Preventive Health Care for the Elderly: A Model for Senior Centers*

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Medical care, as it is currently organized, treats the senior only after something critical occurs, such as a heart attack, rather than supporting those activities necessary for good health—nutrition, exercise, health education, social and recreational activities. More attention needs to be paid by health professionals to helping older persons maintain independence and remain actively involved in life. Yet, preventing illness is not a medically reimbursable service even for the elderly for whom it is significantly important in maintaining a higher quality of life.

Daily, Monday through Friday, one hundred and fifty older adults between the ages of sixty and ninety-five attend the title XX funded senior center at the Gustave Hartman Y (part of the Associated YM-YWHAs of Greater New York). Fifty percent of this population also pay a membership fee of five dollars annually to the Preventive Health Center. This nominal fee allows the PHC participants to receive care for their medical and psycho-social needs, as well as to take part in health-education groups, workshops and lecture series.[1] The program is staffed full-time, by a registered nurse and certified social worker.

The PHC staff services not only its membership, but are accessible to the senior population of the Rockaways, and receive calls and walk-ins from the community regarding health care and hospital discharges. Health-education programming is open to the entire membership of the senior center and is based upon the needs of these seniors as determined by an epidemiological survey of thier most pressing health problems.

The PHC project has four major long term goals. They are:

1. to increase the length of time seniors can remain active and independent in their own community.
2. to demonstrate the cost effectiveness of preventive health care for the elderly.
3. to develop a reimbursement system appropriate for preventive health care.
4. to promote the replication of this model of preventive health care at other senior centers.

The specific objectives of this model project are geared to improving health

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[1] B. Trager, *Adult Day Facilities for Treatment, Health Care and Related Services.* Special subcommittee on Aging, U.S. Senate. Washington, D.C.: U.S. Government Printing Office, 1976.

status as measured by the functional ability of seniors involved in the preventive health-care project, and making health care more accessible to seniors participating in the project.

The initial stages of the project required the development of a rapport with both the medical community, protective of their "turf," and with older adults, themselves generally angry and frustrated about the high cost of medical care. This project has, to date, successfully developed a cooperative and mutually affirmed referral mechanism with local private physicians and other health and social service providers. By linking with existing services the program has made medical and social care more accessible to project participants. Linking with existing community agencies and physicians was done by explaining fully the purpose of the project to the medical community and developing outreach projects in conjunction with currently established hospitals and social agencies.

The PHC social worker attends community meetings and works closely with local hospital social work staff. In so doing, the social worker assists the medical community to provide follow-up to older adults discharged from the hospital into the community. This follow-up may prevent future hospitalizations and/or emergency room abuse.

The nurse's role at the PHC is to act as a mediator for medical issues that may arise between the older adult and their physician. Both staff members encourage the PHC participants to become more educated and thereby more aware of their health needs. As a result the members become both better medical consumers and advocates for their own needs.

The one overarching goal of the program is to increase the length of time seniors can remain active and independent in their own community. By measuring the level of health status and satisfaction, i.e., how well the model program's services contribute to the restoration, improvement, maintenance or arresting deterioration of physical, social or mental functioning (measured both by the medical staff, and by patients' self-report, and compared to seniors in a control group), a determination can be made as to how well the PHC achieves its goal.

The day-to-day responsibilities for programming and participant care are in the hands of the nurse and social worker. Discussion of their duties, experiences and how they approach their tasks follows:

Nursing Care and the Role of the Nurse

There is increasing evidence that physical environment and modes of personal behavior are major determinants of health and disease. Health maintenance implies recommending alterations in life style with respect to nutrition, exercise, and stress management. Prevention refers to primary and secondary disease prevention. Whereas health maintenance or primary prevention consists of activities to head off a disease or accident from occurring, secondary prevention implies periodic screening designed for the detection of disease before it is clinically apparent to the individual.

The most common type of primary care is the physical examination performed by the general medical practitioner. However, it has been shown that the "annual physical," complete with laboratory and x-ray studies is not cost effective, and does not alter the outcome of many diseases.[2] Perhaps a more productive, cost-effective system along with the annual physical exam in the asymptomatic patient, would be selective screening and ongoing health education. The project is developing a system whereby PHC members adhere to an individualized screening plan. The plan takes into account each client's age, sex,

[2] W.W. Rosser, "Periodic Health Examination," *Canadian Family Physician*, Vol. 20, 1974. p. 84.

and risk factors. In addition, each participant is encouraged to take part in health-education programming which emphasizes the prevention of disease and accidents.

