effective; incipient signs of serious illness may well go neglected or untreated. Family rejection may occur. The older person deteriorates to the point where he can no longer sustain himself at home; he becomes isolated and depressed and may be forced to enter an institution.

In response to the complex health and welfare needs of the aged, there are various levels of custodial care which are reimbursed by Medicare and Medicaid. Not only is such care costly, but for many aged individuals, it represents dreary and depressing isolation during their declining years. Efforts to minimize the incidence of potentially catastrophic illness involve expensive medical programs. To avoid even more expensive institutional care, health and welfare planners interested in geriatric problems must establish alternative methods to care for the aged. "Prevention and early detection of disease is an important focus in geriatric medicine for the future."[6] Prevention services are essential in areas which are geographically remote from adequate medical facilities, or where health and welfare services have been impaired because of budgetary retrenchments in municipal and voluntary hospitals. The enormity of the problems faced by the aged suggests that community agencies which are not primarily oriented toward health care, such as community centers, may take the initiative in providing preventive health services.

Potential of the Community Center for Health Programs

Traditionally, the early settlement houses played a large role in meeting the health needs of their constituents. Lillian Wald, a public health nurse, founded the Henry Street Settlement House as an outgrowth of her work with the serious health problems of the lower East Side Jewish immigrants in New York. The East Side of 1893 was a "bottleneck of overcrowded, rickety tenements and narrow streets into which hundreds of thousands of immigrants were pouring every year . . . the sick and dying lay untended in their miserable homes, and the death rate rose to terrifying heights. Practically the only concrete help she could give was nursing care for the sick." Miss Wald began the movement of public health nursing, which she defined as "first, the expert care of the sick in their homes, and second, the education of the patients and their families in the facts of health and life."[7]

The problems of the elderly, today, are not identical with those of the early Jewish immigrants, but many elderly Jews live in substandard housing, eat poorly, and neglect their health until medical attention is virtually useless.

In considering the potential of the present day community center in meeting the health needs of the elderly, one must view the term 'health' in the broadest sense. Health can be defined as a "state of total effective physiologic and psychologic functioning; it has both a relative and an absolute meaning, varying through time and space, both in the individual and in the group; it is the result of the combination of many forces, intrinsic and extrinsic, inherited and contrived, individual and collective, private and public, medical environmental and social, and it is conditioned

4 M. Cantor and M. Mayer, "Health and the Inner City Elderly," *The Gerontologist*, Vol 16, No. 1, Pt. 1, 1976, p. 17.

5 *The Future of Long Term Care in the United States, The Report of the Task Force*, National Conference on Social Welfare, Washington, D.C., February 1977, p. 59.

6 D. Skelton, "The Future of Health Care for the Elderly," *The Journal of the American Geriatrics Society,* Vol. XXV, No. 1, p. 39.

7 L. Wald, *House on Henry Street*. New York: Henry Holt & Co., 1915. Quoted by Bulletin on Henry Street Settlement, p. 1-3.

by culture, economy, law and government."[8] Given this broad definition, the community center, and particularly the senior center, can provide a stimulating, warm and protected environment for an elderly individual, who might otherwise live in semi-isolation, dwelling on real or imagined ills.

The psychic benefits derived from participating in daily social, recreational and cultural programs can be substantial. Hospital personnel observe that all too frequently the elderly use the facilities of the out-patient department for purposes of socialization, even though their presenting problem may be minor and the actual medical attention received perfunctory. It is clearly more productive for the elderly to use the community center as a contact with his peers and as a stimulating vehicle for his involvement in the community. Throughout the country, there is a growing recognition of the importance of the community center as a multi-service institution where social welfare and some aspects of health care can be provided.

