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"THE SENIOR COMMUNITY SERVICE AIDE PROGRAM": A PREVENTATIVE PROGRAMMATIC APPLICATION OF PAID, PART-TIME WORK EXPERIENCE FOR OLDER ADULTS IN A HEALTH CARE SETTING

City University of New York D.S.W. 1980

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BY

PAUL ROBERT PAGEL

A dissertation submitted to the Graduate Faculty in Social Work in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

1980

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1980

This manuscript has been read and accepted for the Graduate Faculty in Social Work in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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AGE

Ah nothing is too late till the tired heart shall cease to
palpitate.
Cato learned Greek at eighty; Sophocles wrote his grand
Oedipus, and Simonides
Bore off the prize of verse from his compeers
When each had numbered more than fourscore years.

Chaucer, at Woodstock with the nightingales,
At sixty wrote the Canterbury Tales;
Goethe at Weimar, toiling to the last
Completed Faust when eighty years were past.

For age is opportunity no less
Than youth itself, though in another dress,
And as the evening twilight fades away
The sky is filled with starts, invisible by day.

--Henry Wadsworth Longfellow--

ABSTRACT

"The Senior Community Service Aide Program": A Preventative Programmatic Application Of Paid, Part-Time Work Experience For Older Adults In A Health Care Setting.

By

Paul Robert Pagel

Adviser: Doctor Jesse Smith

In March of 1978, the Department of Social and Community Services of Maimonides Medical Center, a 610 bed voluntary, non-profit, teaching hospital in Brooklyn, applied for, and was subsequently accepted as a placement site for eight Senior Community Service Aides.

The Senior Community Service Aide Program, supported under Title V of the Older Americans Act, is a program whose objectives--predicated upon the assumption of a new role for older adults--are to provide work experience, training, and job skills development for low income, older adults, while providing social services, especially for the aging.

One objective of the Senior Community Service Aide Program was to extend the scope of social services available to the aging population served by Maimonides Medical Center, through outreach techniques, beyond the parameters of conventional hospital based social work services.

Secondly, the Senior Community Service Aide Program sought to demonstrate the viability of a new role for older adults--that of a paid, part-time para-professional extender of hospital based social services.

During a seven month period running from October 15, 1978 to May 15, 1979, eight Senior Community Service Aide personnel provided social services to 517 clients of Maimonides Medical Center. An evaluation of the program looked at new services generated by the Senior Community Service Aides, and efficacy of the program was examined by collecting information from a sample of the patient population served, and the eight Senior Community Service Aides themselves.

The program was resoundingly evaluated as effective by the recipients of service sampled, by the eight Senior Community Service Aides and finally, the hospital based social workers who were associated with the program from its inception.

The Senior Community Service Aide Program has provided over 2,000 social services to almost 1,000 residents of the community contiguous to Maimonides Medical Center since the inauguration of the program in October, 1978.

PREFACE

The Senior Community Service Aide Program is about older people helping older people. I first became interested in the issues and problems confronting older adults in 1965; I was in the process of completing my Masters Thesis which was a descriptive study of what was then one of the largest nursing homes in the city of Detroit, Michigan. The study involved the administration of schedules and attendant interviews with patients and families. The need for alternatives to institutionalization, in particular the possibility of developing supportive services to help maintain the elderly in their own homes, was a recurrent theme. Three years later, I became involved in the provision of out-patient services when I joined the staff of Maimonides Medical Center, Brooklyn, New York.

In 1968, as Coordinator of Social Services for the Department of Ambulatory Care at Maimonides Medical Center, I had the unique opportunity to participate in what was then the first voluntary hospital based community outreach program of services for the elderly in the Borough of Brooklyn. The program was entitled The Neighborhood Resources for the Aging and was comprised of two men and six women, most of whom were retired community residents dedicated to helping their less well age mates cope with the problems of aging, illness and disability. The

Neighborhood Resources for the Aging Program was essentially a voluntary effort; the eight volunteers received a small stipend from the hospital to defray the cost of transportation incurred in home visitation to the frail elderly. The Neighborhood Resources for the Aging volunteers provided a variety of services, such as helping the homebound elderly apply for and realize entitlements such as Medicaid, S.S.I., Food Stamps, and government rent subsidies. At the time, the concept of using older volunteers in a hospital setting to do outreach was an innovation. Historically, most volunteer programs in a hospital setting focused upon the in-patient population. What was new in the Neighborhood Resources of the Aging model was that volunteers were being deployed to help reduce unnecessary hospitalizations by extending the basic support structures to the elderly in their own homes. At the height of the program, the Neighborhood Resources for the Aging volunteers helped process more than three-hundred new Medicaid applications per year. Their accomplishments were publicized in the Brooklyn Section of the Daily News, January 20, 1976, and televised highlights were viewed on the six o'clock news, WABC, channel seven, July 22, 1975. The Neighborhood Resources for the Aging Program was a source of real help and consolation to the elderly beneficiaries; a source of pride to its membership, the hospital and community, the profession of social work, and

especially to myself as Director of Social Services for most of its programmatic life. Over those years, I saw my role as helping to maintain and advocate for continuation of the program. Although many attempts were made, it was never possible to recruit new members to replenish the original eight, some of whom had died, and others of whom had themselves become less active due to the encroaching infirmities of old age.

Early in 1978, I became aware of opportunities for governmentally financed job opportunities for older Americans living on marginal incomes, in the area of community services to the elderly. The job opportunities were financed under what was originally known as Title IX of the Older Americans Act (later changed to Title V) and was administered under the auspices of the New York City Department for the Aging. Faced with the sad prospect of a program which in its tenth year was moribund, together with the moral and professional obligation to insure continuity of services to the aging population which has come to depend upon the Neighborhood Resources for the Aging Program, I applied for and was awared a Title V contract in March of 1978. The contract approved the Maimonides Department of Social Services as a placement site for eight Senior Community Service Aides for on-the-job training and experience which would prepare them to assume a new role--that of paid, part-time extender of hospital based social

services focused on the needs of the elderly in the community.

At first I regarded the opportunity to utilize the remaining Neighborhood Resources for the Aging Volunteers in a training capacity--almost like senior consultants--as a most fortuitous event. Moreover, the Department for the Aging in awarding the contract, made me aware that their decision to do so was in no small measure due to the decade of prior experience with the Neighborhood Resources for the Aging Volunteers. The new Senior Community Service Aides welcomed the opportunity for personal tutelage, the Neighborhood Resources for the Aging Volunteers, skeptical from the beginning, were unable to hide their feelings of personal disappointment with all the attention the neophyte program was receiving. To complicate matters, the Social Service staff, long identified with the Neighborhood Resources for the Aging Volunteers as their prime referring agents, reacted unfavorably to the newcomers. The spectre of violations of the collective bargaining agreement loomed on the horizon. Shortly after its inception, the new Senior Community Service Aide Program was brought to a halt in May of 1978.

The National Union of Hospital and Health Care Employees took the position that the hospital had violated hiring provisions of the collective bargaining agreement in that it had entered into a contract with an outside

agency which called for the use of labor whose salary at the minimum hourly wage of $3.00 was below minimum union scale. Moreover, the union called for the withdrawal of the Title V workers whose new role at the time called for intervention with hospitalized patients and families. The union took the position that this population was the exclusive purview of the bargaining unit social worker. It was not until late July, 1978 after intensive negotiations involving the union, the hospital and the Department for the Aging that the focus of the program was redefined to exclude hospitalized patients and focus strictly on outreach services to the community. After union approval, eight new Senior Community Service Aides were recruited in early autumn of 1978 and were ready by mid October to begin providing services.

Exactly one year after the award of the Title V contract, the hospital experienced a major financial setback resulting in a mandatory 10 percent budget reduction in all hospital departments. After agonizing over which programs and services to eliminate, I reached the untenable conclusion that none could be eliminated. I knew full well that if I were unable to make a recommendation, one would be made for me. Operating on the premise that full-time social work bargaining unit positions had to be preserved, I recommended the lay-off of the two most junior social workers in their respective categories, the subsequent

reductions did not amount to 10 percent of the total budget. The elimination of the Neighborhood Resources for the Aging Program was the only alternative to additional lay-offs of full-time social workers. The program that, in the vernacular, brought such "nachas" to those associated with it for over a decade, became the victim of retrenchment. The bitterness, recriminations and emotional upheaval which ensued is a matter of history. Most of those left in the Neighborhood Resources for the Aging Program and many staff social workers saw my decision as opportunistic. The Senior Community Service Aide Program, however, did not profit from the demise of its volunteer predecessor, and I consoled myself and the new Senior Community Service Aides with the thought that we must not feel guilty about the fate of the Neighborhood Resources for the Aging Program. In retrospect, however, the Neighborhood Resources for the Aging Volunteers, although they did convey to their successors what they acquired through experience, could never identify with the vision I projected for them; i.e., proud parents, progenitors of a new generation of services, the catalyst for a future step in the evolution of new roles for the aging. The extraordinary, and I must add providential convergence of events and circumstances, however, propelled the new Senior Community Service Aide Program to not only equal the achievements of the Neighborhood Resources for the Aging, but also to provide

a model for future replication, and in so doing, implement the role never fully accepted by the Neighborhood Resources for the Aging Volunteers--that of progenitor of a new generation of programs for older people by older people. With the passage of time, the Neighborhood Resources for the Aging Volunteers moved on to other experiences, some within the hospital, others within the community. The staff social workers rose above their own personal feelings, and like true professionals, once again became the primary referring agents for the Senior Community Service Aide Program and partners in the ongoing educational process which characterizes the mutual objectives of both aides and professionals alike.

The eight Senior Community Service Aides have gone on to distinguish themselves as a model program to such an extent that their services have been the focus of attention of two local Congressmen, Zeferetti and Solarz, who will be able to provide support for a continuation and extension of similar programs.

I acknowledge a debt of gratitude to all of the "supporting cast" at every level, without whose participation at precisely the right time, this program could never have been developed. I am grateful to the sponsors of the program, the New York City Department for the Aging, the administration of Maimonides Medical Center, the administration of the District 1199 National Union of

Hospital and Health Care Employees, RWDSU/AFL-CIO, the supervisors and line staff of the Department of Social and Community Services of Maimonides Medical Center, the supporting network of social agencies, and especially to the eight Senior Community Service Aides whose dedication to the needs of the elderly is a constant sources of inspiration and pride for me. I acknowledge a special debt of gratitude to my Doctoral Committee Professors Phyllis Caroff, Rose Dobrof and my project advisor and counselor Doctor Jesse Smith, for their indispensible help and support in bringing a concept through the academic processes to programmatic fruition. Finally, I would like to express my love and gratitude to my wife Jean for her constant interest, support and patience in living through the process of giving birth to a new program with me.

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I. BACKGROUND

Over the millennia men have been preoccupied--some to the point of obsession--trying to retard the inevitable process of aging. History's romanticized search for the "Fountain of Youth" has led man to the possibilities inherent in the science of cryogenics. Throughout antiquity men have attempted to control what they could not understand, through magic and ritual. Specific jobs were assigned older members of the tribe; the aging were fed breast milk from lactating women and the blood of slain soldiers, in an attempt to restore youthful vitality. In his commentaries, Cicero makes reference to the aging process and extols the virtues of happy retirement. The agrarian societies of antiquity seem to have assimilated their aging with a minimum of trauma, a fact which remained true even in this country while it was still a predominately agricultural economy. Multi-generational families living together on the farm was the rule and the contribution of the aging to family life and society in general was recognized as a cultural and moral value to be cultivated.

With the Industrial Revolution, however, the quality of life for the elderly was altered by a change in societal values, resulting from the socioeconomic metamorphosis produced by the impact of industrialization on the basic unit of society--the family.

The passage of the Elizabethan Poor Laws and the establishment of Almshouses for the poor ushered in an era in which human values and, in particular, the attitude toward the aging in society became predicated upon the extent to which the individual contributed to the economy. Technological advances gave rise to a class structure based on socioeconomic status which served to mitigate against the old value structure which held the aging in a position of reverence. Actually, the Almshouses were the prototypes of today's nursing homes. The economic principle underlying both was predicated upon the proposition, "old stock that is no longer useful should be warehoused and eventually disposed of." The value shift meant that the elderly no longer occupied a place in the mainstream of society and that their continued presence on the scene was an inconvenience at best.

It is ironic that the same technological advances which contributed to the displacement of the elderly from a revered position in the pre-industrial society, to a position of non-person in contemporary society, are responsible for the prolongation of biological life. Today, the numbers of the aging are legion and the contemporary interest in the problems of the aging, indeed the very creation of a hybrid social science, i.e., Social Gerontology, is hardly representative of a return to traditional, altruistic values about the reverence the

aging should be accorded. Contemporary interest in the problems of aging is nothing more than pure, unadulterated Malthusian economics, repackaged in a more utilitarian container. Be that as it may, however, the good old fashioned value of survival which pervades "Everyman," has inspired a new sense of personal identification with the phenomenon of aging, based on an awakening sense of personal mortality.

> Old age is neither inherently miserable nor inherently sublime--like every other stage of life, it has its problems, joys, fears, and potentials. The process of aging and eventual death must ultimately be accepted as a natural progression of the life cycle, the old completing their prescribed life spans and making way for the young.[1]

This excerpt advances the proposition that old age is not a static point of chronological demarcation, but rather a dynamic process which must be understood within the entire life cycle of the individual. If aging can be postulated to begin with birth or quite possibly earlier, since the fetus is a distinct entity in contrast with its developmental predecessor the embryo, aging is a developmental state, not unlike its earlier precursors. If it is a developmental stage then, it enjoys in common with earlier stages that dynamic attribute of forward movement, or the categorical imperative of growth. On principle then, we should not, could not, categorize, generalize or

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[1]Robert N. Butler, Why Survive? Being Old in America (New York; Harper and Row, 1975), p.2.

stereotype older adults as belonging to a group based on one arbitrary determinant such as chronological age; aging, rather is a complex process. On the other hand, the aging process can be operationalized in terms of characteristic physiological deficits such as sensory loss or skeletal changes secondary to osteoporesis. The aging process can also be described in terms of certain characteristic social deprivations relative to the population as a whole; for example, the elderly as a group do have a higher death rate, do not enjoy the same degree of affluence as their juniors, nor do they participate in the mainstream of the economy. The idea of deficit and deprivation when applied to the elderly as being the most characteristic attributes describing the status of an entire segment of the population, however, must be tempered by cognizance of the fact that some differences which distinguish the aging individual are not necessarily deficits. For example, the life experiences born of having lived a venerable number of years are perceived in certain cultures as an invaluable legacy to be bequeathed to younger generations. In other words, we seem to know more about what aging is not, than what it actually is. Aging is neither inherently miserable nor inherently sublime. It is a completely unique experience that can not be described in terms of static polarities, but can best be described in terms of its dynamic potential for growth and change--the thread of continuity that links the aging

process to its developmental predecessors. The concept of the dynamic process of aging promotes the proposition then, of the inherent capacity of older individuals to grow, change their life styles, develop new interests and potential, including new roles. Development of programmatic linkages to operationalize the capacity of the elderly to maximize their growth potential becomes more than a programmatic objective; it becomes a moral obligation to facilitate development of constructive social resources to serve as outlets for the expression of the inherent capacity of the aging to contribute to society in new roles.

The Senior Community Service Aide Program is one such programmatic resource designed to maximize the creative potential of older adults to provide a unique service to the community, not just in terms of traditional volunteerism, but in a new role--that of a paid employee of the City of New York, providing outreach services to a community in need. This new role for older adults is today more than a curiosity; it has been legitimized through legislation and operationalized through governmental subsidization actualizing the value position underlying the entire program--"work dignifies man."

II. CONCEPTUAL FRAMEWORK UNDERLYING THE PROGRAM

Current knowledge of aging can be categorized within

four areas of investigation. These areas are represented by the "biological," the "psychological," the "situational," and the "sociopsychological."[2] Biologists regard the normal aging process as a complex of progressive changes in cellular composition and capacity for growth. Parallel to these changes, and no doubt related to them, is an increasing prevalence of long-term chronic disease arising from cumulated insults to the organism. The results of a multiplicity of factors are seen in the slowing down in performance, the decline in energy reserve and a variety of cosmetic and structural changes.

Psychological aging is being studied in terms of changes in the central nervous system, in sensory and perceptual capacities and in ability to organize and utilize information. The literature is replete with studies of intellectual and motor performance, including changes in learning, memory, creativity, speed of input and output skills and performance of work. Attention is being given to external influences such as cultural expectations and environmental factors. Most of the changes in these areas are currently thought to be normal aging processes or functions of such processes. There is evidence, however, that maturation of some capacities may extend into middle

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[2]Clark Tibbitts, "Origin, Scope and Fields of Social Gerontology," _Handbook of Social Gerontology_ (Chicago: University of Chicago Press, 1960), pp. 7-8.

adulthood and that declines are highly differential and usually very gradual.

The "situational" school of thought about aging addresses variables which have to do with changing circumstances or situations in the family, community and society. These may be called the "sociological," "socio/economic," or "situational" changes. They include: completion of parental role; social attitudes and behavior toward the aging or aging individual; retirement from work and reduced income; restricted mobility induced by disease; disability or loss of energy; need for special living arrangements; and loss of spouse.

The alterations may occur abruptly as is usually the case with retirement, or slowly, as it is with decline in energy reserve and as children gradually orient themselves toward the community. Departure of children and cessation of paid employment result in larger amounts of free time which may be partially offset by the slowing down of physical and psychological processes, but which nevertheless call for intensification of residual roles or development of new ones.

A fourth approach is concerned with the meaning to the individual of the changes previously discussed, and with the internal and external adjustments he makes to them. Interest lies, on the one hand, in his inner reactions with regard to such matters as changing self-image, feelings efforts to maintain ego balance and to maintain tolerance of stress.

On the other side, social psychologists and social gerontologists are studying changing status and roles through successive phases of the life cycle; relationship to family, work and others; and organization of behavior in terms of content and expansion or constriction of life space.

Three important propositions emerge from the convergence of the four behavioral and social science approaches which contribute to the knowledge base upon which program development to meet need is predicated. One is that aging seems to be a developmental process, embodying elements of growth as well as decline throughout most of the life span. Secondly, continued research makes it increasingly apparent that there is a good deal of interrelationship among the several facets of the aging process. And, thirdly, there is an enormous amount of variation in time of onset of the various changes and circumstances within each individual and among individuals.[3]

Of the four approaches to aging, however, the most salient, from a point of view of advancing a conceptual framework upon which the Senior Community Service Aide Program is predicated, evolves from a sociological knowledge base; the conceptual framework most applicable to the specification of the program is to be found in the concept of Social Role. While the concept has been popular for a number of years, there is still no absolute agreement on a

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[3] Ibid.

standard definition. Anthropologists discuss the concept of social role in terms of the behavior of individuals belonging to specific age, sex and occupational groups. In the classic work of George Herbert Mead and Ralph Linton on Social Role Theory, a social role is defined as a collection of patterned sequences of behavior which form a unit designated by a name, e.g., husband, father, breadwinner, retiree. There are "normative roles" characterized by behavioral prescriptions. There are also valuational roles to which are attributed positive or negative values, e.g., bad boy, liar, etc. Linton sees role as the dynamic aspect of status.[4] In other words, the role an individual is assigned or with which he becomes identified is closely related to his position in society. Parsons sees role in larger terms; society itself, he postulates, is a pattern of roles. One of the most notable conceptual contributions to the knowledge base of role theory has been the distinction made between ascribed and achieved role--the former refers to those roles automatically assigned by society and the latter referring to those roles in which an individual finds himself in later years because of learning or experience.[5]

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[4]Wilma Donahue, Harold Orbach and Otto Pollak, "Retirement: The Emerging Social Pattern," Handbook of Social Gerontology, ed. Clark Tibbitts, (Chicago University of Chicago Press, 1960), p. 322.

[5]T. Parsons, "Systematic Theory in Sociology," Essays in Sociological Theory (Glencove, Ill: Free Press, 1949), p. 35.

Psychologists such as R. S. Woodworth pioneered in making other conceptual contributions to the breadth and depth of a definition of role. Woodworth construed role as one of the two most important social influences upon a child's personality development. N. Cameron discussed role from the point of view of a crucial factory in facilitating social adjustment. E. R. Guthrie contributed the notion of conflict in roles as one source of personal mal-adjustment. M. Komorovsky researched role conflict among college girls and provided support for Guthrie's theory that role conflicts exacerbate mal-adaptive behavior.

Social psychologists such as L. S. Cottrell, T. R. Sarbin and N. Cameron have synthesized the conceptual contributions of anthropology, sociology and psychology, and have arrived at another conceptual formulation which emphasizes perception and reciprocity; a role is an internally consistent series of conditions and responses by one member of a social situation which represents the similar pattern for a similarly consistent series of conditions and responses of the others in that situation.[6] T. M. Newcomb took cognizance of the concept of "role," and "role behavior" which refers to the actual behavior of specific individuals as they assume roles. S. S. Sargent

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[6] L. S. Cottrell, "The Adjustment of the Individual to his Age and Sex Roles," American Sociological Review, (Vol. VII, 1942), p. 617.

emphasized the environmental influences in the assumption of roles when he suggested that "a person's role is a pattern or type of social behavior which seems situationally appropriate to him in terms of the demands and expectations of those in his group."[7]

III. AGING AS A SOCIAL ROLE

The concept of role as it is defined in the foregoing review of the literature in sociology, anthropology and social psychology offers maximum utility in describing social role interaction with reference to clearly defined role transitions in those stages of the life cycle antecedent to aging. While there seems to be general agreement in the literature that aging is a developmental process and represents another stage in the life cycle, there is not that same clarity of social roles and behavioral expectations associated with aging as characterized the transition from childhood to adolescence.[8] Most cultures have developed formalized rites of passage to mark the transition from one state of life to another. Ritualistic ceremonies associated with passage from boyhood to manhood are prevalent in most

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[7] T. M. Newcomb, Social Psychology (New York: The Dryden Press Inc. 1950), p. 330.

[8] Newcomb, p. 331.

societies including our own. Moreover, there has been an anticipatory period during which the new social roles attendant to passage from one stage in life to another have been tested. Both family and formal educational structures attempt to gradually introduce the adolescent to the new adult social roles he or she will gradually be expected to assume, through a variety of socialization processes exposing the adolescent to adult situations in which new roles may be tested while maintaining an atmosphere of tolerence should performance not equal expectations. When it comes to social roles and behavioral expectations associated with the aging process, however, what society seems to have developed is a stereotyped role whose parameters are based strictly on chronological age. As far back as 1942, Cottrell and Parsons both refer to the assignment of certain expectations of society founded on chronological age. Those societal expectations refer back to primitive societies where the issue of biological survival of the species depended to a large extent on identifying and isolating those physiological characteristics of the aging person which have the potential to jeopardize the welfare of the larger groups. These characteristics refer mostly to the diminishing physical prowess of the older person which found practical expression in the division of labor.[9]

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[9]Newcomb, p. 334.