Sir Ferguson Anderson has directed us to three areas of concern in geriatric prevention: 1) the preservation of physical health; 2) the maintenance of mental health; and 3) the preservation of social standing and circumstances. In no other age group are these aspects so closely linked.[3]

The Preventive Health Center has already established several methods by which staff can assess the well elderly. Before participants are seen by the nurse and social worker they have completed a health-background form, which is a detailed questionnaire focusing on all aspects of their health;[4] a life-satisfaction form which measures levels of psycho-social functioning;[5] and a satisfaction-with-health-care form which is a measure of satisfaction with the kind of care received in the past.

The staff review these questionnaires before clients are seen. These self report responses help the staff gain a better understanding of the clients' health and social needs. It also offers a systematic method of assembling data and preparing health plans in advance.

Once these forms are completed each participant then meets with the social worker for the initial intake visit. The social worker explains the program in detail to the new participant and attempts to determine the psycho-social needs of the individual. Most importantly, however, the social worker makes the new participant feel welcome as a member in his or her own health-care team.

An important PHC objective is to educate the clients about his or her health and health-care needs as well as to determine which resources might be available to meet their needs in their own neighborhood. In many instances the client is taught to monitor his or her own disease process and is encouraged to ask questions about medications, diet and what to expect in the way of improvement of physical and emotional status.

The client's initial visit with the nurse is designed to obtain a complete data base for each participant so that a preventive health regimen may be instituted. As such, a complete history of the person is taken. During this time, too, the nurse and client begin to establish a rapport. The nurse is sensitive to the client's communication needs and paces herself accordingly during the initial assessment.

In many instances during this first nursing visit only vital statistics such as blood pressure, pulse, respiration, weight and sugar acetone tests are obtained, along with a general review of the participant's biological systems. During the next visit, which is scheduled a few days after the first, a more complete physicial assessment is made, still keeping in mind the client's needs and sensitivities. Often, the nurse must adjust her natural pace to the slower one of the geriatric client. Changing one's pace requires a measure of patience; however, it does have its rewards. The client will be more inclined to cooperate, he or she will feel the nurse's empathy and attentiveness to what they say to her. The natural result of this interaction is that the amount of information gathered is of greater quality. The better the quality, the more accurate the picture of the health status of the client.[6]

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[3] Sir Ferguson Anderson, "Preventive Medicine in Old Age," In J.C. Brucklehurst, *Textbook of Geriatric Medicine and Gerontology*. London: Churchill Livingstone, 1978.

[4] Randi Kopf and Michael J. Salamon, "The Health Background Questionnaire: A Brief Self-Report Measure." In Press, 1981.

[5] Michael J. Salamon and Vincent A. Conte, "The Salamon-Conte Life Satisfaction in the Elderly Scale." Paper presented at the 34th Annual Meeting of the Gerontological Society of America, October, 1981.

[6] Rosine Carotenuto and John Bullock, *Physical Assessment of the Gerontologic Client*. Philadelphia: F.A. Davis Co., 1980.

In instances where clients present more severe problems, eg. severe abdominal pain, chest pain or shortness of breath, the first priority is to refer them to their own physicians. If they have none, the PHC refers them to one of its participating physicians. A physical exam is suggested in these cases to secure a medical diagnosis and to prescribe medical treatment.

Once the clients have been seen by both staff members and have paid the membership fee, they are entitled to an unlimited number of visits with the nurse and social worker. The PHC staff encourages clients to visit them at least once a month for regular blood pressure monitoring and counseling. Many though, come in weekly for health counseling and more intensive monitoring.

The two major areas of health concern that we have isolated in our senior population thus far are hypertension and compliance with required drug regimens.