For health planners, a major concern along with the quality of medical care, is the availability of such care. Community centers where elderly congregate for a variety of reasons could become appropriate places for preventive health programs and health maintenance. Because of their multi-faceted activities, the centers could eventually prove to be most effective in "locating the hidden urban elderly poor most in need of medical care." They could provide the optimum location for bringing "medical services out of the hospital directly into the community, and thereby providing older people with easier access and more personalized service in a well designed setting."[9]

Two factors are important when evaluating the potential of the community center for ameliorating the health needs of the aged. First, contrary to the assumption that those with "greatest needs are most likely to be members of a Center . . . data show that the elderly with an active life style and a strong attachment to the community are more prone to be members of a Senior Center."[10]

The mobile and well functioning older person, with personal and family support, apparently makes optimal use of health and welfare agencies. Unless outreach and recruitment efforts are made, the isolated multi-problem aged individual remains unknown to the Center and other agencies. Thus, he does not avail himself of needed services. It is this individual who becomes known to the system only when his problems are acute and irreversible.

Moreover, there is a question whether the senior center should attempt to meet the needs of the frail or vulnerable aged, i.e., those in greatest need of service. During the proceedings of a Consultation of the Jewish Older Adult, it was observed that there was not sufficient interest displayed to warrant a workshop on the frail or vulnerable aged. This reflects the reality that service to the vulnerable or frail elderly may not be viewed by community centers as an appropriate function for them. The thought was expressed that this particular target population should be served by more specialized agencies, or evolve from cooperative programs with homes for the aged, or hospitals.[11] Some Center directors feel that it is more appropriate to expend effort and money in programming for the youth; however, as the proportion of Jewish aged continues to rise, there will be less of an option and more of a necessity for program planning for the elderly.

Present and Projected Health Models

An inventory of health-related programs in community centers, at present, reveals the following: 1) Forums on health problems of the aged for both staff and members; 2) Health Education programs which attempt to help the individual understand and recognize early symptoms of disease and appreciate the importance of general health-maintenance. They stress proper nutrition, the need for accident prevention, correct use of medication, and the importance of physical exercise and recreational activities; 3) Health Fairs which link hospital and social agencies in health screenings; 4) Appropriate immunization programs; 5) Organized information and referral services to appropriate health and welfare agencies; and 6) Advocacy programs to ascertain that those eligible for health benefits actually receive them. Many of these programs have been developed by social work staffs in cooperation with local voluntary, municipal and public health agencies. The range of these programs depend on staff interest and motivation and the active cooperation of other health and welfare agencies. At times, such cooperation is often more easily obtained in word than in deed.

Can a community center broaden existing health programs and add new dimensions to them? Can changes be made to ensure that existing health programs are more responsive to the health needs of the elderly? To ensure medical soundness what should be the parameters of service provided? The gerontology literature abounds with suggestions and pleas for new modalities of care for the elderly. "The essence of good progressive geriatrics is the expert and rapid assessment of the patient's needs and the prompt relocation of the patient in an area where his needs can be relieved by the mobilization of appropriate service or programs. Thus our systems of care must provide for active treatment, supportive and maintenance care, continuing and reassessment capability, early disease detection, ascertainment and prevention, and health education."[12] With this system, the patient may be maintained at home and spared the necessity of entering an institution. Community centers cannot be classified as health providers equipped to provide active treatment; however, they may place a role in the other areas of geriatric care, depending on the availability of appropriate resources and personnel.

The Centers can and should provide alternatives to nursing home care for those who can be maintained in an ambulatory state. Health programming must expand, *pari passu*, with the increase in the proportion of aged. An ongoing health component in a community center can act as an adjunct to an overtaxed and expensive health system. Such an ancillary health component can provide a continuum from prevention and early detection of disease to more intensive services for physically impaired individuals.

New staffing patterns are indicated. For the delivery of useful preventive health programs, the services of a public health nurse are increasingly being used to supplement those of the social work staff. A projected program called "A Preventive Health Care Team" might be composed of a public health nurse and a medical social worker, servicing a cluster of senior centers in medically underserved areas.

By training and experience, such a team can develop a preventive health component appropriate to the community center. The team would enable the aged individual to recognize early symptoms of disease, to seek appropriate medical care, to understand the nature of his illness and the prescribed medical regime. As a result, he will live independently in his own community without resorting to institutional placement.