Contemporary society continues to adhere to many of these anachronistic role expectations defined by chronological age despite the fact that there have been dramatic changes in the average person's life span and in the economic environment which encourages early retirement and places a premium on leisure time activities. In 1968, Robert N. Butler in his study on aging, coined the word "ageism": a process of systematic stereotyping of, and discrimination against people because they are old, just as racism and sexism accomplished this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old fashioned in morality and skills. "Ageism" allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings.[10] This concept of "ageism" addresses role relationships insofar as it seeks a way to define society's attitude toward the aging as portrayed in stereotypes and mythology about older adults. The concept of "ageism" becomes operationalized when society promotes policies and practices which, at the same time, collectively absolve its members from the burden of caring for aging members and insulate the younger generation from having to deal with such highly charged emotional issues as aging, illness and death. Role changes

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[10] Butler, p. 2.

create special problems for older adults in ways unique to this segment of the population. While it may be possible for an adolescent to rehearse the responsibilities incumbent upon the adult roles of husband or wife, it is more difficult for an aging member of society to anticipate the loss of the role of husband or wife by reason of the death of a spouse. In every stage of life, roles are assumed and relinquished, no less in aging than in the transition from childhood to adolescence or from adolescence to adulthood. For example, the parenting role is relinquished in the sense that children are no longer dependent upon their parents for sustenance; the loss of the role of husband or wife is occasioned by the death of a spouse. An individual who may have enjoyed a physically active life may have to relinquish that life style because of illness or disability and assume a more passive role built around another life style. There is, however, one situation unique to the aging individual that is unlike other social roles which were assumed and relinquished in the various stages of life by reason of the maturational process, and that is in the case of retirement.[11] In contemporary western society, retirement has been defined as a separation from paid employment which has had the

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[11]Robert C. Atchley, "Retirement: Adjustment of Loss of Job at Retirement", Social Problems of the Aging, Ed. Stephen P. Rutter (California: Wadsworth Publishing Co., 1978), p. 50.

character of an occupation or career over a period of time.[12] Another common definition has described the retirement state as a condition of anyone who so defines himself. Both definitions, however, fail to point up the changes in social roles and role relationships that result from a disengagement from work or a career. Taking role relationships into consideration, the definition of retirement upon which this thesis will proceed is the following: "retirement is the creation of an economically non-productive role in societies which are capable of supporting large numbers of people whose labor is non-essential to the function of the economic order."[13] In other words, retirement is the prescribed transition from the role of an economically active person to the position of an economically non-active person in accordance with the norms through which society defines this change.[14] As such, the retired person has a changed status that pervades more than a change in one aspect of life. Having become eligible for a new role, the retiree has had to abdicate his position on the occupational hierarchy. He is in a stage of life in which there has been very little

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[12]Donahue, Orbach and Pollak, p. 330.

[13]Donahue, Orbach and Pollak, p. 331.

[14]Ibid.

anticipation, socialization or training for assumption of new roles as had previously been the case in other phases of the life cycle. This is one reason why there is a great deal of confusion among retirees or those approaching it, as to what the retirement role should be. Only within the past fifty years or since the inauguration of Social Security, has there developed any reference group with which the retired person could identify himself in terms of role expectations.[15] Past societies have been experience with the aged, but they have not had experience with the retired aged.

In 1954, Eugene Friedmann and Robert J. Havighurst produced what for two decades remained the classic statement on the adjustment processes attendant to retirement. Friedmann and Havighurst suggested that there were three transitional phases following retirement. The first phase focused on assuming work of a project nature; e.g., taking a trip, fixing up a home, moving to a retirement community. The second phase was distinguished by a discontent and seeking out new roles ordained by society to be appropriate for retirees. The third phase was characterized by stability and a sense of accomplishment during which the individual engaged in the roles which he had selected or which society had selected for him. Robert C. Atchley refers to Friedmann and Havighurst's three

[15]Donahue, Orbach and Pollak, p. 334.

transitional phases following retirement as Activity Theory which postulates that the job means different things to different people, and that to adjust successfully to the loss of one's job, one must find a substitute for whatever personal goal the job was used to achieve.[16] Activity Theory relies upon the proposition that retirement, by definition, is a regression to a diminished position in society, and that the retiree will seek out and find a work substitute. Atchley argues that Activity Theory explains adjustment in retirement for only a minimal segment of the retired population. In lieu of Activity Theory, Atchley promulgates a Continuity Theory which holds that retired individuals will best adjust to retirement by spending increasingly more time in those roles which characterized their pre-retirement period, rather than develop new roles. While he stops short of suggesting that Continuity Theory applies to all retirees, Atchley does suggest that this theory may apply to the majority of retired individuals.[17] A third theory, Disengagement Theory, advances the notion that retirement is a necessary consequence of the physiological aging process; research in this school of thought supports the proposition that many people do want to withdraw from full-time employment and look forward to the opportunity to do so.

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[16] Atchley, Social Problems of the Aging, p. 53.

[17] Ibid.

Atchley further refined his concept of the adjustment process in retirement with a theoretical construct which he represents as the synthesis of Activity Theory, Continuity Theory and Disengagement Theory. Atchley suggests that the processes of adjustment in retirement are a function of internal compromise and interpersonal negotiations.[18] That is, when a person relinquishes full-time employment, a certain degree of disequilibrium is natural; the degree to which the individual experiences and manages that disequilibrium is dependent upon (1) The manner in which the individual handled anxiety and job related stress while still employed, and (2) The extent to which the job occupied a position of preeminence in the hierarchy of personal goals the individual established throughout his or her life. That individual preoccupied with materialistic goals for which money is the only concern, can be expected to experience more disharmony upon retirement from full-time employment. On the other hand, that individual who defines his or her priorities in life in terms of non-materialistic goals is less vulnerable to the adjustment processes inevitible when retirement modifies the standard of living previously dependent upon full-time employment. However, for that individual whose self-image is such that the job has occupied a position of preeminence throughout

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[18] Atchley, Social Problems of the Aging, p. 58.

his life, the process of adjustment in retirement will be dependent upon locating a substitute job which provides most of the satisfactions that the individual enjoyed prior to retirement. For such an individual, locating employment will mean the virtual reinstatement of that social role which is most syntonic with full-time employment. If there are confounding exigencies, and the retired individual whose goal priorities are so organized around work cannot find substitute employment, then he must decide to change his priorities through a process of internal compromise. If the process of internal compromise is successful, then the retiree is in a position to relate to his external environment through a process of interpersonal negotiations designed to redefine the perceptions of significant others in the environment in terms of a new self-image he projects, and systems of priorities predicated upon that internal compromise which was needed to deal with the realities of being unable to find a viable substitute for the job. Atchley cautions, however, that not quite one-third of the retired population has difficulty in adjusting to retirement; in that group which does experience difficulty, however, 62 percent of the reasons for difficulties are represented by economic and other job related factors.[19]

The theories of Atchley and his contemporaries about the nature of the adjustment process in retirement

[19] _Ibid_.

represent a substantial refinement as contrasted with the generalizations about the mandate for job substitutions of earlier researchers. Atchley provides additional documentation of an observation established by earlier researchers in the adjustmental process of retirement; that is, individuals on the lower end of the socio/economic scale return to work after retirement not only for obvious economic reasons, but for psychosocial reasons having to do with factors external to their jobs, (e.g., having something useful to do, means of keeping busy, developing social contacts) in contrast with higher status occupational groups such as skilled craftmen and professionals whose reasons for returning to work after retirement have more to do with intrinsic job factors such as creativity and maintaining a sense of pride and accomplishment.[20]

For the majority of retired persons, however, inadequate income is still the number one problem.[21] For at least one-third of the retired population in the lower socio/economic groups, the development of a viable new role in the post-retirement period--if it is to be perceived as truly compensatory for the loss of the wage-earner role--must preserve some of those positive attributes

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[20] Donahue, Orbach and Pollak, p. 358.

[21] Robert M. Ball, "Income Security After Retirement," Proceedings of Conference on Social Policy, Social Ethics and the Aging Society, National Science Foundation (Washington, D.C., 1976), p. 34.

associated with the role of wage-earner. (For example, the new role must have some form of monetary component attendant to it, and must be associated with some additional value appeal, keeping busy or useful, developing new social contacts, etc.).

The Senior Community Service Aide Program, authorized by Title V of the Older Americans Act, is a program whose goals are predicated upon the development of new roles for adults in the retirement phase of life through part-time, paid employment in community services focused around meeting the needs of the aging. As such, this program represents one example of an operationalization of Atchley's reference to Activity Theory first described by Friedmann and Havighurst; that is, the Senior Community Service Aide Program has two fundamental objectives which correspond conceptually with that segment of the retirement population for whom Atchley finds Activity Theory applicable. The first objective of the Senior Community Service Aide Program addresses provision of a social service; the second objective addresses the provision of viable employment opportunities for low income older adults for whom the wage-earner role has been preeminent throughout life.

IV. NEEDS ASSESSMENT OF THE NATIONAL LEVEL

"Indeed, it is wrong to view the maturing of the

American population and the graying of the federal budget simply as a problem for our society...We should remind ourselves that support for older Americans is support for all Americans. When Medicare pays an older citizen's hospital bill, it protects that family's savings to pay for college tuition or a new house or their own retirement....All the elderly, we must remember, are ourselves--and our children. When we discuss the elderly in 2025, we are discussing the high school seniors of today."[22]

If there are any colors more true than the red, white are blue, that color might be "gray." One out of every nine Americans is now 65 years of age or older, or close to 11 percent of the population. In contrast, the year 1966 was the last year that the population age 65 and over was less than 9.5 percent. Ten years later, the continuing growth rate of the population over 65, and the accompanying drop in the birth rate accounts for the change in proportion of the older population to close to 11 percent or one in nine.[23]

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[22]Joseph Califano, "Questions for the Four-Generation Society," Speech before the American Academy of Political and Social Science, Phila., Pa., April 8, 1978. Cited in Report of the Special Committee of Aging, U.S. Senate Report no. 95-771, 1978, p. VII.

[23]Herman B. Brotman, "The Graying of Every Tenth American or Every Ninth American," from a report of the Special Committee on Aging of the United States Senate Developments in Aging, Part I, 1977, U.S. Government Printing Office, (Washington, D.C. 1978), p. XV.

When this nation was born in 1776, 2 percent of the population or every fiftieth American was 65 or over. By the turn of the century it was every twenty-fifth American or 4 percent of the total population. By mid 1977, 23.5 million older persons comprised 10.9 percent of the 216.3 million citizens. Almost a quarter of the nation's older citizens live in three states, California, New York and Florida; California and New York each have more than 2 million older people.[24]

In 1976 half of the families headed by an older person had incomes of less than $8,721. as opposed to $15,912. for families whose heads were under 65. The median income of older persons living alone or with non-relatives was $3,495. as compared with $7,030. for under 65 individuals. Some 3.3 million of our nation's elderly had incomes below the poverty line, e.g., $3,417. for urban couples, and $2,720. for individuals. For the elderly, poverty is highly related to the almost two-thirds cut in income that results from retirement. Further erosion in personal income results because older Americans spend proportionately more of their income on food, housing, health and personal care, and less on other items, as compared with other low income groups. The elderly are most victimized by inflation because of their fixed incomes. At best, they

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[24]Brotman, p. XXVI.

can play only a "catch-up game" in the best of inflation rider pension plans.

Many suppose that Social Security provides the elderly with adequate income support. Yet it can be demonstrated that, for those elderly reliant on Social Security as their sole source of income, the program does not lift them much above federal poverty levels. For example, in 1977 average monthly Social Security payments to retired workers and their dependents was $241.24.

Programs for public financing of the health costs of the elderly leave the elderly with large medical expenses which they must pay out of their own pockets. Medicare offers no coverage at all for preventive health care such as a yearly physical examination; nor does it cover chronic illnesses despite the fact that chronic illnesses which pose major restrictions or physical activity affect 40 percent of the elderly. Medicare will not pay for eye-glasses, dental expenses, out-of-hospital drugs, hearing aids and podiatry.

Right now, there are 7 million people in the nation's acute care hospitals; as many as 100 thousand, almost 15 percent of them do not have to be there and can be better cared for at home, in skilled nursing facilities or on an outpatient basis. These patients are generating excess

charges of 7 million dollars per day just for operating costs, or 2.6 billion a year.[25]

There is no question that costs containment in the health care industry comes closest to describing our nation's national health care policy. In 1965, the cost of health care in the United States was 39.9 billion dollars or 5.9 percent of the Gross National Product; in 1976, the cost of health care had risen to 139.3 billion dollars or 8.6 percent of the Gross National Product. In less than a decade health care costs have more than tripled and hospital costs, specifically, rose most rapidly from 34 percent to the total cost of 40 percent. Per capita health care costs in 1976 for older Americans came to $1,521., 3.5 times the cost for individuals under 65. In gross terms in 1976, while older people represented 11 percent of the total population, they accounted for 29 percent of total personal health care expenditures--34.9 billion dollars out of a total 120.4 billion dollars.[26]

In 1977, just over 20 percent of 65-plus men (1.8 million) and 8 percent of 65-plus women (1.1 million) were in the labor force with concentrations in three low earning categories; part-time, agriculture and

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[25]Joseph Califano, Testimony before the House Sub-Committee on Health and the Environment, May 11, 1977. Cited in Report of the Special Committee on Aging, United States Senate Report No. 95-771, 1978, p. 60.

[26]Brotman, p. XIX.

self-employment. Unemployment ratios were low due partly to the fact that in a period of sizable unemployment, older workers are discouraged from seeking jobs and they are not counted as being in the labor force at all.[27]

While it is true that passage of the Social Security Act of 1935 represented the first national attempt to alleviate the financial burdens incumbent upon the family in the care of the elderly, it is equally true that the Social Security Act represented an intergenerational shift of filial responsibility to the Federal Government; the shift in responsibility did not provide for the complete range of supportive services required by the elderly, historically provided by the family. What has happened since passage of the Social Security Act has, in effect, been a series of social legislation modeled upon the concept of nationalized filial responsibility. If the aging required legal services, housing, employment, recreation, income maintenance, health and metal services, even friendly companionship, it becomes expedient to enact legislation to operationalize whatever role or function is required.

The problem is trying to develop national programmatic surrogates for the family, capable of addressing the plethora of the needs of the elderly, is to get beyond the public relations state, into delivering real services to

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[27]Brotman, p. XXII.

the consumer. Even if it were possible to develop programmatic surrogates for the family, it would be impossible to deliver these services on a scale grand enough to compensate for the role the family historically played in providing warmth, love and security for its elderly members.

George Roby, Chief of the Adult Services Division of the Social Security Administration in Washington, D. C. describes his perception of the plight of older people in an urban community in terms of a volunteer program of social visiting to elderly shut-ins:

> I became quickly aware that there were few other people out there. Our aged are deserted. People who normally provide services and human contact have fled the scene. There are no more delivery boys to bring the groceries. "Friendly Visitors" from the church, the family doctor, even visits from close relatives such as children and grandchildren are few and far between. The social worker has discontinued the regular home visit and the public health nurse, bless her, is still out there but in fewer and fewer numbers. The "go to the home" services are almost non-existent. Many old people are on waiting lists for two or more years. Many never survive the waiting list.
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> In three years we have been able to recruit only two friendly visitors from this metropolitan area of two and a half million people who were willing to go into their client's home....Our programs for the aging represent the meanest kind of tokenism. They dangle a carrot that can be nibbled at by too few of those in need. They are a smoke screen to hide a problem that communities will not face up to.[28]

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[28]Butler, p. 158.

V. NEEDS ASSESSMENT WITHIN THE LOCAL COMMUNITY

Since the Senior Community Service Aide Program focuses on provision of services to alleviate problems of the aging, it is important to describe selected demographic characteristics of the programmatic environment in order to understand the relationship between services and unmet needs of the aging.

Maimonides Medical Center is a 610 bed voluntary acute care general medical and surgical hospital located in the Borough Park Section of Brooklyn, whose population is estimated to be 86,484.[29] In order of priority the mission of Maimonides Medical Center is devoted to: (1) Patient care, (2) Education and training, and (3) Research and development. In addition to general medical and surgical services, the Medical Center provides comprehensive obstetrical, gynecological and pediatric inpatient services; additional components of the Medical Center include a Department of Community Medicine and Community Health Services; a Community Mental Health Center; comprehensive Emergency Services Department and affiliations with Downstate Medical Center, Coney Island Hospital, Brookdale Medical Center, Metropolitan Jewish Geriatric Center and numerous other extended care facilities in the community.

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[29] Neighborhood Statistical Profiles, Borough Park, Brooklyn, NB No. 288, Prepared by the New York Dept. of City Planning, Aug. 1978, p. 2.

Maimonides Medical Center serves a community predominantly composed of three ethnic groups: Jewish, Italian, and Hispanic. The single largest group in the area is Orthodox Jewish. It is estimated that this group represents one-half of the total population and is increasing rapidly in size and predominance in the community. Demographic studies indicate that these are primarily newcomers to the community, having come from either Williamsburg, Crown Heights or parts of Europe. Most of this group has been in the community for a period of less than ten years.[30] The group consists primarily of families headed by members under fifty. The average size of the family is substantially larger than that in the community as a whole and of the United States. Considering the family size, the cost of living in New York and the extra expenses related to maintaining certain religious practices, the income was low. Moreover, this group has been hard hit by the recession and has a growing unemployment problem. It should also be pointed out that this group tends to rely on its own resources and does not take advantage of governmental aid programs or social

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[30] G. Landsberg. et al, An Exploratory Study of the Demographic Characteristics, Attitudes Towards, and Use of Health, Mental Health and Social Services in the Chassidic and Ultra-Orthodox Jewish Community of Borough Park, A Report based on a study conducted by the Program Analysis and Evaluation Section (Brooklyn, New York: Community Mental Health Center of the Maimonides Medical Center, 1975), p. 2.

services programs. A 1972 study of the Jewish poor in New York City estimated that 140,300 Jewish families including 272,000 individuals or 15.1 percent of the Jewish population in the City were poor; half of this group are aged and are concentrated in specific areas throughout the City, including Borough Park.[31]

The second most numerous group in the Italian-American community. As of 1970, this community represented approximately 23.4 percent of the population.[32] It is essentially a working class and poor community whose members have traditionally not utilized social agencies to any large degree. The indications are that this population is decreasing. There seems to be a trend whereby the more affluent and better educated younger individuals are leaving the community. Being left behind are groupings of the aged population who may only speak Italian and have special problems of isolation and alienation.

The Puerto Rican community came into the area in increasing numbers in the past ten to fifteen years. Indications are that as of 1970, they may represent 8.7 percent of the population.[33] The main location of this

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[31]Rabbi Jack Simcha Cohen, Jewish Poverty Issues (New York: Metropolitan Coordinating Council on Jewish Poverty, 1975)

[32]G. Landsberg, p. 2.

[33]David Specht, The Hidden Poor: The Needs of Low Income Ethnic Groups Living Outside Proverty Areas (New York: The Community Council of Greater New York Research and Program Planning Information Dept., 1977), p. 24.

group is in the Sunset Park community. However, pockets of Puerto Rican populations have grown up in parts of Borough Park. This community is quite poor and employment is usually in unskilled or laborer jobs. The rates of unemployment and welfare use by the community are substantially higher than for other populations. There are a disproportionate number of female headed households within the area. Moreover, this group often has the disadvantage of being a newcomer to the area and having to live in poor housing conditions.

According to a 1975 census update, the Borough Park community served by Maimonides Medical Center has 12,140 persons who are over the age of 65, or 13.7 percent of the total population of 86,484. This figure takes on meaning in juxtaposition to the total population 65 years or over for the City of New York which is placed at 947,851, or 12 percent of the total population of 7,893,329.[34]

Health Area 69.00 occupies the northern sector of Community Planning District 12, and is contained within the service area of Maimonides Medical Center. It is one of the low income areas identified in a report published by the Community Council of Greater New York Research and Program Planning Information Department, entitled "The Hidden Poor--The Needs of Low Income Ethnic Group Outside Poverty Areas."

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[34] _Ibid_.

As noted in Table 1, from this report (see Appendix p. 168) 20.6 percent (1,059) of the families in Health Area 69.00 had incomes less than $4,000. in 1969. Column 3, in the table shows that 10.8 percent (2,061) of the 1970 population was under the age of 6; 12.5 percent (2,393) were 65 or over and 2,134 persons were receiving public assistance in April 1976.[35]

In a more recent survey of 3,202 residents in the Borough Park community (1979) it was found that approximately 5 percent of the population have a total income of $12,000. or more. Almost one out of every four households have a total income of $7,500. or less.[36]

In terms of overall health status of senior citizens (over age 60) in the Borough Park area, the following summary represents the major documented unmet needs in this area of concern:

1. The majority of senior citizens are not within walking distance of their physicians; hence they are also in seeking out preventive medical care.
2. Most established physicians in the community do not look with favor at accepting new patients with Medicaid or Medicare.

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[35]Specht, pp. 16-17.

36Borough Park Coordinating Committee Survey (C.E.T.A. Title VI) Jan. 15, 1979, p. 5.

3. Senior citizens are resigned to being considered second-class patients as compared to younger patients.

4. Senior citizens spend more time waiting to be attended by physicians than non-senior citizens.

5. The majority of senior citizens living in the community surveyed have little confidence in Medicaid or Medicare, and simultaneously hold equivalent private insurance.

6. Senior citizens visit their doctors twice as much for rehabilitative treatment than they do general examinations.

7. Large numbers of senior citizens are not tested for diabetes, hypertension, hearing and vision.[37]

A list of conditions affecting the elderly has been identified from health status reports compiled under the auspices of the Maimonides Medical Center's Outpatient Division over the past decade. The elderly living in Borough Park suffer from:

1. Fragmented medical care--crisis approach as opposed to preventive care.

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[37] Menachem Lubinsky, Medical Care and the Aged: A Study of the Problems of the Elderly in Receiving Proper Treatment in the Borough Park Community of Brooklyn, (New York: Commission on Senior Citizens of Agudath Israel of America, Oct. 1974), pp. 12-13.

2. Lack of responsiveness of medical care staff to the needs of the elderly. When illness is generally chronic (one or more chronic illnesses) and not acute--staff not responsive to emotional components of illness which prompted emergency services visit.
3. Lack of comprehensive health insurance program to cover health maintenance needs of the elderly.
4. Insufficient supports in community to help maintain elderly in home--i.e., needs attendants, homemakers, housekeepers.
5. Resistance of elderly to utilize/apply current programs which would provide a variety of services, meet needs, e.g., supplementation, food stamps, Medicaid, Meals on Wheels.
6. Limitations of current entitlement programs in terms of eligibility requirements, increase in Medicaid limits.
7. Lack of planning for retirement--limitations of pension systems.
8. Transportations problems which interfere with procurement of medical care, either to private M.D. or hospital, if on Medicare only.

9. Drug coverage not available to all elderly for purchase of medications needed for palliation of symptoms or treatment of chronic conditions.

10. Clinics not comprehensive, proliferation of specialty clinics and one comprehensive geriatric clinic with limited availability which does not begin to meet needs of the aging, even in comprehensive heavy usage of specialty clinics and referral out.

11. M.D.--one home visits, unaccessibility for minor illness treatment--flu, colds, etc. Dumping by local medical doctor of terminally ill, "untreatables."

Hidden "pockets of poverty," large scale unemployment, a high concentration of persons over 65 years of age, and lack of adequate health care services characterize the social/health configuration in Borough Park.

For low income ethnic groups living outside of poverty areas in New York City, like Borough Park, the following programmatic interventions were recommended by the Community Council of Greater New York:[38]

1. Language programs to orient newly arrived immigrants should be instituted.

2. Information and referral programs to supplement

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[38]Specht, pp. 11-14.

existing agencies serving the poor, should be provided with up-dated information on services and entitlements such as food stamps, Medicaid and public assistance.

3. Every immigrant group should have information and referral workers who could facilitate and advocate on behalf of clientele who cannot negotiate the system.

4. Training programs should be established to train existing or new personnel in information and referral techniques.

5. Multi-lingual workers should be available within governmental, social and health agencies.

6. Bi-lingual vocational training and employment programs should be made available, especially to new immigrant groups forced to accept low level, dead-end jobs; for example, the special employment requirements of Orthodox Jew's unique problems in job placement by reason of religious tenets.