Hypertension

An inevitable part of the aging process, and usually considered not worthy of treatment, is an increasing systolic blood pressure. However, more recently, the importance of systolic hypertension, regardless of its course, in the genesis of heart attacks, heart failure, strokes, renal insufficiency and other vascular diseases, has become increasingly apparent. Indeed, when it is realized that cardiovascular disease is the overwhelming cause of illness and death in the elderly community, the question of whether to treat hypertension in older individuals becomes one of the most vital health issues in medicine.[7]

Both Canadian and United States studies indicate that approximately 15 percent of older adults suffer from hypertension.[8] It has also been found that with hypertension-detection and follow-up programs and rigorous treatment of even mild hypertension (diastolic pressure 90 mmhg), significantly decreased mortality rates from all causes result.[9]

Based on these findings there is general agreement that blood pressure of older adults should be measured at regular intervals. Appropriate follow-up, when indicated, is critical. It is usually the nurse who first finds clients with mild to severe hypertension. If she suspects a client of having high blood pressure she asks them to come in for two more blood pressure readings within a two week span. If the readings are still high her nursing diagnosis is then conclusive and she refers them to a physician for further diagnostic and follow-up care. The clients are instructed to report back to the nurse after their visit with the physician. This is an important aspect of prevention because at that follow-up meeting the nurse can determine whether the patient understood the doctor's stated opinion.

To maintain contact with both the client's needs and the medical care they should receive, all clients referred to physicians are given a follow-up form by the patient that the physician mails back. The form asks the doctor to document his or her findings, including any new medications prescribed or other treatments. An appointment is then set up with the client for a follow-up visit with the nurse. At this meeting the nurse takes as much time as necesary to review with the client the doctor's findings, medications, route, dosage, times to be taken and possible side effects, also, to

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[7] Jan I. Drayer and Michael A. Weber, "Hypertension in the Elderly: A New Understanding," *Drug Therapy Hospital,* February, 1981, pp. 39-43.

[8] J.A. Wilbur et. al., "Hypertension, a Community Problem," *American Journal of Medicine,* Vol. 52, 1972, pp. 632-37.

[9] "Five Year Findings of the Hypertension Detection and Follow Up Program," *Journal of the American Medical Association,* Vol. 242, 1979, pp. 2562-71.

explain the results of any laboratory tests that were performed.

Compliance with Drug Regimen

Another major area of concern is the question of compliance with programs of medication. Out of the 70 participating members in the PHC, the nurse has found 30, almost 43 percent, who are hypertensive, and under the care of a physician. More than half of these individuals reported that they don't understand the purpose of continuing their medications when a normal blood pressure was found. As a result, they independently decided to discontinue the treatment. When these individuals do not feel well, they attribute this to an increase in their blood pressure, and begin to take the medications again. They fear telling their doctors that they have not been taking their medications routinely. What happens as a result of this inappropriate use of medication, is that the physician prescribes another medication to compensate for the fact that the previous medications apparently did not seem to work. When the client meets with the nurse they are in a state of anger and uncertainty. They are upset that they have to spend additional funds on new hypertensive medications when they still haven't finished the old ones.

One of the results of establishing a close relationship between the nurse and the client is that the client will usually confide in the nurse and admit to their non-compliance. It is at this point that the nurse has the most influence on the client. She counsels them regarding the risks they are taking in suddenly discontinuing medications, reviews with them the physiology of their condition. She is careful not to suggest side effects but encourages them to call their doctor if they are experiencing any changes in bodily reactions.

Her role is well exemplified in the care of hypertension. Physicians often neglect to tell their hypertensive patients that it may take anywhere from one week to two months for the patient's body to adjust to the new routine of medication. They may also fail to tell the patient that it is not uncommon to experience some side effects, such as nausea, dizziness and, occasionally, vomiting. When older adults experience these side effects they report that their doctor used poor judgment in prescribing the medications and they may refuse to go back for a follow-up visit. If the doctor would have discussed these common side effects with them from the start, the rate of compliance might have been higher. The nurse at the Preventive Health Center serves as the liason between the doctor and patient and acts as an educator for the latter. We have found that not only has medical compliance increased among our participants, but members are now showing a greater interest and responsibility for their health care.

Older adults suffering from arthritis exemplify a "mechanical," but important problem. They are keenly aware of the difficulties posed by child-resistant containers but ignorant of the method to overcome them. This is an important issue in compliance. If they cannot open the medicine container, they won't take their medications. Since medication is the basis of therapeutic and symptomatic intervention in many chronic diseases of the elderly, the nurse has begun to make physicians aware of the compliance barrier imposed by medicine containers.