The goals of the preventive health care team can be divided into three categories: 1) *Health counselling*, based upon an assessment of individual needs, is important and constructive. The team can identify present and potential health problems, evaluate the person's physical and emotional condition, estimate the ability and readiness of the individual and his family to meet his health needs, determine the urgency and complexity of a given situation and decide on priorities for action. After this assessment, the team can assist the individual in seeking the required

[8] J.J. Hanlon, *Public Health*. St. Louis: C.V. Mosby Co., 1974, p. 4.

[9] M. Cantor and M. Mayer, *Op. Cit.*, p. 24.

[10] P. Taietz, "Two Conceptual Models of the Senior Center," *Journal of Gerontology*, Vol. 31, No. 2, (1977), pp. 219-222.

[11] *Proceedings, Consultation on the Jewish Older Adult,* Jewish Welfare Board, New York, Oct., 1976, pp. 24-25.

[12] D. Skelton, *Op. Cit.*, p. 43.

medical care, and support the family in the event of a crisis and/or the development of a chronic situation requiring long term supportive therapy.

2) *Early case finding*, periodic screening, appropriate follow-up and referral are important functions of a Preventive Health Care Team. For many individuals who have neither the means for, nor access to, regular physical examination, early health screening and monitoring can prevent or ameliorate the complications of illness, e.g., hypertension, diabetes, glaucoma, cancer, hearing problems, nutritional deficiencies, anemia, kidney disease, neurological diseases, such as Parkinsonism, disease of teeth and mouth, etc. To accomplish this screening, the public health nurse, in the course of her total assessment of an individual's problems, can perform simple diagnostic procedures, such as measuring vital signs, or evaluating nutritional deficiencies and other obvious abnormalities. It is also imperative that the nurse and the social worker develop working relationships with hospitals and community physicians to ensure that the individual receives needed care and appropriate follow-up. The team may serve as advocate for the aged individual who is frequently intimidated and frightened by contact with medical facilities.

3) *A Home Service Outreach program*, administered by the community center, can provide supportive services for the homebound individual with chronic dysfunction or temporary incapacity. Such services can provide a link between an individual who is struggling to maintain himself in his own home and the community in which he lives. The outreach team could assess the individual's psychosocial and medical needs and make appropriate referrals. Frequently, a homebound individual, in his isolation, does not avail himself of services to which he is entitled. After the identification and assessment of the homebound individual is made, volunteers or paraprofessionals can perform ongoing services for the patient. The public health nurse will evaluate and monitor the individual, thus enhancing the relationship of the patient to his physician. She can ensure that the prescribed medical regimen is followed and that the home environment is conducive to the person's health needs. She can also detect a change in the patient's condition or the presence of complications. Although her duties do not include bedside nursing, she can play an important role in the health management of a homebound individual.

The social worker can work with the patient and the family to help alleviate the emotional, social and financial problems which result from chronic, incapacitating illness. The burdens of such an illness on the patient and the family can be overwhelming!

A second health related model, appropriate to a community center is a Day Center for the Elderly who are frail and handicapped. This type of program offers long term maintenance for the individual who might be confined to a nursing home. An excellent example of this type of program is the Day Center for the Elderly (D.C.E.) of Mosholu-Montefiore Community Center, affiliated with the Associated YMHAs of Greater New York. The D.C.E. was initiated in 1972 as a three year demonstration project under the Social and Rehabilitation Service of HEW, and is currently funded under Medicaid. This model merits imitation in other parts of the country. It provides an alternative to nursing home care for aged impaired individuals, enabling them to live independently in their own community. The daily program includes activities to improve and maintain social and emotional well-being, health supervision, lunch and transportation. Medical consultation is provided by neighboring Montefiore Hospital. The staff includes a social work coordinator, a public health nurse, a licensed practical nurse, a consulting physician, and recreational and occupational therapists. The program thus provides a blend of social, recreational and medical services.