7. With respect to the elderly, more outreach programs are needed to help the elderly realize their entitlements because generic problems of the elderly, such as low, fixed incomes, loneliness, etc., are often compounded by language barriers and cultural stigmas against asking for help.

VI. THE PILOT PROGRAM - NEIGHBORHOOD RESOURCES FOR THE AGING

In October of 1969, Maimonides Medical Center, in a multi-faceted approach to address the unmet needs of the elderly documented in the foregoing discussions, entered into a contract with the Arthritis Foundation, Inc., New York City Chapter, to provide certain special demonstration, research, and training programs on behalf of the elderly, under terms of a grant made by the United States Public Health Service. The program was entitled, "Neighborhood Resources for the Aging," and was funded at an annual cost of $16,000.

The Neighborhood Resources for the Aging Program was a volunteer service arm of the Department of Social and Community Services. This program focused on the medical, economic and psychosocial problems of the aging of Brooklyn's Borough Park Community. Eight senior citizens provided volunteer services to patients of the medical center.

The theory underlying the Neighborhood Resources for the Aging services was self-help. Utilizing well members of the senior population of this community to service their less able and less well-disposed age mates fulfilled two objectives; the first objective in this service was to provide a primary basic person-to-person service to the potential or actual patient by the Neighborhood Resources

for the Aging volunteer. Through the medium of personal contact and home visitation, actual or potential patients were rendered a social service which, more often than not, precluded or forestalled the necessity for acute medical services. Relationship theory in the person of the Neighborhood Resources for the Aging volunteer, under the supervision of a licensed social worker, broke through the vicious cycle of depression and isolation which beset so many of the elderly and precipitated physical and mental breakdown necessitating acute care. Concrete services such as light shopping, acting as an intermediary with strategic community agencies, escorting patients to the hospital, bringing prescriptions for the infirm and homebound, were all line services of a preventive and health maintenance nature.

Secondly, the Neighborhood Resources for the Aging, by the very nature of its activities, served as a social and emotionally constructive outlet for its membership--individuals who might otherwise be consumers of service rather than providers. The Neighborhood Resources for the Aging generated an annual average of four-hundred plus, patient contacts. One Neighborhood Resources for the Aging volunteer alone, for example, made applications for an average of six homebound patients per week at the Medicaid Office.

This unique program utilized senior citizen volunteers

of various ethnicity and religious persuasions in a systematic program of advocacy on behalf of elderly, impoverished, chronically ill adults who required medical and social services, but who by reason of age, illness, disability, and indigency, were unable to acquire services or adequately represent their own interests. The Neighborhood Resources for the Aging program focused then, on the medical, economic and psychosocial problems of the aging residing in the Maimonides Medical Center Ambulance area.

Although the Neighborhood Resources for the Aging volunteer program costs to the Hospital never exceeded $9,000. a year--all of which went toward transportation costs incurred by the older workers in the process of home visitation--the program became a victim of budgetary retrenchments, and the program was excessed in March, 1979. In retrospect, it could fairly be said of the Neighborhood Resources for the Aging program that it represented the best of first generation hospital-based older adults outreach programs. The program as it was structured, however, in volunteer terms, could never be replicated. As the original eight Neighborhood Resources for the Aging volunteers succumbed to the ravages of old age--or to be more accurate--older age, it was impossible to recruit replacements from within the same general population from which the original Neighborhood Resources for the Aging

volunteer program originated. The interest, the dedication, the sense of mission, was not to be found. Before the Neighborhood Resources for the Aging program was discontinued, however, it provided the necessary period of tutelage for the Title V Senior Community Service Aide Program although the volunteers were not enthusiastic about the prospects of paid workers succeeding them. The new program was predicated upon the proposition that second generation programs, if they were to be as effective as their volunteer predecessor or enjoy as distinguished a tenure, would have to receive subsidization from outside the hospital itself. In other words, the auspices would have to change, and if the new role were to prove viable, a partnership between government of the health care industry would have to be developed--the former providing the subsidization and the latter, an environment for training and application of newly acquired job skills.

VII. THE TITLE V SENIOR COMMUNITY SERVICE AIDE PROGRAM

A. BEGINNING THE NEW PROGRAM

By January of 1978, it had became apparent that the Neighborhood Resources for the Aging Volunteer Program was dying by attrition. Despite replacement attempts over the years, to revitalize the membership of the Neighborhood

Resources for the Aging Program, attempts at recruiting replacements had failed. Consequently, a decision was made by the Director of Social Services to apply for a Title V Senior Community Service Aide placement as a logical programmatic successor to the moribund Neighborhood Resources for the Aging Volunteer Program. Unlike the Neighborhood Resources for the Aging Program, the Title V Senior Community Service Aide Program represented a new application derived from the concept of social role theory. This new application postulated that: (1) The older adults not only needed to fill a vacuum created by the loss of the wage-earner role, but (2) Needed to engage in remunerative work as a viable response to the social, psychological and economic deprivations attendant to the loss of the wage-earner role. The Director of the Department of Social and Community Services of Maimonides Medical Center was subsequently awarded recognition as a Title V placement site in March 1978, and approved for recruitment of eight new Senior Community Service Aide positions.

Public Law 94-135, enacted during the 94th Congress, signed into law November 28, 1975, amended the "Older Americans Act" of 1965, expanding specific social service programs and appropriations for older adults. Title V of P. L. 94-135 is known as the "Older American Community Service Employment Program." The substance of the Title V Program focuses on the objective of promoting practical

part-time employment opportunities in community service for unemployed or under-employed persons, 55 years or older, whose income, by reason of their employment status, is marginal. The implementation of Title V is accomplished through contractual agreements between Federal Government and the state and local public or private non-profit agencies or organizations. The federal criteria operationalizing the Title V program include:

1. Employment projects to be limited to eligible older adults (i.e., 55 years of age or older, whose incomes are marginal by reason of under-employment).
2. The employment opportunities must be based in the community in which the eligible older adult resides.
3. The employment opportunity focuses around community service projects sponsored by non-profit, tax-exempt organizations.
4. The employment opportunity must contribute to the general welfare of the community.
5. The employment opportunity must address itself to the public for whom prospects for alternative public or private employment is poor.
6. The employment project cannot displace currently employed individuals or those on lay-off status.

7. The employment project recruitment procedures must conform to existing standards.
8. The employment program must provide "in-house" training and reimbursement for reasonable cost of living expenses incurred by participants.
9. The work environment must conform to existing health and sanitary standards.
10. The employment program must take into account the professional wisdom representing the discipline in which the work setting of programs for older Americans occurs.
11. The employment program must include a proviso for reimbursement of transportation costs incurred by participants in the program.
12. The employment must evolve, insofar as possible, in eligible participants who may already be enrolled in a state unemployment plan.

The Senior Community Service Aide Program, while similar to the Neighborhood Resources for the Aging Pilot Program in striving toward the goal of helping vulnerable, frail, elderly adults maintain independence or semi-independence, living in their own places of residence, is essentially different because of the following input variables:

1. The Senior Community Service Aide Program is a federally sponsored job opportunity

program, administered by the States through their municipalities.

2. The program offers salary and benefits and part-time work experience in a community action setting. As such, the Senior Community Service Aide Program participants are part-time employees of the City of New York.
3. New responsibilities are imposed upon the host agency in which Title V operates. They include new program inputs in the area of recruitment, training, employment and evaluation.
4. The Senior Community Service Aides will receive referrals for services from a broad spectrum, including: inpatient services, outpatient clinics, Emergency Center, Community Mental Health Center, community-based social agencies, etc.
5. The target population potentially served by the Senior Community Service Aide Program includes a broader age spectrum than the Neighborhood Resources for the Aging Volunteer Program which limited its activity to the clinic population, age 65 and over.
6. New linkage with such strategic community agencies as the Council of Jewish

Organizations of Borough Park will be developed for the purpose of recruiting senior staffers for the Title V Program and also to develop linkage with indigenous community resources. A new relationship between the Hospital and its constituent community consumers will be fostered as a result of developing linkages such as have been described.

The literature in the field of evaluative research emphasizes the importance of process or the influence which intervening variables exert on the outcome or effect of a program. The independent variable or preconditions of the program itself remain a "given," the case in point, Title V Senior Community Service Aide Program, is defined by statute and governmental rules and regulations. Both the program participants and site either meet, or fail to meet, the preconditions for participation in the program; of themselves, these rather rigid input variables could not be said to correlate positively with programmatic effects. Rather, the achievement of programmatic objectives is a function of the influence of intervening variables--persons, events and circumstances, some of which can not be anticipated--which do more to bring about the realization of objectives than the input

variables, upon which participation in the program depends.[39] The point in describing these intervening factors and conditions is two-fold:

1. To describe the relationship between the process of the program and the eventual realization of the program's objectives.
2. To specify what programmatic resources (persons and events) were responsible for the direction in which the program moved.

B. PROGRAM PLANNING PHASE: SENIOR COMMUNITY SERVICE AIDE PROGRAM

As originally conceived, the Senior Community Service Aide Program was to have been implemented during late Spring and early Summer of 1978. On March 1st of 1978, the City of New York, Department of the Aging, which administers the Title V Program, notified the Department of Social and Community Services of Maimonides Medical Center that it had been awarded funding approval for eight Senior Community Service Aides. The original contract was predicated upon a needs assessment that addressed itself to the psychosocial and health care needs

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[39] Edward Suchman, Evaluative Research: Principles and Practices in Public Service and Social Action Programs (New York: Russell Sage Foundation, 1967), pp. 51-52.

of the aging, hospitalized on the inpatient services of the Medical Center. As such, the program was based on the practice derived proposition that since 50 percent of the Medical Center's population at any given time was over age sixty-five, the ratio of staff social workers assigned to provide discharge planning services (numbering nine social workers) was grossly disproportionate to address the needs of the target population in any qualitative way. In fact, the inadequacy of social work staff to meet the needs was borne out in the experience of many elderly patients requiring rehospitalization for the same spell of illness because of hasty and ill conceived discharge plans. The original role which was projected for the eight Title V Senior Community Service Aides was a screening and evaluative function. A representative, randomly selected sample of the inpatient target population over sixty-five was to be identified and selected with the aide of a daily computer print-out which in addition to targeting every patient over 65, would tease out three additional high risk variables:

1. Ambulatory status at time of admission.
2. Prognostication, at time of admission, about patient readiness to return home following discharge.
3. Presence and degree of mental confusion as measured by diagnosis of cerebral

insufficiency due to arteriosclerosis at time of admission.

Subsequent to screening, it was projected that the Senior Community Service Aide would follow up with an interview of the patient or relative, complete a questionnaire enlarging the data base upon which an individual patient profile and plan would be developed, under the tutelage of the staff social worker to whom each Senior Community Service Aide would be assigned, and then execute specific job functions related to the individual plan as follows:

1. Xerox, collate, address envelopes and mail completed forms re: DMS-1, Transfer Forms, 418 applications, to extended care facilities and homemaker agencies.
2. Telephone extended care facilities for beds and let social workers know.
3. Have 401 forms completed by M.D. or nurse, and order transportation home and to first clinic appointment.
4. Request and monitor completion of forms by doctors.
5. Pick up completed forms from charts.
6. Write up intake sheets when referral is given directly to worker.
7. Deliver Alternate Care forms.
8. Coordinate the names of patients for

Alternate Care, Medicare, etc.

9. Make follow-up calls to extended care facilities to determine when our patients on their waiting lists will be admitted.
10. Contact inter-departmental offices for needed information.
11. Make follow-up telephone calls to O.C.I.M. offices to determine caseworker's name and when home services will be assigned.
12. Assist in expediting approval for admission of community patients to an extended care facility by hand carrying DMS-L and 418 forms to World Trade Center and Chelsea Center.

It was postulated that the result of this program design would achieve the following objectives:

1. Inaugurate the discharge planning process within 24 hours of admission.
2. Reduce the incidence of "social stay."
3. Identify high risk population requiring discharge planning services through a more objective, controlled, systematic approach, less dependent upon judgmental validation.
4. Demonstrate the cost effectiveness of a team approach.
5. Increase on-line discharge planning

manpower without additional budgetary expenditures by the Hospital.

6. Reduce Social Service dependence upon the referral process--increase functional autonomy of the Social Service Department.
7. Enlarge the minimum data set describing the psychosocial and demographic characteristics associated with the high risk population.
8. Demonstrate the practicability of using computer-assigned techniques to expedite and evaluate discharge planning process.
9. Reduce hospital costs incident to third party denials of reimbursement because of insufficient chart documentation.
10. Marshall available supporting community resources (e.g., OCIM, skilled nursing facilities, health related facilities, Home Care) by instituting all associated paper work within 48 hours of admission.
11. Change the Medicaid formula based on documentation of the individuality of Maimonides patients.

Both process and payoff evaluation were proposed in terms of measuring the program's relative success in terms of an experimental design which would compare patients served in general, with those who were beneficiaries of

of the Senior Community Service Aide Program. Criterion measures such as effectiveness of the discharge plan in terms of savings of hospital days and costs, incidence of readmission, viability of providing new community resource linkages were proposed.

The concept of the Title V Senior Community Service Aide Program had been discussed with the discharge planning social workers several times during the previous year. The unexpected approval of the Hospital for eight Senior Community Service Aides propelled, what had been perceived by the discharge planning social workers as a hypothetical discussion, into the realm of reality. When the approval came, there was a realization that what had been discussed from a planning point of view, was not an imminent reality. Staff attitude toward the Senior Community Service Aide Program stiffened into resistance and ultimately resulted in a confrontation with departmental management after two of the proposed eight Senior Community Service Aides had been brought into the departmental fold. The discharge planning social workers, all members of the collective bargaining unit, argued that the arrangement between the City Department for the Aging and the Medical Center was, in fact, a violation of contract in that the Senior Community Service Aides were being assigned tasks, albeit non-professional, which were the prerogative of the bargaining unit, vis-a-vis the interdigitation with the

discharge planning function. The crux of the principle upon which the union argued its position was based on the proposition that: "all bargaining unit work must be performed by members of the bargaining unit." The Senior Community Service Aides were, in fact, not members of the bargaining unit in a "closed shop." The grievance was discussed at various levels of hospital management and within the union hierarchy, and after an inauspicious beginning, the program was discontinued after little more than a month. The three program participants who had been recruited and were ready to begin were assigned elsewhere by the Department for the Aging.

C. PROGRAM REDIRECTION

The month of May 1978 was essentially a moratorium period during which time the program was reconceptualized and the process of dialogue with the discharge planning social workers was reinstituted. As a result, the Departmental Director gained a new insight into the inappropriateness and ill-timing of the Senior Community Service Aide Program, from the perspective of the union. What had been accepted in theory and principles, became anathema in reality, in view of two well-established facts: (1) Unparalleled social work lay-offs in other bargaining unit hospitals, city-wide, precipitated a crisis

in which the union perceived with heightened sensitivity its responsibility to protect bargaining unit jobs. Since the Senior Community Service Aide Program was based on the proposition that new jobs should be created, the ability of the union to protect the economic interests of its members was jeopardized; (2) The timing of the implementation phase, unfortunately, coincided with the sensitive pre-contract negotiation period between the League of Voluntary Hospitals and the union. This is historically a period during which a good deal of posturing takes place in which psychological warfare between labor and management plays an important role antecedent to contract negotiations. Consequently, programs such as the Senior Community Service Aide Program are subject to review by the union from an entirely different value perspective and can, therefore, be accepted or rejected on a correspondingly new set of principles (e.g., the program poses a threat to bargaining unit solidarity).

In the course of discussion with the discharge planning unit, the issue of "turf" became explicated in terms of the conditioning wrought by the economic exigencies which had, in effect, changed the ground rules. Both departmental management and the bargaining unit social workers agreed on the proposition that discharge planning in all its permutations--including those originally proposed for the Senior Community Service Aides--was the exclusive "turf" of

the bargining unit social workers. Once this issue was resolved on the departmental level, staff and management were able to reach a new understanding that the Senior Community Service Aide Program could still address itself to the needs of the elderly by redirecting its attention to program objectives in the area of community outreach services and resource development on a scale hitherto untested, and for which new measures of effect would have to be designed. With the locus of intervention on the community, it was possible to arrive at a job definition for the Senior Community Service Aide which did not violate either the spirit or the letter of the contract, since the functions being proposed had never been framed in terms of any bargaining unit position--clerical, para-professional or professional.

The specific reconceptualization of the content and scope of the role defined for Senior Community Service Aides as detailed in the Program Design, proposed objectives and measures which had been reviewed and accepted by social work staff. Departmental management committed this understanding to writing and submitted the proposition to union officials through the mediation of the Hospital Personnel Department. At this point in time, the union officials' approval of the Senior Community Service Aide Program, although it had been approved at a staff level as defined within the operational parameters mutually agreed

upon, was being withheld pending outcome of contract negotiations. Implementation of the program was held "hostage" on the principle that no concessions of any nature are given to management during general negotiations for a new contract or, in any event, until a new contract was ratified by union membership.

The first week of July 1978, saw a favorable resolution of the labor-management dispute and a new two year contract was ratified by the collective bargaining unit. While the air had been cleared to some extent with respect to the insecurities engendered by pre-contract negotiations between the hospital and the bargaining unit, another problem loomed on the horizon. The New York City Department for the Aging which had seen five months elapse with no program in place at Maimonides, issued a written ultimatum on July 14, 1978, advising the Director of Social Services at Maimonides Medical Center that if a firm commitment to hire older workers was not resolved by August 15, 1978, the contract with Maimonides would be terminated and the Title V positions assigned elsewhere.

At this point the Director of the Social Service Department began a last ditch effort to appeal to the professional integrity of both union and management leadership to rise above the adversary relationship and rally around the issue and spirit upon which the Title V Program was predicated; service to the aging rather than

the competition for social work jobs. A series of discussions was held with both the Executive Vice President of Maimonides Medical Center and the Executive Vice President of District 1199, representing the bargaining unit, urging them to support the Title V Program effort at Maimonides. Verbal appeals were followed by written appeals. This effort resulted in formal letters of commitment to the New York City Office for Aging on July 25, 1978, by the Hospital and on July 26, 1978, by the union. The condition under which the bargaining unit agreed to approve the Title V Program was basically that (1) The program would employ only senior citizens; and (2) The role and function of the program participants would not encroach upon the role or function of any existing bargaining unit position, professional or clerical.

Following agreement by union leadership, a series of general staff meetings was arranged by the Director of Social Service to have an open discussion of the status of the Title V Program in view of union leadership approval, and the time table set by the New York City Department for the Aging, for program implementation. The focus of the general staff meetings was conciliatory and designed to evoke an open and frank exchange of feelings about the Title V Program. The point was made that approval at the highest level notwithstanding, the program could not begin nor could it grow without the full support and cooperation

of social work staff. Subsequent discussions resulted in reassurances that the program would be conducted in the open, subject to evaluation and would, in fact, encourage monitoring of activities. The locus and focus of the Title V programmatic objectives were specified as outreach service to the aging in the community. As such, the Title V Program enrollees would not operate within the inpatient bailiwick of bargaining unit social workers, but would heavily rely upon referrals from the social workers to provide a community based extension of preventive services to the elderly. After agreement had been reached with social service staff on the conditions under which the Title V Program would begin again, the New York City Department for Aging was notified and recruitment for eight Senior Community Service Aides was reinstated by August 1, 1978.

Because federal guidelines required the recruitment of applicants who not only met both age and income requirements, but whose employment would take place in relevant spheres of community service, the issue of candidate selection became a highly sensitive issue. The New York City Department for the Aging, moreover, had a policy which, in effect, awarded placement sites to agencies and organizations providing services to the elderly. The Borough Park Section of Brooklyn, New York and the geographic area was the single largest employer

and institutional provider of services to the aging. Maimonides Medical Center met both Federation and local governmental criteria for a placement site. In addition, a Title V Program operating under the aegis of a voluntary teaching medical center had yet to be successfully demonstrated in South Brooklyn, a geographical area in which the concentration of elderly residents had been well documented.

The issue of recruitment was handled by a cooperative effort among the various components which would be required to successfully launch the Title V Program at Maimonides. In concert with the New York City Department for the Aging, the Director of Social Services at Maimonides solicited the help of two key social agencies in the Borough Park community to play a major role in the initial recruitment and screening of eligible candidates for inclusion in the Title V Program at Maimonides.

In a series of community meetings, the Director of Social Services advised the community social agency coordinating structure of the intent to launch a Title V Program at Maimonides. Input was solicited and received from the coordinating body which represented virtually every agency or organization servicing the elderly in the community. Subsequently, two agencies in particular were selected. The daily activities of these agencies brought them into association with candidates whose backgrounds

closely paralleled the interests and objectives of the Title V Program. These two agencies were the Borough Park Job Skills Training Center of Federation Employment and Guidance Service--the occupational guidance and rehabilitation arm of the Federation of Jewish Philanthropies of New York--and the Council of Jewish Organizations of Borough Park, one division of which was devoted to career guidance and job placement of qualified community residents. Both agencies had daily access to the religio/ethnic pool of which the Borough Park community was comprised, Jewish, Hispanic, and Italian. The City Department for the Aging agreed that the specific goals of the Title V Program were best served by recruitment of candidates from the indigenous population in the community contiguous to Maimonides Medical Center. Both the Council of Jewish Organizations of Borough Park and the local division of Federation Employment and Guidance Service were anxious to participate in this cooperative venture and agreed to advertise the program and counsel interested applicants from among their clientele.

The Borough Park Branch of Federation Employment and Guidance Service, because its primary mission concerned itself with employment counseling and job placement, became the instrumentality by which candidates indigenous to the community were apprised of the Title V opportunities, interviewed and screened as potential workers. As the

gross screening was accomplished at the Borough Park Branch of Federation and Guidance Service, candidates were referred to the Director of Social Services at Maimonides. These candidates had met income and age eligibility criteria.

The overall recruitment process consumed the months of August and September, and was rather involved because of the sensitive interface among the actors involved. For example, in each instance a candidate was first apprised of the job opportunity by the branch office of Federation Employment and Guidance Service, screened with respect to gross age and income eligibility criteria and provided general counseling to orient the candidate to the social role involved in gainful employment and then referred to the Director of Social Service for a more detailed screening and appraisal process involving job specific qualifications and capacity to function in a service delivery role within an institutional frame of reference. Once a candidate had been selected by the Director of Social Service, he or she was referred to the New York City Department for the Aging, the employer in fact, for certification of eligibility and orientation to the municipal employment system. In this multi-layered process, numerous candidates were rejected at one or another stage, or voluntarily withdrew from certification for various personal reasons.

D. OPERATIONALIZATION OF THE PROGRAM: SERVICE DELIVERY

By October 1, 1978, eight Senior Community Service Aides had been recruited from the community. On October 16, 1978, the first two Community Service Aides officially inaugurated their employment as Title V Senior Community Service Aides of the New York City Department for the Aging and were placed in the Social Service Department of Maimonides Medical Center to provide community outreach services to the elderly. The six remaining Senior Community Service Aides were added incrementally through the first week of November 1978, to allow adequate time for orientation and any institutional shock that might be experienced since none of the eight Senior Community Service Aides had ever worked in a hospital previously.