During the clients' initial visit to the nurse they are instructed to bring in all of their medications with them. The nurse not only describes their use and reviews with them the times they are to be taken but also observes their dexterity, or lack of it, in opening the containers.

Having the nurse on site at a senior center, where the elderly congregate, serves as a reminder to them that their health needs will be monitored closely. A trusting relationship develops and there is an increase of concern on the part of the older adult as to how to maintain their health.

The Social Worker in a Preventive Health Center

The social worker in the PHC is a medical social worker. An individual's social, emotional and economic condition directly affects his or her physical health. Alteration in blood pressure or weight, diabetes, and pain in general are some examples of physical change which strongly influences an individual's emotional status. The individual's emotional status, in turn, is directly affected by interactions with significant others: family, friends, neighbors, and the agencies and bureaucracies serving them, i.e., the medical profession (physician, hospital, clinic), medicare and medicaid. Cohen[10] indicated that illness leads to a number of concomitant problems. Consideration of these other factors, usually social in nature, is an inseparable aspect of the diagnosis and treatment plan. The medical social worker in the PHC attempts to work within the framework of holistic medicine. "Social work must function in the context of the whole person within his life situation."[11]

Problems are intensified by the age of our participants, their losses, poverty, infirmities, loneliness and pain. Preventing deterioration and maintaining the well-being of participants entails an awareness of the individual's life situation. The social worker needs to be in a working relationship with the individual, as well as the systems the individual is connected to and dependent upon. A working relationship with community agencies, hospital social workers, Department of Social Service caseworkers, local physicians, pharmacists and medical suppliers is essential.

The social worker's main focus is health. It is important to educate the PHC participants as to how their psycho-social situation affects their health. One example of the social worker's role in helping older adults deal with stress is the response to a request from the older adult for a blood pressure reading. Upon inquiry the social worker may find a family problem has upset the participant. The social worker works with the participant around this issue offering support, a listening ear and appropriate intervention. It is important to work on strengthening and reinforcing coping abilities.

In general, participants need to be educated as to their roles and responsibilities as patients and as medical consumers. Most have played a passive role in their health care and relationships with the medical profession. The social worker reaches the clients directly as an individual and through group interaction educates participants how they can best utilize physicians and medical systems.

The nurse and social worker share in the programming and treatment of health center participants. The social worker focusses on the interpersonal and environmental aspects of each participant. Dealing in groups with weight loss, blood pressure and arthritis, the social worker leads discussions on the emotional and coping mechanisms utilized by each participant. Using group work techniques, the social worker helps to support, encourage and nurture the interpersonal relationships of the seniors to one another. "The group worker's role is to forward the relationships of its separate members and to make this relationship the most significant."[12] This takes place in the group itself, as well as in the general milieu of the community center.

The social worker facilitiates time-limited weekly health discussion groups. The

[10] Ethel Cohen and Harry A. Derow, "Training of Interns in the Aspects of Illness," in Dora Goldstine, *Expanding Horizons in Medical Social Work*. Chicago: Anchor Press-Doubleday, 1978.

[11] Elizabeth D. Thaxton, *The Problem Oriented Medical Record*. Chapel Hill: University of North Carolina, 1973.

[12] Gisela Konopka, *Social Group Work: A Helping Process*, New Jersey: Prentice Hall, 1972.

participants share issues of concern. The groups have an attendance of twelve to fifteen members and are formed based on need expressed by older adults. The following topics have been discussed in PHC groups; loneliness and living alone, sexuality and the need for affection, mental health and coping mechanisms, community and social services, expectations and the realities of aging, roles and responsibilities of patients and physicians, the high cost of medical care, and the abuse and fraud by medical providers. The trained professional strives to effect group cohesiveness, teaching participants to listen to one another and work together. Members tend to be quite enthusiastic about the groups. They are eager for them to begin each week, always giving positive feedback to the social worker.