This program has helped reduce institutionalization resulting from lack of sufficient family and community supports. Day Centers

for the Elderly are frequently attached to nursing homes or hospitals, where more intensive treatment and supervision are provided. However, there are individuals who have no need for such intensive services, yet are unable to function adequately in a regular senior program. A D.C.E. in a community center offers mental stimulation provided by varied programs and activities. It offers them the opportunity to live within their own community . . . independently and with dignity.

The success of the two models described (The Preventive Health Care Team and the Day Center for the Elderly) and other health related programs is dependent on the qualifications of the staffs. The Jewish Welfare Board recommended that "since health (and physical educational programs) should be related to health goals and needs, more Centers should endeavor to include physicians and other health specialists on their . . . committees and/or to utilize panels or consultants from the health fields."[13] In line with this recommendation, it will become important to include in a community center setting, not only a public health nurse or a health educator, but the expertise of a social worker, who is experienced in medical and nursing home settings. To further illustrate this point, the author is employed as a health planning specialist by the Associated YMHAs of Greater New York to work with social work staffs in implementing health care programs. Relevant training in geriatric health care, new methodologies and skills are necessary for innovative programming. This new element can only strengthen and enrich the contribution of the social work profession in meeting the health needs of the aged.

Funding

The 1971 White House Conference on Aging established certain goals. "Health care for the aging must be provided as an integral part of a coordinated system that provides comprehensive services to the total population; but immediate and special consideration and emphasis must be given to the problem of, and services for, the aged."[14] How can this health care be funded and the quality assured? Specifically, how do these considerations apply to the Jewish aged?

The cost factor in initiating and maintaining new programs is crucial. In some localities with adequate resources, health departments, medical schools and health agencies such as the Visiting Nurses Association, have formed cooperative links with community centers. The Federal Model Projects on Aging (Title III, Section 108) are funded to demonstrate new approaches, techniques and methods that promise to contribute toward wholesome and meaningful living for older persons. Some community centers are being awarded these grants. Some private foundations are also addressing themselves to innovative health related programs that may alleviate the burdensome problems of the elderly.

It is also appropriate to examine how Federation hospitals and community centers can develop more effective cooperative programs to provide health services for the Jewish poor and aged.

The founding of Jewish hospitals during the 19th century grew out of societal needs peculiar to the Jewish community at that time. Poor Jewish immigrants needed medical care, and the Jewish community felt an obligation to care for them. Also, Jewish doctors were frequently unable to obtain residencies and hospital privileges. Eventually, the rationale for a strictly "Jewish hospital" was no longer the same. With the advent of third-party reimbursements through private insurance plans and Federal funding, most individuals in need of care were able to obtain it without discrimination as to race or religion. Jewish physicians, their skills and knowledge in demand, no longer felt discriminated against by most hospitals.

Presently the amount of money allocated by

[13] *JWB Health, PE, and Recreation Study Committee Summary Report,* New York, p. 10.

[14] *Consultation on the Older Adult, Op. Cit.,* p. 63.

Federations to their constituent hospitals represents a small percentage of the hospitals' operating budgets and is generally used to defray outpatient department deficits. Contrary to the situation which obtained some years ago, the proportion of Jews using the outpatient departments of some Jewish hospitals is very small. Thus funds from the Federation may not be used by a hospital to fulfill specific Jewish needs, but are diluted into the pool of general urban philanthropy and public support.

Although the Federation allocations to hospitals are small, they "could and should be used for the subvention of specific services which are quite important, as important in our own day as earlier justifications were decades ago . . . From the point of view of the Jewish community (these allocations) could be used to prod and assist the hospital into developing community programs."[15] There are special Jewish needs in the health field, particularly among the aged. Diabetes, heart disease, and hypertension, although not restricted to, are widespread among, the Jewish elderly, and cause serious debilitation and complications. The delivery of health-care, including preventive health-care, requires trained health personnel. Cooperative efforts between Federation hospitals and Federation agencies could provide this personnel. For example, the staff might include medical residents supervising medical and nursing students. The experience could provide the students with unique exposure to the social and emotional problems of aging as well as the physical manifestations. Simple diagnostic and screening procedures would be handled at the Center, and acute conditions would be immediately referred to the back-up hospital. Services could be reimbursed by Medicare or Medicaid. The lower cost and resulting benefits of preventive services, astutely and competently monitored, should prove superior to the current pattern of crisis medicine and perfunctory medical care.