The orientation process itself was quite complex because of the nature of the practice setting. As each of the Senior Community Service Aides joined the staff, he or she was individually introduced to the Social Service staff. Arrangements were made through the Voluntary Office to have each worker cleared medically (given a physical examination, chest x-ray and a name plate and meal ticket redeemable at the hospital cafeteria). Subsequently, a general orientation to the hospital was held, including a guided tour of the physical plant, orientation film on the role of the volunteer in the hospital setting and notification of selected rules and regulations governing employer/employee relationships, as well as the relationship of staff to

patients and their families. Title V staff members were acquainted with office procedures attendant to completing paper work such as time sheets and applications required by the Department for the Aging, as well as procedures required by the Social Service Department. Reading material of a general nature was provided to orient the new Title V worker to the role of the Social Service Department and the professional social worker within the hospital setting. During the orientation phase which averaged two weeks per Title V worker, each had a personal interview with the immediate supervisor of the program, and an interview with the Director of the Department, at which time entry data, as well as the Title V worker's subjective impressions of the program, were recorded to provide one criterion measure of program effect and individual participant's growth when compared with a measure taken at a much later point in the program's history. During the orientation phase, emphasis was given to providing a relaxed milieu in which the Title V workers could become acculturated to the work environment without feeling any immediate pressure to produce, or become immediately involved in providing services. One of the process objectives during this orientation phase was to provide the ambiance in which the individual Title V workers could experience a sense of togetherness and come to identify themselves as not only individual workers, but more vital

to the interests of the program, as part of a unique service delivery unit.

Consequently, in the scheduling of individual work hours to provide a total of 160 Title V hours over the conventional work week, Tuesday was structured as a "common day" for all Title V workers to receive group supervision and become exposed to the group experience as a vehicle for problem resolution as well. One of the concepts which was employed in weekly "common day" group experience was "peer group supervision." Not only did the Title V workers receive individual supervision in the person of the Program Supervisor, but were exposed to peer group supervision of their volunteer co-workers--the Neighborhood Resources for the Aging Program members who had been piloting community outreach services for more than a decade--under the auspices of the Social Service Department.

The group structure already existed into which the new Title V Program could be integrated. A weekly case conference had been the pattern in providing supervision of the pilot Neighborhood Resources for the Aging Volunteer Program. The two programs were in effect combined, resulting in a combined service delivery structure totaling fourteen persons, with the older Neighborhood Resources for the Aging Volunteers serving in the role of tutors--consultants, if you will, to the new Senior Community Service Aides. In the early stages of the Title V Program, Neighborhood Resources

for the Aging Volunteers, who made home visits, did so accompanied by Title V workers. In so doing, the transportation routes and geographical housing patterns, social agency locations, etc. were learned first hand. Anxieties were reduced dramatically, as well as the time which the Title V worker would have consumed in learning, were it not for the channels of communication of expertise which were cultivated, and subsequently developed between the volunteer Neighborhood Resources for the Aging workers and the Senior Community Service Aide workers. The Neighborhood Resources for the Aging volunteers were able to share their experiences and pass on the benefit of relationships with key individuals in governmental agencies. The same craft developed by the Neighborhood Resources for the Aging volunteers, which had made them so effective in advocating for the entitlements of disadvantaged elderly, were passed on to the next programmatic generation of advocates for the rights of the elderly.

An informal reception for the Title V workers took place on November 18, 1978, to which leadership staff from the New York City Department for the Aging were invited, along with staff members of the Department of Social and Community Services, selected members from allied disciplines such as Home Care and the Geriatric Program in Community Mental Health and the members of the Neighborhood Resources for the Aging Volunteer Program. Title V workers were

introduced and welcomed individually, followed by brief welcoming statements for key staff members. The Title V Senior Community Service Aide Program was officially in place at Maimonides Medical Center.

The formal in-service training and education sequence was inaugurated on November 21, 1978. This sequence was distinct from the preliminary orientation period during which the Title V Senior Community Service Aides were largely getting their organizational bearings with respect to the environment in which they were to work.

As was mentioned earlier, both the Neighborhood Resources for the Aging Volunteers and the eight Senior Community Service Aides were exposed to in-service education in a group. From a theoretical point of view, the success of training was predicated upon the degree to which mutually supportive dynamics in the group process could be maximized to enable the eight individual Senior Community Service Aides to perceive each other--and the members of the companion Neighborhood Resources for the Aging Program--as resources in a collegial atmosphere, since in practice they would be called upon to act as a team. Since the format of in-service training depended upon an application of peer group supervision supported by social work supervision, the instructional units provided during the training sessions relied methodologically upon the use of analogies to explain concepts and principles. On the basis

of experience with the predecessor Neighborhood Resources for the Aging Program, it was empirically demonstrated that analogic was the more palatable reasoning process insofar as receptivity and feedback from the older adults was concerned. Didactic lectures were avoided, and informal discussion of both theoretical and practice principles presented was encouraged. Anecdotal and case study techniques were used to illustrate conceptual material. Two Social Service supervisors and the Director of Social Service were responsible for conducting the in-service training sequence. The duration of each training session averaged an hour and a half, twice a week. A series of field visits to strategic social agencies was planned to interdigitate with both in-house training sessions and patient care activities.*

The application of the peer group supervision concept produced many favorable unanticipated results. The new Senior Community Service Aides were able to provide real services sooner than if there had been no tutelage by the volunteer group. Although some of the Neighborhood Resources for the Aging volunteer group resented the idea of sharing their role with eight newcomers, they nevertheless communicated their experiences over the preceding decade, and ultimately "walked" the eight Senior Community Service Aides through the laborious mechanics of completing

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*The in-service evaluation and training content is detailed in the Appendix pp. 132-143.

application forms for Medicaid and other entitlements. Sharing the service delivery role also freed up considerable time which some members of the volunteer Neighborhood Resources for the Aging Program redirected to community resource development and public relations.

As was discussed earlier in the section on the pilot program, budgetary retrenchments which afflicted the Medical Center brought the Neighborhood Resources for the Aging Program to a close after ten years of volunteer service. Before the program closed, however, the Title V Senior Community Service Aides had benefited from six months of association with the Neighborhood Resources for the Aging Volunteers in a tutorial, yet collegial environment, and the legacy of service to the community had been bequeathed to the new program, despite the emotional trauma which accompanied the termination of the Neighborhood Resources for the Aging Program.

By the beginning of April 1979, the final phase of the program was ready to be inaugurated. This phase of the program was projected to run until May 15, 1979, following which recall of data for tabulation and statistical analysis would begin.

Because measurement of program effect upon recipients of service required administration of a questionnaire within the context of a structured interview in the recipient's home, the field interviewer, who was an undergraduate social

science student at Brooklyn College, began to collect data from a sample of the recipient population at the beginning of April 1979. By the beginning of May 1979, the student interviewer had initiated a total of fifty-seven interviews, forty of which were actually completed. By May 15th all data had been collected and recall began, using computer assisted techniques. The findings were subsequently analyzed and implications of the program for the various "publics" (e.g., recipients, participants, hospital, Department for the Aging, social workers) presented in the first draft of the final report in September of 1979.

VIII. EVALUATION

A. STUDY DESIGN

Programs that are conceived in such dynamic environments as health care provider settings, if they are to survive beyond the embryonic state, are dependent upon their relevance to service delivery. In a hospital setting like Maimonides, service to the patient population is the raison d'etre for all programs, and successful operationalization of any service delivery concept--in response to whatever valid needs exist--is a function of the interplay among many intervening variables such as administrative sanctions, staff cooperation and

accessibility to documentation to name but a few. The survival of any new program--aside from the primacy of the service delivery requirements--is equally dependent upon the extent to which that service delivery potential can be evaluated in terms of progress toward realization of intended effects or objectives.[40] Because of the compromises dictated by such practical considerations as mentioned above, new programs may tend to assume some of the institutionalized patterns of the parent organization. Such was the case when it came to selecting a study design or general approach to the collection and analysis of data for the Senior Community Service Aide Program. The objectives of the program for all practical purposes, determined the choice of study design. While the approach used for the Senior Community Service Aide Program did not conform to any established research design, such as a classic pre-test--post-test design, longitudinal study design, or experimental design, if one were to attempt to classify the approach used, it would probably most closely resemble the one-shot case study with observations and measurements of the program made, with one exception, after the fact.[41] At the time the Senior Community Service Aide Program was implemented, there were no analogous programs

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[40]Suchman, p. 91.

[41]Suchman, p. 93.

of comparable size or scope with which to compare. Moreover it was inappropriate to construct control groups in a hospital milieu to insure that realization of objectives were due to the effects of the program; consequently, much of the favorable evidence supporting the effectiveness of the program is testimonial in nature. Nevertheless, the measurements taken were faithful to the objectives in that they addressed specific components of the program, such as whether or not the program delivered quantifiable services and provided a viable employment opportunity and demonstration of the role of part-time, paid, para-professional extender of hospital based social services.

As important as defining the study design program, is the issue of defining objectives and the most relevant measures that will specify a program's success or movement toward achieving its objectives. It is important to specify program input variables which refer largely to the organizational context in which the program takes place and the predictable eligibility criteria for participation in the program.

Analysis of intervening variables and conditions which detail ongoing processes within the program are vital to the assessment of any action program. Finally, the differential effects of the program and selection of indices of program objectives must be addressed.[42]

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[42] Suchman, p. 115.

The Senior Community Service Aide Program is essentially a people-oriented program; that is, the program is comprised of people: (1) Who are assigned a specific role in order that they may provide a specific set of services to a specific clientele; and (2) Who in the process of providing that service, are demonstrating the viability of a new role, that of a paid part-time, professional extender of hospital based social services. The objectives of the Senior Community Service Aide Program are twofold:

1. Provide specific supportive services to patients of the Medical Center and contiguous community and evaluate the effects of these services upon recipients.
2. Demonstrate the viability of a new role (Senior Community Service Aide) as a paid, part-time, para-professional extender of hospital based social services, and evaluate the effects of this role upon the participants hired for these positions.

B. LONG RANGE GOALS

The services of the Senior Community Service Aide should make it possible to delegate responsibility for many of the standardized procedures, thereby enabling the

professional worker to meet emergency needs more effectively because of greater freedom from responsibility for unavoidable administrative contingencies. The time thus made available to the social worker should be used also for increased case work services, greater participation in joint planning and consultation with medical staff, expanded teaching responsibilities and numerous other activities which are part of the professional worker's function in a hospital social service department.

The use of Senior Community Service Aides should strengthen a trend already apparent in the development of many hospital programs--that of "humanizing" its relationship with the community, exemplified by a more personalized approach in instances where friendly, supportive or recreational services might supplement the overall service delivery structure.

The Senior Community Service Aide Program ought to provide a more effective way of interpreting social work to the community. The Senior Community Service Aide's acquaintance with social work settings, use of techniques, and familarity with many of the social worker's tools, such as interviewing, recording, statistics, and supervision, might result in a appreciation of their necessity and might lead to an understanding of "why social work costs so much."

The Senior Community Service Aide's knowledge should lead to a keener awareness of the less obvious phases of

social work and health care and the relationships of both, within the social welfare structure of the community. The increased acquaintance with, and appreciation of the preventative aspects of social work practice and the interrelationship of social, economic and emotional factors with physical and mental health, should also be contributions to community understanding and support for the goals of social work.

The Senior Community Service Aide's heightened appreciation of social work should help to remove the esoteric connotation surrounding social work which continues to be an obstacle in communication between professional and special interest groups and, within those groups, help to broaden the base of popular understanding of the meaning and purpose of social work.

To the professional worker, the Senior Community Service Aide should bring greater consciousness of method and objectives of a paid, part-time work experience within a hospital setting. As a result, the social worker will be challenged to think more clearly about function and to use different criteria when evaluating and determining the services in which generic skills could be more effectively applied.

C. CRITERION MEASURES OF EFFECT

In order to measure the effects of program's objectives,

specific, observable, operational indices were developed to measure the degree to which each of the objectives was achieved. The long range goals of the program were not measurable within the seven month time frame of the program.

The Senior Community Service Aide Program, in the main, seeks to have its effect upon persons serviced. As such, it is a client or consumer oriented program as opposed to seeking to modify agency response or alter public opinion in some way. While these latter effects can be considered secondary, the primary effect upon which the program will rise or fall is the production of a tangible product in the form of services that will be of immediate benefit to the target population. The generation of a new service, therefore, such as providing relation therapy to an elderly shut-in, which did not previously exist in the precise form in which the program generates such a service, constitutes an illustration of an intended effect of this program and its proximate measure would consist in the systematic tabulation or enumeration of every unit of such service provided in response to a corresponding need in the client. There are eight activities--operationalizations of the program's objectives (specific units of activity such as friendly visiting) which are expressed as either direct services to patients or as supporting services. The Direct Services are:

1. Conduct friendly visits to in-patients and

homebound patients who have limited or no family supports; to read to, to talk with, etc.

2. Visit nursing homes or other residential care community facilities to ease the impersonal nature of group care by developing a neighborly, friendly relationship that may contribute to patient's return to the community.
3. Escort elderly patients from hospital to home or from home to clinic or hospital, or other facilities.
4. Review financial situation to determine eligibility for comprehensive medical, socialization and chore services for patients; complete Medicaid applications and process them at the central Medicaid Office, for senior citizens who are homebound or unable to travel.
5. Assist patients and family members with paper work attendant to referrals and/or applications for Supplementary Security Income, food stamps, Meals on Wheels, Title XX--Homemaker/Housekeeper, Legal Aid services, housing, mental health services; accompany patients to agencies and advocate for entitlements.

Supportive Services include:

6. Attend and participate in regular sessions of

the weekly Geriatric Clinic and assist physicians, nurses and social workers in interpreting needs of elderly patients who have special needs, e.g., patients with hip fractures, diabetes, cataracts, mal-nourishment, etc.

7. Help monitor a patient's health status, following hospitalization, obviating the necessity for readmission for lack of adequate supportive services to help maintain the patient in his home.
8. Actively engage or otherwise enlist support of community residents, civic, social and ethnic groups, political clubs, churches, synagogues, fraternal and philanthropic organizations; become involved in the plight of the elderly and recommend remediation via legislative channels.

D. PROCESS OF DATA COLLECTION

Inasmuch as the focus of the Senior Community Service Aide Program was service oriented, it was considered important to not only count the number of new services the program generated, but discover something about identifying characteristics of the population. Therefore, a data entry survey (a copy of which is included in the Appendix p. 147)

was obtained for every recipient of service. In addition, a referral card was completed for each recipient of service, specifying the name of patient, age, address, telephone number, referral source, presenting problem and a space for a brief narrative on any individual circumstances bearing on the task. As the process of service delivery unfolded, daily activity was recorded on the Senior Community Service Aide statistical worksheet as an indicator of the extent to which the new role was being operationalized. Entries from the daily statistical worksheet were coded to represent such key variables as presenting problem modality, site of service delivery, actual services provided and areas for follow-up. In combination with the demographic data, the daily statistical worksheet made possible the delineation of key social health status variables at time of referral in contrast with services actually provided by the Senior Community Service Aide. Finally, those problem areas that remained unresolved or required long-range follow-up at time of termination of service were recorded by the Senior Community Service Aides. The daily statistical worksheet and patient data profile were intended to provide the basis upon which the program success in providing a real service to patients could be evaluated. Ongoing monitoring of the patient data profiles and the daily statistical worksheets was also intended to provide feedback to correct program deficiencies and help contend with unforeseen

circumstances; to function as a quality control vehicle for supervisory purposes and to insure compliance with evaluation requirements of the New York City Department for the Aging.

If the patient data survey and the daily statistical worksheets could be construed as measures of the extent to which the Senior Community Service Aide Program generated a new service, the subjective dimensions or what the recipient population thought and felt about the program, represented an equally valid, if not more relevant, measure of the program's efficacy. The instrumentality developed to measure this dimension was an open-ended questionnaire administered through the vehicle of a structured interview intended to be administered in the recipient's home. Many of the questions posed to recipients were designed to elicit responses predominantly in areas related to their feelings about the usefulness and importance of the service provided by the Senior Community Service Aide.

The second part of the questionnaire was intended to solicit suggestions about improving the service delivery format and scope of the Community Service Aide Program. All interviews were conducted by a Brooklyn College student majoring in the social sciences who worked approximately two afternoons per week under the supervision of the Director of Social Services. To prepare for the interviews, role playing was utilized to familiarize the student with both the form and structure of the questionnaire, and the

parameters in which the student would have latitude to interpret or explain the intent of a particular question to a recipient without diminishing the validity and reliability of the instrument. For example, one of the questions related to what importance--if any--the services provided by the Senior Community Service Aide had in improving the quality of life for recipients. Inasmuch as "quality of life" might be difficult to respond to, the student interviewer was given the latitude of substituting a synonym or explanation which might be more within the ethnic "weltanschauung" of the individual, in the interest of soliciting some response rather than no response at all. The student's latitude, however, was limited to specific circumstances, with the understanding that when an interpretation or clarification was applied, it would be standardized for all recipients who had a similar problem in understanding a question. Telephone appointments were always made with recipients beforehand, and the same explanation was provided as to the purpose of the interview and questionnaire at the time appointments were made. At no time did the student interviewer ever formally meet or discuss her role with the Senior Community Service Aides themselves. The eight Senior Community Service Aides were apprised of the fact that the program was being evaluated, in general terms, as an ongoing condition for continued participation in federal funding for employment programs

administered through the New York City Department for the Aging. At no time, however, were the eight Senior Community Service Aides aware of the specifics of the methodology being applied to evaluate programmatic effects.

The mechanics of drawing the sample for this universe involved random selection of an equal number of cases from each of the eight Senior Community Service Aides. A sample of fifty-eight recipients was selected from a total recipient population of approximately five-hundred recipients at the end of March, 1979. It was predetermined that each sampled recipient would be contacted a total of three times, in the event that the initial attempt to schedule an interview was unsuccessful. If, for some reason, the recipient could not or would not respond, the interviewer was instructed not to take the first "no" as final, but to make every effort to engage the recipient in reconsideration of participating in the interview process.

The final number interviewed was forty. Options to schedule the interview on the hospital campus, coinciding with a clinic visit or, as a last resort, soliciting information over the telephone, were made available at the recipient's behest if it became apparent to the interviewer that the alternative was no response whatever. Sixty-six percent of the recipients were interviewed in their own homes. Virtually all interviews were person-to-person as opposed to telephone or letter. Since the student

interviewer was reimbursed for the costs of traveling to the home of recipients and for the costs of telephone calls made for the purpose of scheduling appointments, a good deal of flexibility was possible since the appointments could be made from the home of the interviewer, reducing time expenditures which would have been involved in traveling to and from the hospital campus. By the same reasoning, the possibility of contamination was minimized since opportunities for interaction with the Senior Community Service Aides were greatly reduced. The student interviewer arranged her first appointments with the recipients on March 28, 1979. A projected date for terminating this evaluative phase was set for May 15, 1979. Since the date of beginning service delivery and data collection was October 15, 1978, the total time frame in which the evaluative research component of the program was conducted spanned seven months.

Another objective of the Senior Community Service Aide Program was to evaluate the impact of the program upon the eight Senior Community Service Aides themselves. This objective addressed the critical dimension of role viability from the perspective of the actual program participants. There were several criterion measures of effect, both of a formative and summative nature, which were applied. One issue here was: Did this program provide gainful employment over a substantial period of time for

the eight Senior Community Service Aides? (Employment, of course, includes all of the attendant fruits of remunerative labor, e.g., fringe benefits such as sick-leave, vacation, holidays, pension, workmen's compensation, etc.) Above and beyond the payment was the related question of job satisfaction. In other words, did the pay check and fringe benefits, plus the experience of working in a hospital environment, engender job satisfaction, a sense of worth and accomplishment, as contrasted with the preemployment period prior to joining the Senior Community Service Aide Program. At the very outset of the program each enrollee was asked to complete a basic face sheet, from which a work profile was created for each program participant. In addition to vital statistics, each program participant was asked to complete a brief questionnaire at time of formal acceptance in the program. This questionnaire posed six open-ended questions to assess, to some degree, the expectations regarding the performance of the new role and, in general, to determine the expectations of the eight program participants in terms of what they hoped to achieve as Senior Community Service Aides. The intent was to use this information as a pre-test measure which could be contrasted some seven months later with data from a program participant survey which would attempt to measure in greater depth the extent to which each of the Senior Community Service Aides felt that the program had affected their lives. They were asked to describe or

specify areas of growth, interest, disinterest, application of job skills, etc. This measure taken at the end of the research time frame of seven months would provide a criterion measure of effect or outcome in terms of the subjective perception of the program participants themselves. Ongoing or process measures of program effect were taken at various stages in the program's history. For example, site evaluations by the New York City Department for the Aging were conducted; two progress reports, at three month intervals, were submitted to the New York City Department for the Aging, documenting the categories and numbers of services being provided, and ongoing supervision on both an individual and group level provided opportunities to assess the growth process and draw inferences about role viability.

IX. FINDINGS

A. SERVICE DELIVERY

One objective of the Senior Community Service Aide Program was to provide a tangible service which would be of benefit to the target population, primarily the indigent elderly. Two criterion measures were used to assess the degree to which the service delivery objective was achieved: 1) Tabulation of new services generated by the program to corresponding needs in the recipient population; and

2) A recipient survey which was designed to sample forty recipients (five for each of the eight aides) as to their satisfaction or dissatisfaction with the services provided for them. Two instruments were designed to measure the degree to which the program achieved success in meeting this objective. The first instrument consisted of two components: 1) A data entry survey on which was recorded selected bits of demographic information for each of the five-hundred and seventeen recipients of service, for the purpose of identifying and enlarging salient descriptive characteristics of the recipient population. 2) The second component of the first instrument consisted of a daily statistical tally sheet on which was recorded the following bits of information: source of referral, problem areas as identified by the Senior Community Service Aides, the environment in which the service was provided, the method by which the service was provided, the specific services provided and, finally, areas of follow-up as identified by the Senior Aides. The demographic data that were recorded included the following information: age, sex, marital status, religion, housing information, employment status, average monthly income, source of income, recipient's medical resources at time of referral, medical needs as identified by the Senior Community Service Aides, and, finally, recipient's perception of their own health status at time of referral. Both components of the first instrument,

namely, the daily statistical tally sheet and the recipient data entry sheet are considered primary source documents and copies are included in the Appendix. From these primary source documents, the demographic and statistical data were coded and transferred to computer data cards. The computer program which was created facilitated tabulation of both demographic and service data which are presented in the following tables. Table I addresses key selected demographic data about the total recipient population. Table II deals with the second part of the first instrument, namely a tabulation of daily statistical activities which provide the basis for arriving at a determination about service delivery capability and work productivity in relation to achieving the primary objective of the program. Tables III and IV present a similar demographic and statistical format except that these figures apply only to the sample of forty recipients who were interviewed. Tables III and IV are presented in order to provide some basis for comparison of the sample with the total recipient population. In those cases where data is missing, the reason given usually referred to the fact that the recipient's health status was such that he or she could not or did not remember an event, circumstance or historical fact.