Most of the elderly carry a tremendous emotional load. Older adults need to talk and to be listened to. This process begins immediately upon intake with the social worker. Having a Preventive Health Program based in a community center offers staff an opportunity to screen emotional and medical problems which might otherwise go unnoticed. The medical social worker, along with the nurse, discovers cases of emotional distress in need of a long term counseling and/or the intervention of a psychiatrist. It has been our experience that it is important to have a good working relationship with a mental health program. Our community center is fortunate in that in addition to the PHC it has an onsite counseling program for older adults. Few members however, directly request such a counseling service. Most participants find it easier to talk with the staff of a general health center as opposed to a mental health program, due to the possible stigma associated with the latter and possibly a lack of education as to the role of counseling. Participants tend to open up more easily to the general health professional,[13] which is the role the PHC social worker takes. Often the medical social worker can begin meeting with the participant on a regular basis focusing on the link of psychological well being with health. Through such a working relationship the medical social worker can introduce and, if necessary gently connect the participant to mental health counseling. The medical social worker clarifies the role of the participant. The participant is helped to realize that the mental health program is designed to help those needing long-term counseling. In general, the social worker aids participants in securing concrete community services, giving information, and advocating as a referral agent. Consistent support and counseling are offered to the senior members as they meet daily with the social worker within the community center.

The PHC social worker supervises volunteer, self-help programs reaching out to the older adult community. These programs include: a telephone structure to provide reassurance, a widowed person's service and a home-activities program for homebound older adults.

In the Telephone Reassurance program volunteers call homebound seniors on a daily basis to have a friendly chat. The volunteers report back to the social worker any problems or unanswered calls. The social worker follows up on these cases, providing telephone counseling, information and referral and arranging for concrete services. Police or building management are notified if the homebound clients cannot be located and are feared to be in danger inside their apartments.

The Widowed Person's Service reaches out to newly widowed persons in the community. The social worker supervises and

[13] Marcella Weinna, Albert J. Brok and, Alvin M. Snadowsky, *Working with the Aged.* New Jersey: Prentice Hall, 1978.

assists in the training of widowed volunteer aides. The aides, themselves widowed at least eighteen months, are trained in the counseling needs of newly widowed persons. The social worker receives referrals from the community, mainly hospital social workers. The PHC social worker contacts the widowed person making an aide assignment when appropriate.

In another aspect of the PHC program, local high school and college students and community residents have been trained to work with homebound elderly. They offer companionship and escort service to otherwise isolated individuals.

These programs are geared to the maintenance of health in that they respond to the needs of the most highly threatened population of older adults, recent widows and the frail homebound. By offering support and counseling the PHC helps them through their most difficult and trying times.

The main purpose of our program is to keep our community seniors active and independent. When possible we attempt to effect changes in the lives of our seniors. We help the PHC members cope with that which cannot be changed. We offer preparation, education and a lot of love and sincere caring.

Evaluation

A review of programs currently underway indicates that those who took part in PHC activities gained significantly and have greatly improved. The process evaluation has, however, turned up a number of issues that challenge the continuance of the program.

The most pressing problem is funding. This project was started with a generous grant that will shortly run out. The most realistic approach, given the ephemeral nature of most funding by grant, is to have preventive health services become a reimbursable alternative medical treatment. We have explored that issue on the state level and hope that our inquiries will be successful.

A dilemma faced by most social service agencies is the lack of facilities for programming. Preventive health care programs require a great deal of room. Offices, examination rooms and waiting rooms, along with storage areas for supplies, are required. If other agency staff are not included in the planning process a lack of clarity as to who gets what space may result in a situation that threatens the program. To overcome this problem, along with any other staff attitudes and biases that may exist, the PHC staff meets twice monthly with all other programming staff. Program needs are delineated and potential competition is thus avoided.

To overcome any biases toward the program from the medical profession the PHC has held regular meetings with hospital personnel and independent service providers. In addition, a medical advisory board, consisting of private practitioners, professional consultants and hospital personnel, meet quarterly to review the program's progress, make recommendations, review patients' charts and discuss other program issues. By opening a dialogue and allowing the program to be understood the PHC is better able to service its population needs.

Summary

The PHC at the Hartman Y was designed to meet the health needs of older adults residing in the Far Rockaway area. By providing preventive health care programming, including health monitoring, counseling, screening and through the use of both staff and community resources, the PHC has begun to make its participants more aware of their health needs, with the result that these older adults will remain functional for a longer period of time.