As the cost of living and medical care has risen drastically, there has been an increase in Federal programs to meet these costs. Jews, however, even those subsisting on low, fixed incomes, traditionally resist participation in public health and welfare programs. Culturally, the Jewish people strive to maintain their personal independence and to solve their own problems and those of their fellow Jews. Many, especially the elderly, are reluctant to apply for welfare. They often do not utilize benefits to which they are legally entitled.

Therefore, it is now time to use the philanthropic Jewish health dollar to meet the needs of the Jewish population per se, especially those with the most pressing health needs . . . the aged. Jewish health and welfare agencies have always sought to provide innovative services of high quality. Cooperative efforts can be mobilized to achieve this goal. We must respond to the needs of the aged with new and sound approaches, and reapplication of existing resources.

[15] C. Sheps, "The House of Health," *Moment*, December 1975, pp. 57-58.

What is a Preschool Doing in a Jewish Community Center?

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It is perhaps eclectic acceptance of Judaism as well as the Center's function as a community organization which enables a J.C.C. preschool to attract children from a diversity of Jewish backgrounds and to offer a wide variety of experiences in Judaism for Jewish children. When a child attends a Center preschool, he enters into many activities of the Jewish community with no age, sex or denominational segregation.

What is a preschool doing in a Jewish community center? Some may charge that it's too late to ask that question after several generations of early childhood programs have existed in Centers throughout the country. Others may think it is an unsophisticated question of a program which supposedly has attained a certain degree of maturity. Some children are now enrolled in the same Jewish Center preschools their parents attended. Even if the question was asked when nurseries first evolved in Centers, needs are no longer the same. Change is rapid and continuous in our society. In order to clarify who we are and what we are doing, we must raise this question constantly. Actually the question has two parts: first, why have a Jewish preschool and, second, why have a Jewish preschool in a Jewish community center?

It may be particularly appropriate to raise the question of Jewish preschools now, as the state begins to take more responsibility for early childhood education. In recent years we have watched the statistics climb until over 50 percent of American mothers are part of the labor force. Of those working, more than one third have preschool age children and are making increasing demands on the public sector to sponsor preschool programs. Some legislators even recognize the importance of capitalizing on the curiosity of the young, and nationally subsidized programs such as Head Start and Title I preschools in public school systems are not uncommon. The government, as pressure increases, is likely to respond and we may eventually find the state providing a complete preschool program. Can we then justify a more costly, private experience?

It is commonly acknowledged and readily documented that renewed interest in Judaism is expanding the role of Jewish education today. Parents are now more concerned that their children have a positive attitude toward being Jewish and that they feel a sense of belonging to a Jewish group. Although Jewish education once carried the more narrow responsibility simply of teaching Jewish subject matter, it must now take on the awesome task of inspiring Jewish commitment. The advantages of a secular preschool may become increasingly less attractive to Jewish parents if there continues to be a growing need and reliance on Jewish education to preserve Jewish identity.

The preschool from many points of view is the most appropriate place to begin a semi-formal experience in Jewish identification. By the time a child is three, he is interested in belonging to a group. He enjoys conventions and rituals. It is a crucial stage for forming values and building a healthy self concept. In a Jewish preschool the child has the opportunity to become socialized not only in a peer group but in a Jewish group. He receives the benefits of a fine educational and social experience along with the enriching bonus of a fully integrated Jewish curriculum.

Jewish curriculum in a J.C.C. preschool is a natural part of the educational process. The child begins to become knowledgeable about the historic background of his heritage, its holidays, traditions and terminology. The "Cultural transmission of the selective memo-

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