TABLE I

SELECTED DEMOGRAPHIC CHARACTERISTICS
OF TOTAL CLIENT POPULATION

CATEGORY		NUMBER
SEX		
Men		130
Women		387
AGE		
Men	40-50	17
Women	40-50	29
Men	51-60	10
Women	51-60	42
Men	61-70	26
Women	61-70	91
Men	70+	77
Women	70+	222
Data Missing		3
MARITAL STATUS		
Single		60
Married		80
Widowed		336
Divorced		22
Separated		4
Data Missing		15
RELIGION		
Jewish		261
Catholic		200
Protestant		19
Other		4
Data Missing		33
CHURCH/SYNAGOGUE PARTICIPATION		
Yes		174
No		215
Data Missing		128
HOUSING STATUS		
Own		43
Rent		426
Data Missing		48

TABLE I. (Continued)

CATEGORY	NUMBER
OTHERS IN HOME	
Yes	202
No	243
Data Missing	72
OTHERS IN HOME RELATED	
Yes	198
No	4
Data Missing	315
EMPLOYMENT STATUS	
Unemployed	463
Part-Time	6
Full-Time	4
Self-Employed	0
Data Missing	44
OCCUPATIONAL STATUS	
Professional	10
Skilled Labor	6
Business	4
Clerical	5
Data Missing	492
MEDIAN MONTHLY INCOME OF RECIPIENTS	$283.53
INCOME SOURCES	
OASI	324
OASI + Pub. Assist.	35
OASI + SSI	45
Pub. Assist.	26
Pub. Assist. + SSI	13
Pension	6
Data Missing	68
RECIPIENT'S PERSONAL MEDICAL RESOURCES AT TIME OF REFERRAL*	
Medicaid	235
Medicare	301
Private Insurance	15
B/C-B/S	48

*Some recipients have more than one medical resource.

TABLE I. (Continued)

CATEGORY	NUMBER
RECIPIENT'S MEDICAL CARE	
Private M.D.	103
Clinic	315
Data Missing	99
MEDICAL NEEDS AT TIME OF REFERRAL*	
Medicaid	248
Medicare	110
Private Insurance	17
M.D.	20
Nursing Care	44
Medicines	103
Medical Aides & Appliances	32
Transportation	77
Hospitalization	26
Homemaker	73
Home Health Aides	47
Other Medical Needs (e.g., assist with extended care facility placement, advise regard to personal or environment hygiene)	123
RECIPIENT'S PERCEPTION OF HEALTH STATUS AT TIME OF REFERRAL	
Good	27
Fair	167
Poor	284
Data Missing	39

*Most recipients had more than one medical need identified.

TABLE II

SERVICE CHARACTERISTICS

CATEGORY	NUMBER
SOURCE OF REFERRAL	
Self	47
Agency	416
Nurse	8
M.D.	3
Neighbor	8
Data Missing	35
PROBLEM AREAS AS INDICATED BY SENIOR COMMUNITY SERVICE AIDES*	
Financial Problem	165
Health Problem	354
Mental Health Problem	34
Nutritional Entitlements	24
Governmental Entitlements	124
Legal Problem	3
Housing Problem	4
Family Relations Problem	11
Social Recreational Problem	65
Escort Problem	153
Other (e.g., evaluate living arrangements, locate relatives, act as interpreter, determine proper address, shopping baby-sitting)	135
LOCALE (Service Delivery Environment)	
Home	341
Community	15
Social Agency	71
Hospital	44
Clinic	46
INTERVIEW METHOD	
In Person	513
By Letter	-
By Telephone	3
Data Missing	1

*Most recipients have more than one problem area identified.

TABLE II. (Continued)

CATEGORY	NUMBER
SPECIFIC SERVICES PROVIDED*	
Relationship Therapy	178
Agency Referral for Social Services...	84
Assistance with Government Entitlements	197
Assistance with Other Health Problems.	108
Shopping/Chore Services	110
Information Services	25
Child Care Services	10
Outreach/Preventative Services	97
Assistance in Helping Patients Use Medical Facilities	132
FOLLOW-UP AREAS AS IDENTIFIED BY THE SENIOR COMMUNITY SERVICE AIDES**	
Financial Problems	134
Health Problems	295
Mental Health Problems	29
Nutritional Entitlements	26
Governmental Entitlements	112
Legal Problems	8
Housing Problems	4
Family Relation Problems	15
Social/Recreational Problems	58
Escort Problems	138
Other (e.g., ongoing friendly visits, advocacy situtations, shopping services)	107

*Most recipients received more than one service.

**Most recipients have more than one area for follow-up identified.

TABLE III

SELECTED DEMOGRAPHIC CHARACTERISTICS OF SURVEY SAMPLE

CATEGORY		NUMBER
SEX		
Men		6
Women		34
AGE		
Men	40-50	0
Women	40-50	2
Men	51-60	0
Women	51-60	9
Men	61-70	1
Women	61-70	6
Men	70+	5
Women	70+	17
MARITAL STATUS		
Single		3
Married		8
Widowed		24
Divorced		3
Separated		1
Data Missing		1
RELIGION		
Jewish		25
Catholic		10
Protestant		2
Other		2
Data Missing		1
CHURCH/SYNAGOGUE PARTICIPATION		
Yes		15
No		15
Data Missing		10
HOUSING STATUS		
Own		3
Rent		31
Data Missing		6

TABLE III (Continued)

CATEGORY	NUMBER
OTHERS IN HOME	
Yes	18
No	18
Data Missing	4
OTHERS IN HOME RELATED	
Yes	16
No	2
Data Missing	22
EMPLOYMENT STATUS	
Unemployed	38
Part-Time	1
Full-Time	0
Self-Employed	0
Data Missing	1
OCCUPATIONAL STATUS	
Professional	1
Skilled Labor	1
Business	1
Clerical	0
Data Missing	37
MEDIAN MONTHLY INCOME OF RECIPIENTS	$269.25
INCOME SOURCES	
OASI	26
OASI + Pub. Assist	4
OASI + SSI	2
Public Assist	2
Public Assist. + SSI	1
Pension	0
Data Missing	5
RECIPIENT'S PERSONAL MEDICAL RESOURCES AT TIME OF REFERRAL*	
Medicaid	20
Medicare	18
Priviate Insurance	1
B/C-B/S	6

*Some recipients have more than one medical resource.

TABLE III (Continued)

CATEGORY	NUMBER
RECIPIENT'S MEDICAL CARE	
Private M.D.	11
Clinic	27
Data Missing	2
MEDICAL NEEDS AT TIME OF REFERRAL*	
Medicaid	16
Medicare	4
Private Insurance	0
M.D.	3
Nursing Care	4
Medicines	11
Medical Aides and Appliances	3
Transportation	4
Hospitalization	0
Homemaker	4
Home Health Aides	3
Other Medical Needs (As in Table I)	8
RECIPIENT'S PERCEPTION OF HEALTH STATUS AT TIME OF REFERRAL	
Good	3
Fair	13
Poor	22
Data Missing	2

*Most recipients had more than one medical need identified.

TABLE IV

SERVICE CHARACTERISTICS FOR SAMPLE

CATEGORY	NUMBER
SOURCE OF REFERRAL	
Self	1
Agency	37
Nurse	0
M.D.	0
Neighbor	1
Data Missing	1
PROBLEMS AS INDICATED BY SENIOR COMMUNITY SERVICE AIDES*	
Financial Problem	17
Health Problem	24
Mental Health Problem	4
Nutritional Entitlements	4
Governmental Entitlements	11
Legal Problem	1
Housing Problem	1
Family Relations Problem	0
Social Recreational Problem	7
Escort Problem	12
Other (As in Table II)	7
LOCALE (Service Delivery Environment)	
Home	24
Community	1
Social Agency	3
Hospital	8
Clinic	4
INTERVIEW METHOD	
In Person	40
By Letter	0
By Phone	0
Data Missing	0

*Most recipients have more than one problem area identified.

TABLE IV. (Continued)

CATEGORY	NUMBER
SPECIFIC SERVICES PROVIDED*	
Relationship Therapy	18
Agency Referral for Social Services	2
Assistance with Govt. Entitlements	12
Assistance with Other Health Problems	4
Shopping/Chore Services	8
Informational Services	5
Child Care Services	0
Outreach/Preventative Services	6
Assistance in Helping Patients Use Medical Facilities	12
FOLLOW-UP AREAS AS IDENTIFIED BY THE SENIOR COMMUNITY SERVICE AIDES**	
Financial Problems	13
Health Problems	20
Mental Health Problems	3
Nutritional Entitlements	3
Government Entitlements	10
Legal Problems	2
Housing Problems	0
Family Relation Problems	0
Social/Recreational Problems	6
Escort Problems	9
Other (As in Table II)	6

*Most recipients received more than one service.

**Most recipients have more than one area for follow-up identified.

To summarize the foregoing data, over a seven month period from October 15, 1978 to May 15, 1979, the services of the program reached three-hundred and eighty-seven women and one-hundred and thirty men, for a total of five-hundred and seventeen recipients. Forty-three percent of the recipients' population were women over seventy, and as might be expected in these advanced years, sixty-five percent of all recipients were widowed. About half the total population served were Jewish and another thirty-eight percent were Catholic.

Four-hundred and sixty-three recipients were unemployed. The median monthly income for the recipients was $283.53, corresponding closely to the Medicaid levels for a single person at $275.00 a month. Social Security accounted for the predominant source of income as would be expected in a population over sixty-five. More than half the population were receiving care in a clinic as opposed to being under the care of a private physician. The leading need for service centered around assistance in realizing health care entitlements, mostly Medicaid. Over half the population perceived their health status as poor.

Table II described provision of direct services to the client population. Four-hundred and sixteen of that population were referred by hospital based social workers or social workers based in community agencies. Health problems, requests for escort services and requests for

assistance in applying for and advocating for governmental entitlements accounted for the major presenting problems. Sixty-seven percent of the recipient population was seen in their own homes and virtually all recipients were seen in person by the Senior Community Service Aide. The leading tangible services provided were in the areas of friendly visiting (relationship therapy), assistance in helping patients use medical facilities (escort services), and advocacy for governmental entitlements. For areas, namely, finances, health, governmental entitlements and escort services were identified most frequently as requiring follow-up by the Senior Community Service Aides.

Tables III and IV address selected demographic characteristics of the sample and service activity respectively. The sample is substantially the same on the measured characteristics of the recipient population as a whole; so, it is reasonable to believe that the survey was applied to a group representative of the population.

A second criterion measure which was designed to assess the degree to which the program realized its service delivery objective consisted of the survey which was administered to a sample of forty recipients in their own homes, by structured interview. This measure, in contrast to the daily statistical tally which addressed a quantitative dimension, was developed to provide some way of exploring the qualitative aspects of the program by surveying consumer

satisfaction or dissatisfaction with the services provided. (A copy of the recipient's survey instrument is contained in the Appendix pp. 148-151.) A summary of the findings revealed that most recipients stated that after preliminary introductions and explanations by the aides as to their roles, they understood who the aides were, where they worked and what they did. Most of the first contacts with the Senior Community Service Aides came in the recipient's own homes a relatively short period of time before the date of the survey. In terms of the services provided, most recipients received help with their Medicaid entitlements, escort services or were the beneficiaries of friendly visits. Most of the recipients viewed these services as of great assistance to them, and regarded them as quite important in improving the quality of their lives. There was unanimity with regard to the feeling that the aides provided a needed service, were cordial in the process, and had not left any major problems unresolved. At the same time most recipients expressed a need for continuity of services to protect against unforeseen contingencies. All expressed the view that the program should be continued. Augmenting these findings, the student research assistant who administered the surveys, observed that a weakness of the Senior Community Service Aide Program was in the area of follow-up services after the initial contact. The student research assistant stated that in most of the homes

she visited it was not possible for her to address herself solely to the research role. Most of the recipients perceived her role as that of another helping agent similar to the Senior Community Service Aides, and they proceeded to pour out their problems. Fortunately, the student research assistant was able to provide service in the form of counseling and emotional support as well as direct referrals to community resources. The observations made by the student research assistant served to underscore the need for ongoing follow-up, the initiative for which would reside with the Senior Community Service Aides, under the guidance of the program supervisor as to whether follow-up would involve a home visit, periodic telephone reassurance, or some other appropriate outreach measure.

B. ROLE VIABILITY

A second objective of the program sought to demonstrate the viability of a new role for older adults--that of a paid, part-time para-professional extender of hospital based social services. This objective went to the heart of the program inasmuch as the legislation upon which the Senior Community Service Aide Program was predicated sought to develop new roles for adults in the retirement phase of life through the medium of subsidized employment in community services, especially directed towards meeting

some of the needs of the elderly. (A brief biographical sketch of each of the eight Senior Community Service Aides is outlined in the text on page 111.) In order to measure the viability of such a new role, the input of the aides themselves became desirable in terms of assessing the degree to which the participants felt the program had achieved the objective of providing them with a new role commensurate with their perception of what constituted a viable job opportunity for each of them. Consequently, a criterion measure was designed to assess the various needs and aspirations of the eight Senior Community Service Aides at the inception of the program in October 1978, and another was projected at the end of the research phase to permit comparison of original attitudes and motivation with perceptions based on experiences some eight months later. The Participant Survey was given to each aide to complete at the time of entry into the program. It posed six open-ended questions designed to provide the aides with an opportunity to define their motivation for entering the program, to describe in general terms their feelings and attitudes about working in a hospital setting with a patient population, and finally, state their personal aspirations for their participation in the program.

The survey which was completed at the end of the seven month research phase posed twelve questions of the open-ended variety, focused upon the Senior Community

Service Aides' feelings and perceptions about their new role as a paid, part-time para-professional extender of hospital based social services in the community. The questions covered three areas of impact: 1) The Community Service Aides themselves, 2) Patient recipients of service, and 3) Hospital social workers with whom the aides were associated. Another area of questioning had to do with the aides' comments about the adequacies and deficiencies of the in-service training component. A final area of questioning solicited comments on specific steps which could be taken to improve the program on the federal, municipal and hospital provider levels of sponsorship. The responses to both surveys will be summarized, emphasizing common themes expressed by the eight Senior Community Service Aides.

Six of the eight aides first heard about the Senior Community Service Aide Program and were subsequently recruited and screened for inclusion in the program under the auspices of Federation Employment and Guidance Service. Seven out of the eight Senior Community Service Aides cited the desire to help others as the primary interest in entering the program. Seven of eight had prior life experience with ill people and hospitals in general. Loneliness was seen as the most common problem associated with illness. A desire for social contacts and as a means to occupy time in a worthwhile endeavor was important to most of the aides. Five of eight expressed the hope or

belief that they would be able to help themselves in the process of helping others, and three aides specifically referred to their hopes to improve their financial situation as a result of working in the program.

With respect to the responses to the evaluation survey completed in May, 1979, all eight aides saw themselves as helping agents, addressing themselves to provision of direct services such as escorting patients, friendly visiting or helping patients obtain their health related entitlements. Seven of the eight aides felt that the program had constructively changed their lives, especially in terms of sensitizing them to the problems of the elderly, such as sickness and disability, and by helping them achieve a sense of proportion in terms of their own life problems.

Provision of direct services was the common response to the question dealing with the aide's relationship to patients. Seven aides felt that they were of greatest assistance to social workers in that their work had helped relieve some of the work load. Seven aides disliked paper work associated with the program. All eight aides felt that the program should be continued and expanded if possible, with increased governmental standardization of the program and greater attention given on all levels to publicizing the achievements of the program. In terms of training, seven of the eight aides felt that the training sequence had been adequate or superior and six felt that

the training component could be improved through an expanded program of visits to strategic social agencies in the community.

C. PROFESSIONAL STAFF

From a practical point of view, it was important to undertake an assessment of the Senior Community Service Aide role as it impacted upon hospital based social work practitioners because of the initial labor problem which brought the first incarnation of the program to an abrupt halt as it was originally conceived.* Argued under the rubric of violations of the collective bargaining agreement, other more generic issues were obscured by the union grievance machinery. Had there been no formal bargaining unit to represent the interests of hospital based social workers, it is this writer's belief that the issue of role prerogatives would still have surfaced, and if no delineation of role had taken place, the program in any form, would have eventually failed. Although an initial agreement was reached following formal recognition by the collective bargaining unit that the Senior Community Service Aide Program, as it had been reorganized, could proceed so long as it stayed within the agreed operating

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*This issue is discussed under the heading, "Program Redirection."

parameters, such recognition by no means constituted a commitment on the part of hospital based social workers to actively participate and enhance the success of the program. The objectives of the program were dependent not only upon the good will and open minds of hospital based social workers for their success, but required active support and cooperation if these objectives were to reach fruition. For example, the objective of providing new services to a client population depended predominantly upon referrals from hospital based social workers. Secondly, any demonstrations of role viability required not only referrals from social workers, but a willingness to share clinical material if the Senior Community Service Aides were indeed to extend the services beyond the institutional parameters, if not in an atmosphere of collegiality, at least as social agents would perform their roles with respect to obligations toward a mutual client population.

Consequently, in order to take cognizance of this critical dimension, a professional staff survey was constructed to elicit feed-back from professional social work staff who, at one time or another during the eight month period, entered into some professional interaction with the members of the Senior Community Service Aide Program.

At the conclusion of the evaluation period in May of 1979, a professional staff survey, (a copy of which is

included in the Appendix pp. 156-160) was distributed to twenty-three social workers at one of their regular meetings; all but one responded. In summary, the findings with respect to the responses of the social work staff yielded the following information:

The social work staff by and large, perceived the role of the Senior Community Service Aide in terms of three components:

1. Delivery of specific services.
2. As an advocate for the client.
3. As an adjunct or aide to the hospital based social worker.

Most staff felt that the Senior Community Services Aides had been adequately prepared for their roles by virtue of exposure to in-service training opportunities. The majority of social work staff utilized the Senior Community Service Aide Program as a resource to provide such specific services as were in keeping with their perception of the aide's role, e.g., helping patients become eligible for Medicaid entitlements. There was unanimity with respect to the social work staff's perception that counseling was a function of professional social workers, and not appropriate for the Senior Community Service Aides. Most of the social work staff expressed the view that the program had been integrated into the services offered by the Department of Social and Community Services. Most staff felt that the

services had been accepted by the clientele, families and social agencies in the community. Most staff were of the opinion that the program should be continued, and saw the program as effective in fulfilling its two objectives of providing needed service and providing a viable job opportunity for participants in the program.

X. DISCUSSION OF THE FINDINGS

A. IMPLICATIONS FOR THE RECIPIENT POPULATION

It is probable from ten year's experience with the Neighborhood Resources for the Aging Program, that had the Senior Community Service Aide Program not come along to carry on a program of services for the community's indigent elderly, the deprivations which would have been experienced by the aging would have resulted in incalculable losses both in human and monetary terms. Expressed in a more positive way, the Senior Community Service Aide Program seems to have made a great deal of difference in the lives of those recipients who were beneficiaries of the service. The recipients benefited, not just in terms of the quantifiable expressions of service that resulted in so many hundred friendly visits, escort services or Medicaid applications completed, but more importantly, in human terms of having the benefit of knowing that someone still cares after a

discharge from the hospital, after one has been discontinued from Home Care, when one attends clinic rather than receive more personal care on a nursing unit, or when one is placed in a residential care facility. It is unknown precisely how many elderly did not have to be hospitalized or rehospitalized because supportive services in the person of the Senior Community Service Aides were brought to the home. It is difficult to measure the therapeutic effect of a friendly visit or a reassuring telephone call, in terms of the impact on utilization of acute care facilities.

A sample of forty recipients interviewed in their own homes responded to questions about their feelings of satisfaction or dissatisfaction with the Senior Community Service Aide Program. The responses of those sampled were overwhelmingly positive; and this sample is probably representative since their demographic characteristics and service characteristics corresponded closely to those in the larger service population. It can be argued that positive responses from the elderly recipients sampled were to be expected in view of the dependent relationship the recipients had in relation to the Senior Community Service Aides. The mystique of the medical establishment undoubtedly exerted its influence on the recipients' responses. To conclude that the program was entirely effective or an overwhelming success must be tempered by an appreciation of the environmental framework in which the

questions were asked, and the frame of reference from which the recipients were responding. It is common knowledge that health care services constitute one of the paramount needs of the elderly, and more so if the elderly subsist on marginal incomes. It would be naive to expect total candor in response to any survey whose purpose was to evaluate the services of someone who had been helpful. This circumstance being what it is, however, the tempering impact of the situational context should not be construed as an apology for arriving at the conclusion that the program did succeed insofar as those recipients sampled were concerned, and was effective in having some impact on the quality of their lives. The mandate for follow-up registered by 70 percent of the recipients sampled, more than any other factor, is an indicator that outreach, preventative services such as the Senior Community Service Aide Program need to proliferate and be woven into the ongoing service delivery fabric of the health care establishment. Thus, the population whom they serve can come to rely upon and to expect hospital based community support services as an integral part of the health care package to which they have a right.

B. IMPLICATIONS FOR THE AIDES

While the Senior Community Service Aides successfully demonstrated the viability of their new role, there was

dissonance with respect to the conceptual material upon which was postulated the practicability of the new role. The concept of retirement and the three transitional roles which follow thereupon, discussed by Atchley, did not seem to obtain in the case of the eight aides.[43] In the first place, none of the aides had much of a work history from which to retire; there was little continuity in their working history. Most of the aides had not worked recently, with the exception of one aide who had worked intermittently as a taxi driver. For the most part, the kind of jobs held by the aides were not the kinds of jobs, (e.g., taxi driver, steno-typist, clerical work, bank teller, department store sales, etc.) which Atchley hypothesized psychological deprivations and difficult adjustments following retirement. At the time they joined the program all of the aides reported Social Security as their sole source of income. It is likely that all of the aides were motivated--at least in part--to join the program because they wanted and needed to supplement their incomes. All the aides were referred through the auspices of Federation Employment and Guidance Service--an employment agency. While there are references to a desire to help people and keep busy in a worthwhile endeavor, money was quite possibly the prime motivator for

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[43]Atchley, Adjustment to Loss of Job at Retirement, p. 42.

the aides to join the program. Indeed, before the program was six months old, one of the aides resigned to take a better paying job. (This person was replaced; the other seven aides remained for the duration of this study and continued to participate in the program six months later.) In the final evaluations, most of the aides recommended increased governmental subsidization and more working hours. Secondary gains, such as recapturing satisfaction reminiscent of a pre-retirement period, finding alternative solutions to personal problems through work with people, had their place in the motivational hierarchy of the aides; none of these, however, was a job substitute.

In the view of this writer, it is improbable that any of the aides would have been attracted to a volunteer experience such as the Neighborhood Resources for the Aging was, or S.E.R.V.E. is today.* Not only did the aides never have the luxury of volunteerism, but their prior life experiences were dissimilar to the traditional "retired person" who seeks out volunteer experiences in a hospital setting. The traditional role of volunteers in a hospital setting tends to focus on in-patient units, e.g., feeding disabled patients, reading to them, running errands for personnel, etc. The distinguishing characteristics of the Neighborhood Resources for the Aging Program was that its

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*Serve and Enrich Retirement through Volunteer Experience.

focus was community based. This focus would have been impossible even for this volunteer program had it not been for the fact that the hospital subsidized their travel expenses. The New York City Department for the Aging treats travel expenses of the aides as a legitimate, separate cost item in order that the salary which the aides receive for their work not be dissipated by transportation costs. The point is that without money, the program could not continue for the city nor for the aides.

The volunteer experience in the hospital setting conforms more to Atchley's conceptualization about adoption of post retirement roles.[44] That is, for the volunteer, previous life experiences to which were attached the positive value of psychological satisfaction have more potential to be replicated in an experience which does not depend for its success on remuneration. The implications for development of similar programs in other settings depends to a large extent on the willingness of the host agency to recognize the preeminence of money in operationalizing the role and accepting the fact that the program can stand on its own merits without apologizing for not having been a substitute for something that never was.

C. BIOGRAPHICAL PROFILES OF THE SENIOR COMMUNITY SERVICE AIDES

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[44] Ibid.

The first Senior Community Service Aide is a sixty-three year old widow, a resident of Brooklyn, who lives along. She had three years of high school. Her employment history includes work as a receptionist for the Telephone Company, a clerical position with an insurance company and a supervisory position with another insurance company. She had had not worked for ten years prior to accepting the position as Senior Community Service Aide and her only recent income prior to accepting this position was Social Security.

The second Senior Community Service Aide is a sixty-three year old woman, the widow of a rabbi, a resident of Brooklyn, who lives alone. She holds a Bachelor's degree and has completed graduate courses. She worked as an elementary school teacher and has special training in early childhood education. She last worked in 1972, and prior to taking the position as a Senior Community Service Aide, was living on Social Security.

The third Senior Community Service Aide is a widow in her sixties who resides with her son in Brooklyn. She completed three years of high school and worked in office settings and as a companion to the elderly. Prior to accepting the position of Senior Community Service Aide, she lived on Social Security benefits.

The fourth Senior Community Service Aide is a sixty-four year old widow, a resident of Brooklyn, who lives alone. She completed two years of high school and

previously worked as a salesclerk. Her only source of income prior to accepting the position was Social Security benefits.

The fifth Senior Community Service Aide is a sixty-three year old separated woman, a resident of Brooklyn, who lives with her son. She has a high school diploma and an employment history of various clerical positions in the banking and insurance industries. She had not worked for ten years prior to accepting the position as Senior Community Service Aide and had been living on Social Security benefits prior to accepting this position.

The sixth Senior Community Service Aide is a sixty-nine year old widow, a Brooklyn resident, who lives alone. She has a high school diploma and worked as a companion aide to the elderly. Prior to accepting the position of Senior Community Service Aide, she was living on Social Security benefits.

The seventh Senior Community Service Aide is a sixty-five year old married man, a resident of Brooklyn. He is a high school graduate who had worked as a taxi driver. Prior to accepting this position he maintained himself on Social Security and disability benefits.

The eighth Senior Community Service Aide is a sixty-five year old divorced man, a Brooklyn resident who lives alone. He has a high school diploma and is a business school graduate with some college courses completed. His prior

employment history included positions in merchandising and sales management. He lived on Social Security benefits prior to accepting the position of Senior Community Service Aide.

A composite picture of the eight Senior Community Service Aides presents many commonalities. All eight Aides were recruited from the Brooklyn community. All are between the ages of sixty and seventy. All had sporadic employment histories. All maintained themselves on Social Security benefits prior to accepting the position as Senior Community Service Aide. There are other commonalities; most of the group are widowed and living alone. Five of the aides are bilingual (language listed was Yiddish). The greatest dissimilarity occurred in terms of education where there was a range from two years of high school to courses taken toward a graduate degree. Only one aide had been recently employed (as a taxi driver) before the program. Six of the aides were referred to the program under the auspices of the Federation Employment and Guidance Service. One aide heard about the position through the Public Library and another aide through a publication of the Department of Labor.

D. IMPLICATIONS FOR PROFESSIONAL STAFF

Analysis of the results of the professional staff survey offers some interesting insights into whether the role

of the Senior Community Service Aide produced an effect upon the traditional role of the hospital based social worker. The instrument which was used to measure the degree to which any impact was felt in this area was the Professional Staff Survey, a copy of which is contained in the Appendix. As had already been mentioned, the emergence of the Senior Community Service Aide Program on the scene of the Maimonides Social Service Department produced a reaction from the staff, from the very beginning. At the time the Professional Staff Surveys were distributed to the social service staff, the volunteer Neighborhood Resources for the Aging Program had been disbanded after a decade of service due to a hospital wide budget retrenchment. Many social workers still felt threatened and uncomfortable with the role of paid para-professionals, despite the union's official position on the acceptability of the Senior Community Service Aide Program in relation to the bargaining unit position. It was because of this negative attitude on the part of the social service staff that the expectations for an acceptable response rate to the survey, not to mention favorable appraisal of the program, were minimal. Surprisingly enough, 95.6 percent of the surveys distributed to the social service staff were returned either wholly or partially completed. The nature of the responses themselves revealed that social service staff, in general, rose above their personal bias and concentrated on evaluating the

services of the program from a professional point of view. In this regard then, the results of the Professional Staff Survey provide another perspective based on the extent to which those closest to the eight Senior Community Service Aides regarded the viability of the role of paid, part-time extenders of hospital based social services, and assessed the impact on their own traditional roles as hospital based social workers.

All of the staff apparently understood the role of the Senior Community Service Aide, not so much in terms of their participation in the in-service training sessions, which were conducted for the benefit of the Senior Community Service Aides, but rather as an extension of the role of the Neighborhood Resources for the Aging volunteers. It is interesting to note in the responses that only once does a reference to salary occur in any of the remarks of the social work staff, and in that one connection, the connotation is positive since the social worker is referring to a greater motivation because of salary. While it is clear from the social workers' remarks that full integration of the Senior Community Service Aide Program with the service delivery structure of the Social Service Department has not yet been realized, more than half of staff, 55 percent, felt that the program was being integrated into the total package of service. The social work staff clearly delineated areas of competence in terms of provision of tangible services,

especially advocacy services related to helping the indigent elderly realize their Medicaid entitlements. There is equal clarity with respect to a concern that those traditional social work roles of counseling patients and families who need emotional support are areas in which Senior Community Service Aides do not enjoy competence, and moreover, are prohibited from entering. Other social work roles which were seen as areas in which the Senior Community Service Aides exhibited the least competence included follow-up and referral to community agencies. It is no coincidence that social work utilization of the program was seen in terms of those same areas of competence. The utilization of the volunteer Neighborhood Resources for the Aging Program had been along similar lines and yet, 25 percent of social work staff expressed the feeling that the Neighborhood Resources for the Aging Volunteer Program had been superior to the Senior Community Service Aide Program. Reasons cited included references to a deeper sense of commitment on the part of the volunteer program and more accessibility and flexibility. Indirectly, these comments can be linked to the paid status of the Senior Community Service Aide workers whose motivation certainly arises from money considerations and whose flexibility and accessibility were not the same as their volunteer predecessors. These comments seem to indicate that the paid status of the Senior Community Service Aide workers may have remained an

impediment to full integration of the program on the part of some social service staff, albeit a minority. A very important indicator of the effect of the Senior Community Service Aide role on the hospital based social worker was to be found in the statement by 68 percent of staff that the program had been effective in meeting objectives and providing a relevant community outreach service. (See question 14 of this survey). This response would suggest a positive impact on the role of the hospital based social worker. Still another indicator of positive role impact was the fact that half of the staff defined their relationship with the Senior Community Service Aides in positive terms. Another important indicator was to be found in response to the question which asked whether or not the Senior Community Service Aide Program should be continued, expanded or disbanded; 90 percent of staff felt that the program should either be continued or continued and expanded. The final question which solicited suggestions on how the program could be improved was answered by 89 percent of staff. While residual doubts about the program's future remain, and most social workers clearly delineated areas of role competence, it would appear that the majority of social work staff reached the conclusion that the Senior Community Service Aide Program had been effective in meeting its objectives and had a constructive impact upon their roles as hospital based social workers.

Strategies for replication of Title V Senior Community Service Aide Programs in similar settings will have to take into account the fact that no new role or program or services can be mandated by fiat. Whether or not traditional social work role prerogatives and generic issues of professional turf are framed in collective bargaining agreements, deployment of para-professional personnel must recognize the differences in educational background, professional experience, position and title. To pretend that these differentials do not exist, however well meaning the intent may be, is to court disaster and to preordain programmatic failure. The program at Maimonides worked in the final analysis because the professional social workers wanted it to work and provided the necessary support because of their conviction that the program's objectives had enough merit to stand alone. If professional social workers can identify a sense of professional commitment in their own roles which will inspire them to help their para-professional colleagues toward a mutual goal, the success of a Senior Community Service Aide Program is almost assured.

E. IMPLICATIONS FOR THE HOSPITAL

For Maimonides Medical Center, the Senior Community Service Aide Program assured a continuity of services for the aging population of the Borough Park community, as well

as patients within the hospital community itself. For a decade prior to the inauguration of the Senior Community Service Aide Program, its predecessor the Neighborhood Resources for the Aging Volunteer Program, had provided outreach services to the elderly. The impact of the gradual attrition of membership of the Neighborhood Resources for the Aging Program as a result of death and illness upon the indigent elderly of the community was lessened by the fact that the Senior Community Service Aide Program was able to pick up the cudgel without any serious disruption in continuity of services. Both the volume and nature of services provided by the Senior Community Service Aide Program corresponded to the output of the precursor voluntary program at the height of its performance. In particular, the proficiency which the Neighborhood Resources for the Aging Program had demonstrated with respect to helping patients realize their Medicaid entitlements, was equaled by the Senior Community Service Aide Program by the close of the seven month evaluation period. This service benefited the hospital in that patients who had not previously been covered by Medicaid, the costs of whose care the hospital was legally obliged to provide under the provisions of the Hill-Burton Act, became eligible for Medicaid by virtue of the intervention of the Senior Community Service Aides. What this meant is that the hospital could be reimbursed at the prevailing Medicaid

rate of $230. per day in-patient and $44. per day clinic rate. Not only can the Senior Community Service Aide Program be argued to be cost effective in terms of potentiating new revenues for the hospital, but the cost of running the program was largely absorbed by its sponsors, the New York City Department for the Aging. The hospital's contributions were essentially concerned with covering areas of training, giving supervision and administration of the program. In contrast, direct costs of running the voluntary Neighborhood Resources for the Aging Program amounted to approximately $9,000. per year. The Senior Community Service Aide Program provided the hospital with essentially one-hundred and sixty hours of free services per week. It is possible that the preventative outreach services of the Senior Community Service Aide Program served to forestall many tragic cases of unnecessary and costly hospitalizations and rehospitalizations due to social neglect, aggravating the health and mental health problems of the elderly. The program potentiated enormous savings in hospital revenue which could have been lost due to decertification by third party insurance carriers. Another not so obvious benefit which accrued to the hospital as a result of the Senior Community Service Aide Program was the precedent set by the union ruling in favor of permitting paid para-professionals to engage in adjunct social services within the hospital community. The precedent involved the

fact that for the first time the union permitted non-bargaining unit workers from another organizational auspice, receiving a lower schedule of pay, to work alongside members of the collective bargaining unit. The successful negotiating process and the spirit of cooperation between labor and management facilitated the development of guidelines which potentiated a savings in costly arbitration procedings for both parties and provided a model for replication in other departments of the hospital and in similar health care provider settings.

The public relations benefits which accrued to the favorable publicity from the Senior Community Service Aide Program cannot be over-estimated. The hospital's reputation for sensitivity to the problems and needs of the elderly was maintained and enhanced. The successful relationship between the governmental sponsors and the voluntary sector as represented by the hospital, added credibility to the hospital's reputation as hospitable to future governmental contracts and grants.

In summary, the Senior Community Service Aide Program was a boon to Maimonides Medical Center in that it demonstrated the viability of a concept established a decade earlier and did so on a much broader scale and in a way which proved less costly to the hospital than the volunteer experience.

F. IMPLICATIONS FOR GOVERNMENTAL SPONSORS

The United States Department of Labor and the New York City Department for the Aging defined a successful demonstration of Title V of the Older Americans Act, as a program predicated upon; (1) A successful provision of a work experience in which the older worker had the opportunity to learn new job skills; and (2) Insuring the provision of a quality service by the older worker through professional supervision focused on services for the aging. The Maimonides Senior Community Service Aide Program provided a successful demonstration in both areas. In terms of the first criterion, the in-service training experience which was provided at the outset of the program was instrumental in equipping the aides with rudimentary job skills needed in the satisfactory performance of their new roles.* The aides themselves later corroborated this impression in their responses to a survey which was completed at the end of the seven month evaluation.

In terms of the second criterion, the program delivered services whose focus was upon alleviating the problems of the indigent elderly.

At the time of the writing of this report, there was

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*A copy of the course outline for the in-service training sequence is included in the Appendix pp. 133-142.

only one other Title V Program in a voluntary hospital setting in New York City; that program was in the Bronx and of more modest proportions.

In an interview with the Program Coordinator of the New York City Department for the Aging, which took place on September 5, 1979, it was disclosed that New York City has never received its proper allocation of Title V job slots on the basis of population. There are 3,624 approved Title V job slots in New York State; based upon its population and poverty level, New York City is entitled to 1,573 job slots; however, the City has received only 675 approved positions, leaving a deficit of almost 900 positions to be filled. The successful experience of Maimonides Medical Center will provide support for replications of the Senior Community Service Aide Program concept in similar health care provider systems.

The favorable press coverage (copies of which are included in the Appendix) especially the interest and support of two area Congressman (see Appendix pp. 172-173) should enhance the credibility of the New York City Department for the Aging in terms of continued federal support and additional Title V job slots. The future of Title V programs lies in their ability to alleviate unemployment for a sizable number of older adults who might otherwise be required to rely on Public Assistance to supplement their incomes. The Maimonides model provided a successful

demonstration that the application of paid part-time extenders of social services within a voluntary hospital system is viable and warrants replication in similar settings.

G. SOCIO/ECONOMIC POLICY IMPLICATIONS

As has been discussed, the population for whom Title V programs are potentially helpful are those individuals who require supplementation of marginal incomes for whom the alternative for survival might amount to supplementary public assistance. The Title V program is not a time filler or a mood elevator for recently retired individuals who are attempting to resurrect socially and psychologically satisfying roles or activities enjoyed during their productive years. The question of retirement for most older workers is a voluntary one, and is governed by the following proposition: "Other things being equal, those people will choose retirement whose value of time used in alternative activities comes closest to their value of time used on the job."[45] The Title V program, on the basis of the Maimonides experience, did not turn out to be a program geared to

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[45] George S. Tolley and Richard V. Burkhauser, "Federal Economic Policy Toward the Elderly," Social Policy, Social Ethics, and the Aging Society Conference Proceedings, PB-263 519, 1976, p. 45.

retired individuals. What policy implications then govern the justification of programs for individuals who have not retired in the classic sense of the word? One way of looking at the socio/economic policy implications is to view programs like Title V as socio/economic vehicles of transfer of rights to consumption between those who are producing today and those who are currently consuming more than they produce. Every individual, first as a child, is a net consumer then a producer in adulthood, and after the close of the productive years, again a net consumer. The problem seems to be one of saving enough money during one's productive years to provide a sufficient income during one's later consumer years. One way of approaching this problem is to save enough money to purchase an adequate retirement annuity. Social Security is an example of an annuity, but with today's double digit inflation, this form of annuity alone will not even provide basic sustenance. If the individual cannot afford to retire on Social Security alone, he can continue working. In so doing, however, he may displace a younger worker in the market place. The policy question facing society is one of deciding how to equitably distribute the rights to consumption. The working individual, during his productive years, contributed to the gross national product by virtue of taxes which were invested in capital improvements which the individual may never have personally received during his life time. During these

productive years, the working individual consumes less than he produces. Some of these savings go into a fund, Social Security, to provide an adequate income for him after his productive years come to a close. In this sense he deserves his share of the fund because he has contributed to it. Today, however, more people live longer, the birth rate has dropped and the number of people in the productive years is dwindling, while at the same time the call on the social investment fund which we know as Social Security, is greater than ever. Either people will have to save more during their productive years by consuming less, or plan to work longer. The additional income to Social Security will come from increased taxes and contributions to annuity funds from private insurance. Given longer life spans and the need for more production, society should devise creative opportunities for productive work for its members living beyond traditional retirement ages. It would be counter-productive to increase retirement annuities without adding to the number of productive individuals contributing to the fund. Such creative job opportunities need not penalize the younger members of the labor force. Some of the possible options include:

1. Stepwise partial retirement.
2. Flexible hours as well as shorter hours.
3. Seasonal work.

4. Pay at less than "minimum wage" justified by lower productivity or semiphilanthropic tasks.
5. Tax free pay.
6. Reduction or elimination of "no-earnings" test for pensions.
7. Flexibility about where work is done (at home).[46]

The Title V Senior Community Service Aide Program is an example of the fourth option.

The aging have earned the right, and society has an ethical obligation to provide adequately for its older citizens. Social Security alone is not the answer. One solution lies in providing more options such as salaried or governmentally subsidized service activities illustrated by Title V job programs which provide opportunities to continue in the role of producer rather than consumer of goods and services.

XI CONCLUSIONS

In summary, the Senior Community Service Aide Program

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[46] James N. Morgan, "The Ethical Basis of the Economic Claims of the Elderly," Social Policy, Social Ethics, and the Aging Society Conference Proceedings, PB-263, 519, 1976, p. 68.

at Maimonides provided a successful demonstration of the viability of the role of paid part-time extender of hospital based social services. The program succeeded in generating new services to the target population--the indigent elderly--which were important to the recipients of service, monetarily beneficial for the institutional provider and met the statutory requirements of the governmental sponsor. Since the primary motivation of the aides for entering the program was to obtain employment to supplement their Social Security incomes, the successful demonstration of the new role does not necessarily imply that the Senior Community Service Aides could assume full-time, salaried positions within the Social Service Department of the hospital. While the content of the in-service training experience, together with the practical day-to-day experiences appeared to prepare the aides to function in the role of para-professional, no generalization can be made about the upward job mobility of the aides. This issue is a matter of concern for the New York City Department for the Aging inasmuch as the policy of the sponsor is to encourage host agencies to hire aides within appropriate job classifications. Replication of the Maimonides model in other hospital settings will remain the single most important indicator of the viability of deploying Title V funds to subsidize programs whose primary objectives are to provide both services for the elderly and also serve the under-employed older adult

through gainful employment in community services. The prospects for new public service job programs will probably expand by virtue of federal, state and municipal attempts to lessen the impact of unemployment on the economy. The Maimonides experience suggests that development of Title V Programs in hospital based social service departments is a valid, practicable and productive application of social work values, knowledge and techniques, and should be encouraged as a cost effective and professionally correct means of extending the scope of social services to consumers and potential users of health care services in the community.

By way of epilogue, I am happy to report three new programmatic developments in the Senior Community Service Aide Program: Firstly, the Aides completed a twelve week training seminar entitled: "The Consumer Ombudsman Program" made possible through a grant by HEW/OE, and administered by New York City Community College - Institute of Study for Older Adults - of the City University of New York. As a result, the Aides have been prepared to expand the scope of their outreach initiatives into three new areas: namely, Emergency Services, Out Patient Department, and identifying pediatric trauma victims with emphasis on service delivery and follow-up services. Secondly, a working manual of daily routines and procedures has been developed as a reference for managers of future hospital based Title V Programs, as well as a practical handbook for the Aides. Finally, the

National Council on Aging, together with the New York City Department for Aging, which administers Title V Programs on the local level, has begun to insist upon documentation by sponsoring agencies of efforts to place Title V Enrollees, in either full-time, salaried positions in the host agency, or appropriate jobs in the community. This attitude reflects the harsh realities of the job market, as well as the need to implement the primary objectives of the Title V Legislation--that is, to promote full-time employment opportunities for older adults living on marginal incomes. Subsidized employment is seen as the means to the end--never the end in itself. In other words, training provided by host agencies should facilitate entry into the job market. Consequently, all eight Aides have been encouraged to apply for full-time positions within the Medical Center. If, as a result, attrition in the Program occurs, new Title V participants will be enrolled for training. Whether or not the current cadre of Aides is prepared to surrender their subsidized roles, with their many fulfilling attributes, in favor of the higher salaries and benefits which accrue to full-time employment--only time will tell. The point is that the connective tissue is in place, potentiating the leap from unemployment to employment, which is the point at which theory and practice converge.

XII

APPENDIX

COURSE OUTLINE

IN-SERVICE TRAINING AND EDUCATION SEQUENCE

TITLE V SENIOR COMMUNITY SERVICE AIDE PROGRAM

PART I AN INTRODUCTION TO SOCIAL WORK

PRINCIPLES	DISCUSSION	PRACTICE
1. Medical Social Work a) Focuses upon the social needs and problems of individuals whose recovery necessitates care in hosp. or clinics.	1. a) Why people enter or do not enter hosp. to seek medical care. Fears, anxieties, mores, culture. What patient expects from hospitalization. What hosp. expects from patient. Adjustment to hosp. or clinic.	1a) Understand the needs of th patient for help with social problems, financial relationships, sharing, et
b) Is concerned with the social and health needs of the patient, patient's family, groups of patients, the community in which the patient lives, and the larger society.	b) Relationships between patient, family and community--expectations of each. Effects on healing process.	b) To help the patient understand that they are not alone in their illness. There is a family and a community. Involve them i planning.
c) Preventive & causative effects		
2. Functioning of the Medical Social Worker a) Understanding of the natural history of the disease process. Knowledge of social & psychological variables,	2. a) Disease processes--Cancer, Cardiac, Fx. Hips. etc. Relationships between illness & social and psychological aspects on the total patient.	2a) Understand the special needs of patients with various diagnoses. Limitations in activity, self-expression, special medical or rehab. needs, housing, diets.
b) Concern about the consequences of the illness in the social functioning of the patient & his family & for the personal and social variables that influence adjustment to the illness.	b) How illness effects the family, role changes, adjustment problems, etc.	b) Family may need financial assistance in applying for Medicaid, food stamps, public assistance. May need referral for budgetary counseling.
c) Helping with health planning--by assisting the individual in developing of personal resources.	c) Health Prevention-emphasis upon health & its fulfillment rather than disease.	
3. Social Casework a) Problem solving process 1. Establishment of a good working relationship between caseworker and client--involving warmth, objectivity, trust & sharing of work.	The helping & enabling Process. Helping others to help themselves. Understanding the importance & uniqueness of the individual.	Speak to and comfort patient--activities which will make for establishment of a meaningful relationship.

PRINCIPLES	DISCUSSION	PRACTICE
3. A) 2. Social diagnosis-parameters of problem defined and resources for solving the problem determined.	Facts which help us to understand patient. What is told to us. How it is told. Interpretation of facts.	Support him when necessary. Be a good listener. Understand his meaning. Get the facts. Be able to present the meaning of facts to you.
B) Principles of Casework 1. Self-determination 2. Acceptance 3. Individuality 4. Confidentiality 5. Non-judgmental attitudes 6. Controlled involvement 7. Purposefulment.	What these principles mean to you. Self assessment. Awareness of ability to accept these principles.	Incorporation of principles in the helping process. Self-awareness;
C) Treatment Help client "work over" his emotional reaction to the situation.	Self expression--client's interpretation & understanding of life experiences. Counseling.	Allow client to talk, but under stand what he is saying. Relationship therapy (Friendly visits)
4. Social Group Work A systematic process of guiding social and group reaction to achieve specific goals. Clients are helped in, and with group, toward better social functioning. Through the group experience practice, relationships, may be formed which aid individuals in their social maturation.	Patient's groups. Staff groups. How we achieve goals of better social functioning.	Our Tuesday morning meetings Social Wkrs. Unit Meetings. Geriatric Clinic Meetings. Group Community Meetings.
5. Community Organization To alter the environment in order to prevent the onset or reoccurence of disease or injury & to minimize disability. Community efforts are directed toward the alleviation of conditions that contribute directly or indirectly to the occurence of disease among groups of people.	Relationship between the community, medical settings, and illness. Environment/community changes. to alleviate health problems. role of community in meeting medical needs.	Develop a resource file. Use Directory of Social & Health Agencies of N.Y.C. Use Geriatric Guide to E.F.C.'s & Health Services. Community Council of Social Agencies Reviews.

PRINCIPLES	DISCUSSION	PRACTICE
6. Education Learning to help others. Increasing fount of knowledge. Sharpening and development of skills. Theories learned from practice. Consultant - opinions & advice given when requested.	Why is ongoing education necessary? Teaching others and learning from others. Our role as consultants.	Exchange of information with staff and others. 1. On one-to-one basis with M.D R.N., or other staff. 2. In a group--this meeting, un meeting, Tues. morn. mtg. visiting agencies, etc. Giving information as reques by others.
7. Crisis Intervention A personal catastrophe that actually interferes with the patient's ability to function adequately.	What is a crisis? Individual responses to a crisis. Role of interviewer.	Know how to deal with: Emergency needs for medical treatment, transportation, medicine, food, money, housing, E.C.F.
8. TITLE IX PROGRAM Service to special groups-- Outreach, medical needs,of aged, advocacy.	Title IX Social Work Role.	Duties of Title IX S.C.S.A. -shopping -child care -escoring -information -friendly visits-referrals -negotiation of systems & agencies. -applications for financial & medical needs.
9. Supervision Legal requirement Educational request Teaching role Administrative role Protection to worker and client.	The supervisory process of this program. Ongoing education	Responsibility of worker to supv Keep supvsr. informed Report as scheduled Sharing of responsibility of car to present development of overwhelming situations. Exercise freedom of expression.

PART II PATIENT AND HIS FAMILY

PRINCIPLES	DISCUSSION	PRACTICE
1. The patient is a whole, complex entity with specific medical & emotional needs.	A. Concept of patient as a whole--the complexities of the individual with specific needs. The role of the patient--Ideally; 1.To want to get well 2. Participate in the healing process. 3. Follow instructions, follow therapeutic regimen--take medicines, follow diet, but in reality, the role of the patient may be just the opposite	Understand the relati ship between physical emotional needs. See total patient.
2. The patient has a role to play in the healing process which is effected by his belief, attitude and judgment.	B. Meaning of illness--cultural effects of the ethnic or class group of which patient is part. Understanding of patient's value system as derived from social class, ethnic group. 1. Not his fault 2. Exempt from normal responsibilities. 3. Must be cared for--loss of self-esteem. 4. Death, suffering. 5. Hospital treatment is to be feared, mysterious, very serious or overwhelming. 6. separation from family, community, 7. Costly--exhaust financial resources. 8. Interruption of normal activity. 9. Point up education inadequacies. 10. Alter life style. 11. Belief & fantasies come to the surface.	Understand the meanin of illness as it evolves from patient' past experiences, soc ial class, ethnic group, and value syst

PRINCIPLES	DISCUSSION	PRACTICE
3. The meaning of illness to the patient is better understood when there is a knowledge of behavioral responses. There are behavioral responses to illness which represent past experiences, needs good ways of coping with stress and adjustment to illness.	C. Behavioral Responses 1. Dependency 2. Denial 3. Use of dependency to contact others. 4. Cheerful 5. Guilty 6. Stoic 7. Fright 8. Withdrawal 9. Depression 10. Ambivalence 11. Displacement of energy in others. 12. Fear of death 13. Anxious 14. Loneliness 15. Hostility	Be alert for delayed responses to illness. Understand words as used by patient which convey attitudes towards illness and knowledge of the disease.
4. Case Reviews	Specific Cases--reviews 1. Family guidance in obtaining treatment. 2. Patient needs lots of support-environmental--clear up appointments. 4. Unwillingness to apply for Medicaid--stigma of Relief.	Patient needs support of staff, family and society--to get well. Listen carefully.
5. Role of Family toward Illness	Role of family in helping patient get well. Comparison of post and present family inter-relationships.	Be alert to individual family member's reaction to the illness. Help them to understand.
6. Role of Physician & staff toward illness.	Evasion of truth re: illness can make pt. feel lonely, anxious, depressed, hostile. Support of staff builds up responses & strengths of patient.	Give physician and staff understanding of the illness and its meaning to pt. and family. Get the patient, family and staff together.

INTERVIEWING

PRINCIPLES	DISCUSSION	PRACTICE
Interviewing is the major tool of the social worker. Interviewing is an art, a skilled technique. It is a special way of discussing the needs of another person and the help the other person needs.	I. Difference between conversation & interviewing. Conversation is mutual sharing of information or of confidences. Interviewing is more one-sided; the helper & the person who needs/wants to be helped.	Read Friendly Visiting Interviews & discuss it. Who is the helper & helped one? How was that interest in helping conveyed? Respect the client; awareness of the client's needs, (spoken & evidenced) Ability to anticipate and to make it easier to take help, concern for individual's rights.
	II. The nature of the "help;" i.e. the problems that bring people to our Soc.Serv.Dept. & to our Senior Community Service Aides.	Interview for Medicaid & discussion at conference. Facts--need, real or felt Feelings--guilt about taking help, or anger if not eligible.
Good interviewing in social work is based on an ability to convince the other of your interest in helping--the establishment of "rapport" a special relationship. The nature of the information to be obtained is both fact & feeling.	III. How do you establish rapport in order to obtain this special breed of information--fact & feeling about the facts. A. Understand human nature--that feelings are always a part of the facts--subjective & objective facts. B. Feelings are individualized--listen to the person to learn what his specific feelings are. C. The other's feelings are not necessarily the same as your feelings. D. Be aware of own feelings, biases, moral attitudes. E. People have ambivalence (see 2 sides of issues)	Visit in homes & escort & nature of discussion--visit hospitalized patients. Read Interview--How id this woman feel about life--lost family, nursing home, What did woman do?
The art & skill of interviewing requires practice of special kinds of listening and questioning known as techniques--depending on the purpose of the interview.	IV. Examples of Fact & Feeling A. About family-- B. About illness-- C. About taking help, Medicaid, Escort Servs., medical care.	

PRINCIPLES	DISCUSSION	PRACTICE
	Techniques Focusing questions Examples	
	Purposes-- Eligibility for entitlements Interest in Services Drug problems, etc.	
The interviewer needs to be aware of his own need for success, for being approved of, and liked by the client. This is not always achieveable.	How do you feel when patient likes you, acts like he doesn't, is ungrateful or wants more. How do you feel when you can't give client what he needs or wants.	

USE OF RESOURCES

PRINCIPLES	DISCUSSION	PRACTICE
The hospital is an instrument of society that delivers a service need--medical treatment. Medical treatment in trend of today's society consists of both preventive and curative efforts.	What is "society" The larger group-- The community-- The needs of society--economic medical care, social education, psych. Definitions Prevention-- a) childrens' medical needs for immunization, abuse/neglect b) pregnancy care c) medical check-ups. Cure 1. diseases & treatment--OPD 2. disease--IPD	Visit community agcys-Boro Pk.13-Av Blind--Social Resources--Frail--Elderly. Visit clinics--Maimonides Hosp. Visit Pediatric Fl.--Aron-6 Aron-2 nursery area Visit Emergency Room Read & discuss typical E.R. Sheets Feelings & reactions to families.
Medical treatment as defined in this broader concept is affected by social and economic situation of the patient. The hospital uses Soc.Serv. Dept. as its agent to deal with the needs of the patient. The Social Serv. Dept. thus needs to know the community and its agencies and how to use them.	Discuss typical resources to meet the needs as outlined above in re: typical cases 1. The antepartum patient & her need for a home, for economic support, for medical care and for security that baby be provided for-- Agencies used--Dept. of Soc. Services of NYC, Medicaid--State/Fed.--as administered by the City Dept. of Soc. Servs.	Discuss typical problem cases. --Out of wedlock pregnancy-- Visit with social wkr in service cases where patients have not returned for follow-up care. Infants at risk Women at risk--Pap. & Ca. Neglecting mothers.
Agencies as set up by society, are funded by tax payer funds and are under the Human Resources Administration or by private funds, usually sectarian (FED. of Jewish Philanthrop. Catholic Charities, Fed. of Prot. Welf. Agencies)	2. The drug addicted baby & the problems, & the hospital's responsibility for baby--Agencies & the Child Abuse/Neglect law. Drug Programs for mothers. 3. a) The sick baby at birth & the resources used. b) The frightened, insecure mother--Visiting Nurse Soc., Bur. for Handicapped Chil.--health Plcmnt. Bur. of Child Welf.--homemaker service. Adoption, BCW & the Private sectarian agencies. Day care, for older children.	

PRINCIPLES	DISCUSSION	PRACTICE

4. Follow-up treatment of infant
   well-baby care--hosp., immunizations,well-baby
   clinic of hosp., City clinics of Board of Health,
   Emergency Room, Special Infant Care Clinic-Hosp.

5. The abused and neglected child, the Disabled
   child
   - The Law & Court--Abuse & Neglect
   - The Bureau for Handicapped Child.
   - The Blind, United Cerebral Palsy., etc.

6. The Patient & typical medical problems,
   breast, gyn.
   OPD--Homemaker, Medicaid,
   IPD--Homemaker, H.R.F., V.N.A., Home Care
   - Amer. Ca. Society, Cancer cases.

7. The Aged - J.A.S.A., CHI.A.O., Cath. Charities,
   The Services to the Frail-Elderly at
   C.M.H.C.

8. The Disabled--
   - Blind, C.V.A.-Rehab.
   - Services to maintain home life
   - Homemaker services
   - Meals on Wheels
   - Use of V.N. & Home Care
   - Services to patients who cannot maintain home life--Nurs.Home,
     - Health Rel. Facil.
     - Senior Citizens Homes

CODE SHEET

COLUMN	INSTRUCTIONS
REFERRED BY:	WRITE IN: EXAMPLE: SELF AGENCY NURSE DOCTOR NEIGHBOR
PROBLEM AREAS:	WRITE IN APPROPRIATE LETTER OR LETTERS DESCRIBING AREA OF NEED(S) OR REASON(S) FOR REFERRAL A Financial B Health C Mental Health D Nutritional Entitlements E Governmental Entitlements F. Legal G Housing H Family Relationships I Socialization and Recreation J Escorting K Other (specify)
LOCALE	WRITE IN APPROPRIATE SITE OF INTERVENTION: EXAMPLE: Home Community Social Agency Hospital Clinic
METHOD	WRITE IN APPROPRIATE RESPONSES: Interview Letter Phone Call

SERVICES PROVIDED	WRITE IN APPROPRIATE NUMBER OR NUMBERS WHICH BEST DESCRIBE THE SERVICES YOU PROVIDED: 1 Relationship Therapy 2 Agency Referral for Social Service 3 Assistance in Obtaining or Completing Applications for Government Entitlements (eg. Medicare, S.S.I., Medicaid, V.A. Benefits, Etc.) 4 Assistance in Helping Patients Become Eligible for Other Health Care or Related Programs (eg. food stamps, meals on wheels) 5 Light Shopping or Chore Services 6 Informational Services 7 Child Care Assistance 8 Outreach or Preventive Services 9 Assistance in Helping Patients Use Medical Facilities (eg. Clinic Registration, Escorting about Clinic, etc.)
FOLLOW-UP	REFER BACK TO APPROPRIATE LETTER DESIGNATION(S) IN "PROBLEM AREA OR REASON FOR REFERRAL" COLUMN

SENIOR COMMUNITY SERVICE AIDE
PROGRAM RECIPIENT'S DATA
SURVEY QUESTIONNAIRE

1. NAME________________________________

2. ADDRESS________________________________

3. SEX__________

4. AGE________ BIRTHDATE MONTH______ DAY_____ YEAR______ BIRTHPLACE____________________

5. MARITAL STATUS: SINGLE____ MARRIED_____ WIDOWED_____ DIVORCED______ SEPARATED____

6. OTHER PEOPLE IN HOUSEHOLD: NUMBER_____ RELATIONSHIP______ AGES_____ CITIZENS______
   REGISTERED VOTERS_____ SEEKING WORK_____ EMPLOYED_____ LOCALLY_______

7. EMPLOYMENT STATUS: UN-EMPLOYED_____ PART-TIME_____ FULL TIME_____SELF-EMPLOYED____
   OCCUPATION___________ LOCAL EMPLOYMENT_________ SEEKING WORK_________

8. TRANSPORTATION:_______ OWN CAR_____ CAR-POOL_____ OTHER__________
   PUBLIC TRANSPORTATION______ FARE: FULL FARE______ TRANSPORTATION CARD_______

9. MONTHLY INCOME: YOURS______ OASI_____ OTHERS______SOURCES OF INCOME: PUBLIC ASST.______
   FOOD STAMPS______ S.S.I.______ RENT SUBSIDY_________ OTHER______________

10. HOUSING: OWN HOUSE______ OR HOUSE MORTGAGED_______ APARTMENT RENT_____ NO. ROOMS____
    NO. APARTMENTS IN BUILDING_____ NO. VACANCIES IN BUILDING_____
    HOW LONG LIVED THERE?_______

11. FRIENDS AND RELATIVES LIVING ELSEWHERE:
    NUMBER______ HOW OFTEN SEEN?_____ WHEN LAST SEEN?______ RELATIONSHIP________

12. MEDICAL RESOURCES: MEDICAID_____ MEDICARE_____ PART A---PART B____________
    PRIVATE HEALTH INSURANCE_____ BLUE CROSS--BLUE SHIELD-HIP-OTHER______________

13. MEDICAL CARE RECEIVING: PRIVATE DOCTOR_____ ATTENDS CLINIC_________
    WHEN LAST RECEIVED TREATMENT______________ FOR WHAT__________________

14. MEDICAL NEEDS: MEDICAID_____ MEDICARE_____ PRIVATE INSURANCE_____ DOCTOR_______
    NURSING CARE_____ MEDICINE_____ MEDICAL AIDS/APPLIANCES_____
    TRANSPORTATION FOR CARE_____ HOSPITALIZATION_____ HOMEMAKER______
    HOME HEALTH AIDE____________________ OTHER_________________________

15. ILLNESS NEEDING TREATMENT:
    HOW IS YOUR HEALTH?: GOOD_____ FAIR_____ POOR_____ WHAT'S WRONG?__________________

S.C.S.A. AND N.R.A.
DAILY STATISTICAL WORK SHEET

DATE SUBMITTED____________

WORKER____________________

DATE	PATIENT'S NAME	AGE	REFERRED BY	PROBLEM AREAS	LOCALE	METHODS	SERVICES PROVIDED	FOLLOW UP	HOURS	EXPENSES

Approved by:________________

Date:__________

Total Hours________

Expenses__________

Revised Nov. 1978-PRP

PROGRAM PARTICIPANT'S DATA ENTRY SHEET

I. WHERE DID YOU FIRST HEAR ABOUT THE TITLE V SENIOR COMMUNITY SERVICE AIDE PROGRAM:UNDER WHAT CIRCUMSTANCES?

II WHAT FIRST INTERESTED YOU IN THIS KIND OF PROGRAM?

III WHAT KIND OF PERSONAL EXPERIENCES HAVE YOU HAD IN WORKING WITH ILL PEOPLE AND WITH HOSPITALS IN GENERAL?

IV IN YOUR EXPERIENCE,WHAT DO YOU FEEL ARE THE MOST SERIOUS PROBLEMS POSED BY ILLNESS AND DISABILITY?

V WHAT DO YOU HOPE TO ACCOMPLISH IN THE SENIOR COMMUNITY SERVICE AIDE PROGRAM?

VI WHAT DO YOU EXPECT FOR YOURSELF AS A RESULT OF WORKING WOTH THE SENIOR COMMUNITY SERVICE AIDE PROGRAM?

PARTICIPANT EVALUATION SURVEY

1. HOW WOULD YOU DEFINE YOUR ROLE AS A SENIOR COMMUNITY SERVICE AIDE WORKING IN THE DEPARTMENT OF SOCIAL SERVICES AT MAIMONIDES HOSPITAL

2. HOW LONG HAVE YOU BEEN WORKING AS A SENIOR COMMUNITY SERIVICE AIDE?

3. DO YOU FEEL THAT YOUR EXPERIENCE WORKING IN THE SENIOR COMMUNITY SERVICE AIDE PROGRAM AT MAIMONIDES HAS CHANGED YOUR LIFE IN ANY WAY; PLEASE GIVE SOME REASONS FOR YOUR THINKING.

4. DO YOU FEEL THAT THE IN-SERVICE ORIENTATION AND TRAINING SESSIONS YOU RECEIVED WERE ADEQUATE IN PREPARING YOU FOR YOUR WORK? PLEASE GIVE REASONS FOR YOUR ANSWER.

5. IN WHAT WAYS DO YOU FEEL THE TRAINING AND ORIENTATION PROCESS MIGHT HAVE BEEN ENHANCED?

____

____

____

____

____

6. WERE THE FIELD VISITS TO SOCIAL AGENCIES IN THE COMMUNITY USEFUL?

YES_____

NO _____

UNDECIDED___

WHAT OTHER FIELD VISIT EXPERIENCES COULD HAVE BEEN ARRANGED THAT MIGHT HAVE BEEN USEFUL TO YOU IN YOUR WORK?

____

____

____

____

____

7. EXPLAIN THE MOST IMPORTANT WAYS IN WHICH YOU FEEL THAT YOUR WORK HAS HELPED:

1. PATIENTS____________________________

2. THE HOSPITAL_________________________

____

3. THE COMMUNITY WHICH IS SERVED BY THE MEDICAL CENTER.

____

____

____

8. GIVE SOME ILLUSTRATIONS OF HOW YOU THINK YOUR WORK HAS HELPED THE SOCIAL WORKERS AND OTHER STAFF MEMBERS.

9. WHICH ASPECTS OF THE WORK THAT YOU HAVE DONE DO YOU PREFER DOING; WHICH ASPECTS ARE THE LEAST DESIRABLE; PLEASE EXPLAIN.

10. SUMMARIZE WHAT YOU FEEL HAVE BEEN THE MOST IMPORTANT CONTRIBUTION(S) MADE BY THE SENIOR COMMUNITY SERVICE AIDE GROUP AS A WHOLE UPON PATIENT CARE AT MAIMONIDES MEDICAL CENTER.

11. DO YOU THINK THE SENIOR COMMUNITY SERVICE AIDE PROGRAM SHOULD BE CONTINUED AS IT IS, MODIFIED, EXPANDED, OR DISCONTINUED; WHATEVER YOUR ANSWER IS, PLEASE ELABORATE UPON THE REASONS FOR YOUR THINKING.

12. WHAT SPECIFIC STEPS CAN BE TAKEN TO IMPROVE THE OVERALL EFFECTIVENESS OF THE SENIOR COMMUNITY SERVICE AIDE PROGRAM, BY:

1. GOVERNMENT____________________________

____

____

____

2. NEW YORK CITY OFFICE FOR THE AGING__________

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3. SOCIAL SERVICE DEPARTMENT--MAIMONIDES MEDICAL CENTER ....

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SENIOR COMMUNITY SERVICE AIDE PROJECT

QUESTIONNAIRE FOR RECIPIENTS OF SERVICE

PATIENT'S NAME ________________________________

DATE ________________________________

INTERVIEWER ________________________________

PLACE OF INTERVIEW ________________________________

1. When you first met the Senior Community Service Aide, how did he or she introduce themselves?

____

____

____

2. After the Senior Community Service Aide introduced himself or herself, did you feel that you understood who they were, where they worked, and what they did?

Yes____

No____

3. If not, can you explain why this was unclear to you.

____

____

____

4. Where did you first meet the Senior Community Service Aide?

At Home ( )
In Hospital ( )
In Clinic ( )
Other (Please Specify) ( )

5. How did the Senior Community Service Aide first contact you?

In Person ( )
By Phone ( )
By Letter ( )

6. Approximately how long has it been since you first met the Senior Community Service Aide?

____

____

7A. Which of the following services were provided by the Senior Community Service Aide? (Please check appropriate services in Column A)

		(A)	(B)	(C)
a)	Medicaid Application	( )	( )	( )
b)	Other Governmental Entitlements (e.g. Medicare Benefits, S.S.I.)	( )	( )	( )
c)	Escorting service to hospital or clinic or other health care facility in the community.	( )	( )	( )
d)	Escorting service to home.	( )	( )	( )
e)	Delivered medications or other supplies to home.	( )	( )	( )
f)	Friendly visiting and conversation.	( )	( )	( )
g)	Light shopping or chore services.	( )	( )	( )
h)	Assistance with legal problems.	( )	( )	( )
i)	Housing problems (Sec. 9)	( )	( )	( )
j)	Nutritional needs (eg. food stamps, Meals on Wheels.)	( )	( )	( )
k)	Recreation and socialization needs, (e.g. senior citizen centers or groups)	( )	( )	( )
l)	Child care services.	( )	( )	( )
m)	Referral to community agencies (e.g. Jewish Family Service, Jewish Assoc. for Services to the Aged, Council of Jewish Organizations, etc.)	( )	( )	( )
n)	General information about community Resources or hospital based services.	( )	( )	( )
o)	Other (specify) ____________________.	( )	( )	( )

7B. How would you rate the usefulness of service(s) provided by the Senior Community Service Aide? (Please put appropriate number in Column B)
1) Great Assistance 2) Quite Useful 3) Useful 4) Slight Use
5) Useless

7C. What importance do these services represent in improving the quality of life for you? (Please indicate in Column C)
1) Great Importance 2) Quite Important 3) Important
4) Of Little Importance 5) Irrevelant

8. Did the Senior Community Service Aide seem interested, and present a friendly attitude?

Yes__________

No__________

9. Were there any services that you requested of the Senior Community Service Aide that he or she could not or would not provide?

Yes____

No ____

If yes, please specify what they were.

____

____

____

10. Do you foresee a future need of any other services for yourself with which the Senior Community Service Aide might be of some assistance?

Yes____

No ____

If yes, please specify.

____

____

11. As you view the community in which you live, do you feel that there are certain needs or problems facing you or your neighbors which might be alleviated through the services provided by Senior Community Service Aides?

Yes____

No ____

If yes, could you please indicate which needs or problems you feel are most important.

____

____

____

12. Do you feel programs such as the Senior Community Service Aid. Project should be continued and expanded?

Yes____

No ____

Please give reasons for your position.

____

____

____

13. Do you have any other thoughts or comments on the Senior Community Service Aide Program?

____

____

____

PROFESSIONAL STAFF SURVEY

DATE:

DISCIPLINE:

1. WHEN DID YOU FIRST BECOME AWARE OF THE TITLE IX SENIOR COMMUNITY SERVICE AIDE PROGRAM?

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2. UNDER WHAT CIRCUMSTANCES DID YOU BECOME AWARE OF THE SENIOR COMMUNITY SERVICE AIDE PROGRAM?

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3. HOW DO YOU UNDERSTAND THE ROLE OF THE SENIOR COMMUNITY SERVICE AIDE?

____

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4. HAVE YOU ATTENDED ANY OF THE IN-SERVICE TRAINING SESSIONS CONDUCTED FOR THE SENIOR COMMUNITY SERVICE AIDE ENROLEES; IF SO, PLEASE DESCRIBE ANY INPUT YOU HAVE HAD INTO THE TRAINING PROCESS AND WHETHER OR NOT YOU FEEL YOUR INPUT HAS BEEN SUFFICIENT OR NOT?

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____

5. DO YOU FEEL THE TRAINING PROCESS HAS ADEQUATELY EQUIPPED OR PREPARED THE SENIOR COMMUNITY SERVICE AIDES FOR PERFORMANCE OF THEIR ROLE? PLEASE EXPLAIN YOUR POSITION.

6. HAVE YOU MADE ANY REFERRALS TO THE SENIOR COMMUNITY SERVICE AIDE PROGRAM?

YES_____

NO _____

PLEASE RATE THE FREQUENCY OF YOUR REFERRALS.

FREQUENT	SELDOM	NEVER
_____	_____	_____

7. IN WHAT SITUATION OR UNDER WHAT CIRCUMSTANCES HAVE YOU MADE REFERRALS TO THE SENIOR COMMUNITY SERVICE AIDE PROGRAM? PLEASE DETAIL.

8. IN WHAT AREAS DO YOU FEEL THE SENIOR COMMUNITY SERVICE AIDES ARE MOST COMPETENT TO PROVIDE SERVICE; WHY?

9. IN WHAT AREAS DO YOU FEEL THE SENIOR COMMUNITY SERVICE AIDES ARE LEAST COMPETENT TO PROVIDE SERVICES; WHY?

10. DO YOU FEEL THAT THE SENIOR COMMUNITY SERVICE AIDE PROGRAM HAS BEEN INTEGRATED INTO THE TOTAL PROGRAMS OF SERVICE PROVIDED UNDER THE AUSPICES OF THE DEPARTMENT OF SOCIAL AND COMMUNITY SERVICES; PLEASE INDICATE REASONS FOR YOUR POSITION.

11. HAVE YOU RECEIVED ANY FEEDBACK FROM PATIENTS OR FAMILY MEMBERS AS TO THEIR SATISFACTION OR LACK OF SATISFACTION WITH RESPECT TO SERVICES PROVIDED BY THE SENIOR COMMUNITY SERVICE AIDES; PLEASE EXPLAIN.

12. HAVE YOU RECEIVED ANY FEEDBACK FROM ALLIED HEALTH AND/OR SOCIAL AGENCIES REGARDING THEIR EXPERIENCES WITH SERVICES PROVIDED BY THE SENIOR COMMUNITY SERVICE AIDES; PLEASE EXPLAIN.

13. WHAT DO YOU FEEL ARE THE SIMILARITIES AND DIFFERENCES IN THE OBJECTIVES AND ROLES OF THE NEIGHBORHOOD RESOURCES FOR THE AGING VOLUNTEER PROGRAM AND THE SENIOR COMMUNITY SERVICE AIDE PROGRAM?

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14. DO YOU FEEL THE SENIOR COMMUNITY SERVICE AIDE PROGRAM HAS BEEN EFFECTIVE IN MEETING OBJECTIVES AND PROVIDING A RELEVANT OUTREACH SERVICE TO COMMUNITY CONSUMERS OF HEALTH CARE SERVICE; PLEASE EXPLAIN.

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15. HOW DO YOU VIEW THE RELATIONSHIP BETWEEN THE SENIOR COMMUNITY SERVICE AIDE AND YOURSELF AS A PROFESSIONAL HEALTH CARE PROVIDER REPRESENTATIVE OF THE SOCIAL WORK PROFESSION OR ALLIED HEALTH DISCIPLINE?

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16. DO YOU FEEL THAT THE SENIOR COMMUNITY SERVICE AIDE PROGRAM SHOULD BE CONTINUED, EXPANDED OR DISCONTINUED, AND WHY?

____

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17. PLEASE INCLUDE ANY THOUGHTS, SUGGESTIONS, OR COMMENTS ON HOW THE SENIOR COMMUNITY SERVICE AIDE PROGRAM MIGHT BE IMPROVED OR MADE MORE RELEVANT.

DEPARTMENT FOR THE AGING
250 BROADWAY
New York, N.Y. 10007
JANET S. SAINER, *Commissioner*

July 18, 1979

Mr. Paul Pagel
Director of Social Services
Maimonides Medical Center
979 48 Street
Brooklyn, N.Y. 11219

Dear Mr. Pagel:

I would like to take this opportunity to commend you for the very fine project which you are currently operating with the Senior Community Service Program enrollees.

The concern of our program in implementing the intent of the Department of Labor regulations, is two fold:

> One, to insure that the older worker is placed to their satisfaction and gains an excellent work experience under good supervision, in order to learn job skills, and the second goal is to insure that quality service is provided by the older worker.

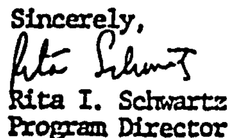
In both of these goals you have succeeded and I must again state how very pleased the workers are with their position and what a fine example your project serves as a work site.

Please extend my thanks to the hospital administration for the time and energy which they have expended on behalf of the older worker. It proves, that with good support, people can work their way back into the labor force, learn new job skills and feel productive about the service they give.

Keep up the good work and continue to send us reports.

Best wishes.

Sincerely,



Rita I. Schwartz
Program Director

RIS/vb

TITLE V SENIOR COMMUNITY SERVICE AIDE PROGRAM

DEPARTMENT FOR THE AGING EXPENSES

20 working hours per week/per worker
X$3 per hour (salary) per worker
$60. per week/per worker
X.20 fringe benefits
=$12.00
=$72.00 per week/per worker
X52 weeks
$3744. per year/per worker
X8 workers

$29,952. per year
$500 transportation costs
$30,452. Total

HOSPITAL EXPENSES

Supervision (Equivalent of 1 full day)
$6,384. Annualized

Administrative Expenses (Lunch, paper goods, phone, electricity, postage, etc.)

20% = $6,090.40

$42,926.40 TOTAL

DEPARTMENT FOR THE AGING

ALICE M. BROPHY, Commissioner

250 Broadway
New York, N.Y. 10007

Senior Community Service Project - Title IX

What Is The Senior Community Service Project?

The Senior Community Service Project (SCSP) is authorized by Title IX of the Older Americans Act to provide work experience, training and skill development for low-income, older persons. The jobs funded under SCSP focus on community services, especially services to the aging.

How is the Senior Community Service Project Funded?

The program, authorized by Title IX of the Older Americans Act, is administered by Department of Labor. Department for the Aging receives its funds from National Council on Aging and New York State Office for the Aging.

Who Can Be A Placement Site?

Any public or non-profit voluntary agency which provides community service can be a placement site. Preference will be given to agencies which serve the elderly or are involved in intergenerational activities which foster a positive image of the elderly in the community.

What Kinds Of Positions Are Available?

Program participants can be assigned to a great variety of jobs ranging from clerical to social service paraprofessionals. Some examples are outreach workers, home health aides, information and referral assistants, administrative aides and receptionist/clerks.

Who Is Eligible To Be Hired?

All persons must be 55 years of age or older. The income eligibility ceilings are listed below. All income received by a household is included in eligibility determination. However, if the applicant or any household member receives Public Assistance or SSI, the person is automatically eligible even if the benefits exceed the specified eligibility level.

Income Eligibility Levels

Size of Family	Income
1	$ 3,140.
2	$ 4,160.
3	$ 5,180.
4	$ 6,200.

over

Who Pays The SCSP Enrollee?

All SCSP enrollees are employed by the City of New York Department for the Aging. They receive the same benefits as other part-time City employees. The work site is responsible for maintaining records and forwarding them to the Department.

What Are The Responsibilities Of The Work Site?

Since the program is considered a work experience and job development program, the site is expected to be supportive of the enrollee. Support includes adequate supervision and appropriate on-the-job training. The site agency should realize that persons hired under this program may not be job ready, but do possess the ability to learn to perform the required job responsibilities.

Also, it is expected that an agency make every effort to hire the enrollee if an appropriate vacancy becomes available. We are mandated to have a given number of unsubsidized placements of enrollees and expect cooperation from host agencies.

How Do You Apply To Be A Placement Site?

Write to:

Senior Community Service Project
Department for the Aging
250 Broadway - 17th Fl.
New York, N.Y. 10007

Or call 233-2235 for further information.

How Does A Person Apply For A Job?

If a person meets the age and income limits, write to:

Senior Community Service Project
Department for the Aging
250 Broadway - 17th Fl.
New York, N.Y. 10007

Or call 233-2235 and ask for an application to be sent.

DEPARTMENT FOR THE AGING

250 BROADWAY
New York, N.Y. 10007
JANET S. SAINER, Commissioner

SENIOR COMMUNITY SERVICE PROJECT STANDARD WORKSITE LETTER OF AGREEMENT	Agency: MAIMONIDES MED.CTR.DEPT.OF SOCIAL SERVICES Address 979 48th St Borough BROOKLYN Zip Code 11219
Sponsoring Agency: MAIMONIDES MED CTR	Phone Number (212) 270-7380
Address 4802 10th Ave Brooklyn, N.Y. 11219	Date of Agreement: From July 1, 1979 to June 30, 1980

In keeping with the mandate of the regulations for the Senior Community Service Project as funded under Title V of the Older Americans Act, it is required that the placement site for the enrollee agree to the following:

1. Job Description

   a) Provide the Department for the Aging with a written detailed statement, outlining the job scope and additionally furnish a copy to the enrollee.

2. Supervision

   a) State who is responsible for the enrollee's direct supervision.

   b) Provide continuous on-site supervision which will include:

      1. Clear job instructions which will foster skill development.

      2. Guidance in establishing good work habits.

      3. Proper health and safety conditions.

3. Orientation and Training

   a) The agency is to provide an initial orientation which will appraise the enrollee of the agency's services, policies, lines of authority and job expectations.

   b) Provide Released-time for attendance at DFTA training sessions and encourage attendance at other appropriate training sessions.

   c) On-going supervisory sessions are suggested, not only to handle such administrative tasks as signing and distribution of time sheets, but to also serve as a training period.

4. Unsubsidized Placement

1. Develop an employment plan which will foster placement of enrollees in unsubsidized positions.

2. Consider enrollees for appropriate vacancies with host agency.

3. Seek funds to provide unsubsidized employment of enrollees.

5. Administrative Responsibilities

1. Maintain a record of the enrollees attendance.
2. Submit bi-weekly time sheets and absence forms to the Department for the Aging.
3. Submit a quarterly progress report in narrative form.
4. Immediately inform the Department for the Aging of all changes in the enrollee's status, including;

   a) Termination
   b) Change of job assignment
   c) Change of Supervisor
   d) Change of hours

We further agree that this activity will not displace any other paid employee or volunteer nor discriminate with regard to race, color or creed. All employees employed by this worksite prior to and during the term of this agreement shall be covered by the provisions contained in this letter.

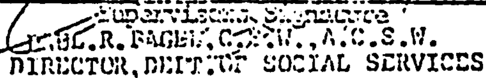
The New York City Department for the Aging will monitor for compliance with the terms of this agreement.

MAIMONIDES MEDICAL CENTER'S DEPT OF SOCIAL SERVICES

Sponsoring Agency

DEPT OF SOCIAL SERVICES OF MAIMONIDES MEDICAL CENTER

Work Site

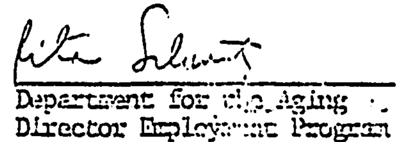


Supervisor's Signature

[illegible] R. FAGEN, C.S.W., A.C.S.W.
DIRECTOR, DEPT. OF SOCIAL SERVICES

Date

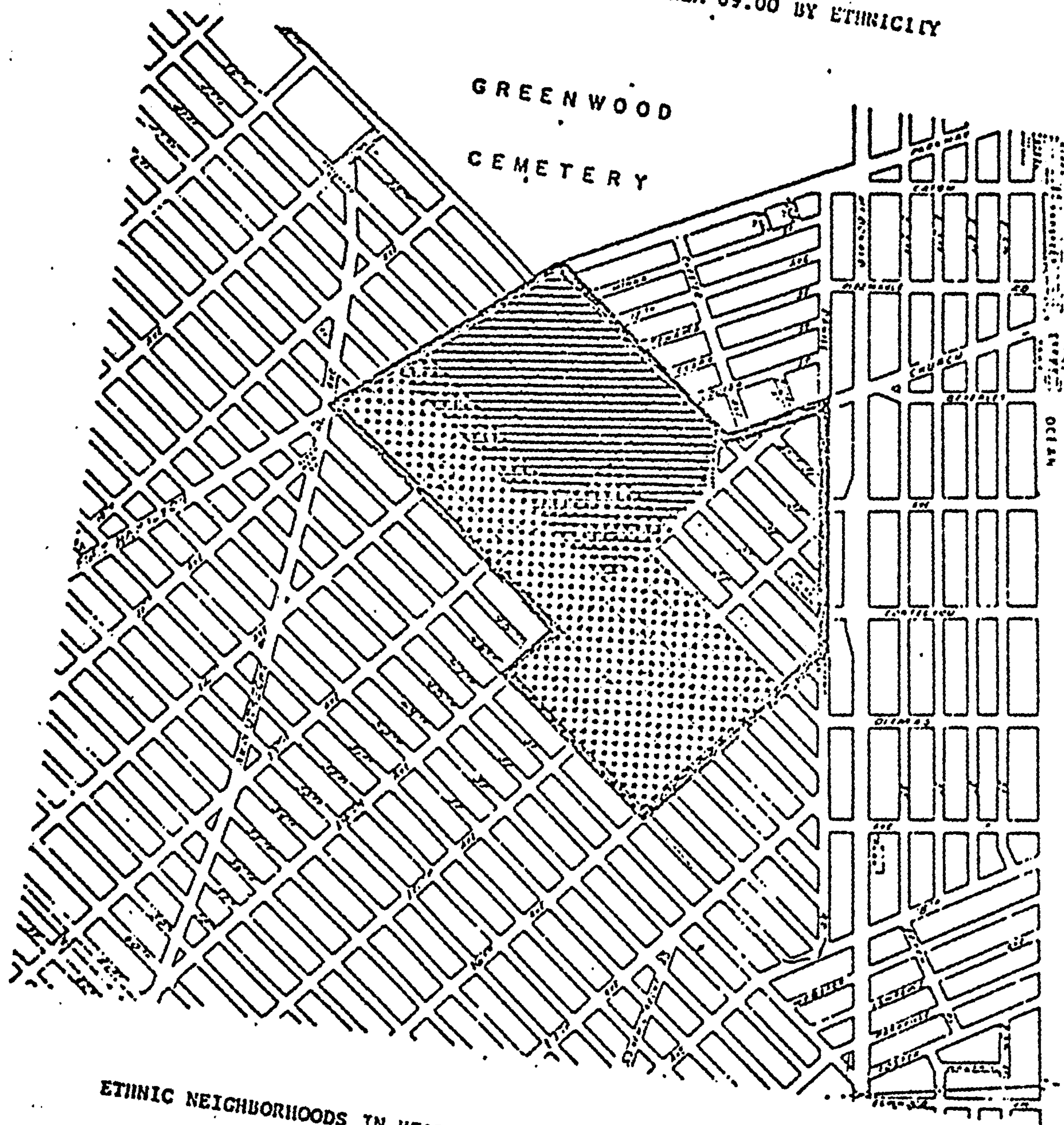
AUGUST 8,1979



Department for the Aging
Director Employment Program

Date

MAP 1: DETAIL OF HEALTH AREA 69.00 BY ETHNICITY



ETHNIC NEIGHBORHOODS IN HEALTH AREA 69.00

Italian

Hispanic

Jewish

Table 1. Description of "Low-Income" Health Areas Outside of CAP Poverty Areas: Total Population, Families with Yearly Incomes Less than $4,000, Population Under 6, Population 65 and Over, Public Assistance Recipients, and Juvenile Delinquency Rate

Area Description	"Low-Income" Health Area	Total Persons (1970)	Families Below $4,000 Income (1969) No.	%	Persons Under 6 years (1970) No.	%	Persons 65+ years (1970) No.	%	Public Assistance Recipients	Rate[a]	Juvenile Delinquency Rate[b]
New York City Total		7,894,862	321,971	15.6	743,048	9.4	947,573	12.0	964,130	12.2	70.8
New York City Low-Income Areas		1,064,650	45,481	15.9	91,616	8.6	153,419	14.4	163,548	15.4	n.a.
Bronx Total		1,471,701	79,318	20.3	161,621	11.0	170,857	11.6	278,101	18.9	84.6
Bronx Low-Income Areas		366,849	17,941	17.7	36,511	10.0	52,487	14.3	100,183	27.3	n.a.
Bedford Park	4.20[c]	28,216	821	10.0	1,630	5.8	6,156	21.8	1,799	6.4	51.0
Fordham	9.00[c]	30,939	1,211	13.5	2,046	6.6	6,850	22.1	4,493	14.5	70.7
East Tremont	11.00	19,089	1,326	26.6	1,991	10.4	2,373	12.4	4,270	22.4	53.2
Fordham	15.20	21,028	1,104	19.4	2,290	10.9	2,834	13.5	8,036	38.2	117.7
"	16.00	27,742	1,352	17.5	2,134	7.7	5,474	19.7	10,111	36.5	113.4
Morris Heights	22.10	29,014	1,645	20.4	3,737	12.9	3,047	10.5	11,668	40.2	82.5
"	22.20	27,390	1,679	22.2	3,529	12.9	2,912	10.6	10,079	36.8	106.5
Concourse	23.10	23,758	1,159	16.8	2,177	9.1	4,184	17.6	7,939	33.4	96.3
"	23.20	15,012	765	17.5	1,158	7.7	2,890	19.2	5,081	33.9	158.9
West Farms	30.10	27,454	1,282	17.7	2,964	10.8	2,748	10.0	3,804	13.9	81.4
Clasons Point	30.20	45,580	1,958	15.8	5,012	11.0	4,075	8.9	9,864	21.6	100.4
"	30.30[c]	17,134	674	15.9	1,959	11.4	1,271	7.4	4,123	24.1	77.3
High Bridge	33.10[c]	22,611	1,110	18.2	2,734	12.1	2,474	10.9	8,923	39.5	147.2
"	33.20[e]	31,882	1,855	20.3	3,142	9.9	5,199	16.3	10,003	31.4	101.8
Brooklyn Total		2,602,012	123,492	18.0	272,471	10.5	288,096	11.1	385,464	14.8	76.4
Brooklyn Low-Income Areas		401,209	17,042	15.3	33,678	8.4	59,420	14.8	37,962	9.5	n.a.
Greenpoint	1.00	14,070	621	16.6	1,250	8.9	1,523	10.8	1,419	10.1	54.8
"	3.00	11,174	528	17.8	1,032	9.2	1,304	11.7	1,115	10.0	64.8
Crown Heights	48.00[e]	27,950	1,116	15.4	2,749	9.8	3,170	11.3	3,900	14.0	82.8
Flatbush	53.20[c]	31,284	1,209	13.6	1,931	6.2	6,820	21.8	4,641	14.8	86.0
"	54.00[c/e]	28,262	1,074	13.9	2,610	9.2	4,063	14.4	4,373	15.5	101.3
Sunset Park/Gowanus	66.00[c]	24,778	1,255	18.7	2,327	9.4	3,588	14.5	3,809	15.4	54.5
Borough Park	69.00	19,146	1,059	20.6	2,061	10.8	2,393	12.5	2,134	11.2	45.8
Canarsie	75.20[e]	62,589	1,822	10.4	5,537	8.8	4,876	7.8	1,803	2.9	38.0
Bay Ridge	77.00[e]	18,295	688	14.7	1,688	9.2	2,531	13.8	2,876	15.7	76.0

8...The Brooklyn Graphic...Wednesday, October 10, 1979

ZEFERETTI VISITS MAIMONIDES SENIOR CITIZENS

On his recent visit to Maimonides Medical Center's Senior Community Service Aid Program, Congressman Leo C. Zeferetti (standing at right) met with: seated, left to right, Senior Community Service Aides Ruth Goodman, Chaiman Cubert, Rae Wolfe, Edith Kurzberg, Ida Levy, Doris Reynolds. Standing left to right: Livingston Moyston, Supervisor of the Senior Community Service Aide Program; Maimonides Department of Social Services; Mel Feinstein, Director, Employment Program, N.Y.C. Department for the Aging; Lil Semmels, Project Coordinator, Department for the Aging; Loretta Garvey, another of the Aides; and Zeferetti.

Congressman Leo C. Zeferetti paid a recent visit to Maimonides Medical Center to discuss problems of the elderly with Senior Community Service Aides who work at the hospital under a special Federal and City program known as the Senior Community Service Project. Administered by the U.S. Department of Labor and N.Y.C. Department of Aging, the Project is authorized by Title V of the Older Americans Act to provide training and work experience for persons over 55 years of age. The jobs funded under the program focus on community services, especially services to the aging.

At Maimonides, the Senior Community Service Aides, all of whom are local area residents, were trained by and work under the supervision of the Department of Social Services. They have been providing important, personalized services to hundreds of elderly individuals in the community through direct contact and home visits. Some of the services they provide are helping people to obtain government benefits they may be entitled to such as Medicaid, Food Stamps, or SSI; providing information and referral services and acting as a liaison with community agencies; escorting patients to and from doctor visits; bringing medication to the infirm and homebound.

Very often, the assistance provided by the Senior Community Service Aides makes the crucial difference that allows a person to remain at home rather than face hospitalization or institutionalization. With their unique vantage point and first-hand experience, the Aides had many insights about the problems and needs of the aging to share with Congressman Zeferetti, who has been active in Congress in efforts on behalf of the elderly.

Friday, October 19, 1979 • JEWISH PRESS •

. Cong Zeferetti Visits Maimonides

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Zeferetti Tours Maimonides

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Senior Community Service Aide Group - U.S. Congressman Leo Zeferetti (center standing) with Paul R. Pagel, Director of Social Services (R).

Senior Community Service Aide Group - U.S. Congressman Stephan Solarz (center standing) with Paul R. Pagel, Director of Social Services (standing far right).

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XIV

AUTOBIOGRAPHICAL STATEMENT

My academic orientation and preparation for a career in social work began with my undergraduate education at the University of Detroit, Michigan--where I completed a pre-professional social work major, with a minor in psychology. This academic preparation combined theoretical material with field work exposure in both case and group modalities of social work. In 1963, I earned a Bachelor of Philosophy Degree.

My graduate education at Wayne State University, Detroit, Michigan, was completed in 1965, at which time I was awarded a Master of Social Work Degree.

My Masters Thesis was undertaken as a descriptive and analytic study of what was then the largest nursing home in the City of Detroit, Michigan.

Upon graduation I entered full-time employment with a special family and child service unit of the Detroit Department of Public Welfare. In February 1966, I resigned my position by reason of obligation for military service.

In February 1966, I received a commission as a full Lieutenant in the Commissioned Corps of the United States Public Health Service and was assigned as a staff social worker at the United States Public Health Service Hospital,

Staten Island, New York.

Three months prior to my completion of military service, I was promoted to the position of Chief Social Worker, and reassigned responsibility for the total development of the Social Work Program at the United States Public Health Service Out-Patient Clinic in Manhattan. This clinic, at that time (1966) treated in excess of 100,000 patients per year.

At the completion of my tour of duty in February 1968, I returned to Detroit, Michigan. I joined the staff of the Special Education Department of East Detroit Public Schools, as a school social worker.

With the end of the school semester, I sought temporary employment with the Detroit League for the Handicapped where I provided individual counseling and rehabilitative services to the profoundly physically and mentally handicapped, supervised a staff social worker, provided interdisciplinary consultation, conducted in-service training sessions, and successfully developed a social work program in a satellite branch of this agency.

In September 1968, I returned to the East, having made the decision to make New York my permanent residence and professional base. I joined the staff of the Department of Social and Community Services at Maimonides Medical Center that same month, and was appointed Coordinator of Social Services for Ambulatory Care--a position encompassing

administrative supervisory, consultative, and direct service responsibilities in four divisions including Emergency Service, Out-Patient Department, Home Health Agency, and Nursing Home Affiliation.

In December of 1970, I was promoted to Assistant Director of the Social Service Department. My responsibilities, in addition to those referred to earlier, were enlarged to include supervision of four generic supervisors, organization, development and delivery of social services with heavy input in developing in-service training programs.

In June 1971, I was appointed Acting Director of the Social Service Department and in December 1971, I was promoted to Director. My responsibilities in this position to date, have included the entire administration of the Department--in number, twenty-two full-time staff positions, personnel policy and program development, social work consultation to the other major clinical departments, community relations, in-service training and education, and planning input into the overall network of health services to the community. Additionally, I participate in the hospital's program of administrative responsibilities which includes comprehensive management responsibilities for the entire Medical Center one evening each month.