subsidy needed per case will continue to rise.

3. New referrals, stimulated by community awareness, will mean more cases added to the current caseload, whether for long-term assistance or short-term emergency help. The addition of new cases will tend to exceed the loss of cases—those taken off subsidy because of death or acquisition of other resources making them financially independent.

The major conclusions to be drawn are:

a. Programs of financial subsidy by the Jewish community for the poor and marginal income families are desirable and needed.
b. Once such programs are instituted, larger numbers of "younger" families get referred for assistance than originally anticipated, indicating that poverty among Jews is not confined primarily to the aged.
c. Such programs involve marked increase in expenditure of staff time (professional, clerical, bookkeeping) to study the cases, to determine eligibility, to make home visits, prepare budgets, provide mechanisms for continued grants and continued casework follow-up with clients, whether or not they received a grant.
d. Budgeting for such programs must therefore include funding for additional staff as well as for steadily rising costs for direct financial assistance.
e. There must be a clear understanding on the part of staff, board and the Federation that once a regular financial assistance program is instituted in the community there is no way of retreating and withdrawing the grants without causing serious hardship to those who need this assistance, and have come to expect such supplementation. It becomes part of the "rising expectations" not only on the part of clients but also the community, the volunteer workers who come in contact with these families, the board members who set agency policies and who have helped raise money in campaign drives, and the leadership of Federation who have developed a sense of commitment to the concept that the Jewish community "takes care of its own."

This convergence of forces and pressures will tend to insure continued commitment to financial assistance programs once the process has begun and there is continued interpretation of the need. It emphasizes the importance of knowing from the beginning what one is getting into when making a commitment to help the Jewish poor and marginal-income families, and the long-term consequences of such a commitment.

An Experimental Geriatric Group Home

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"Since intensive service is not the intent of the group home . . . (it) should be reserved for the more independent and motivated applicants. The admission of moderately dependent people who are not motivated toward independence should be limited to those whose families are available to provide the necessary linkages with the community."

By any criteria the elderly easily qualify as a vulnerable group. They are poorer economically, have more health problems (physical and mental), experience more interpersonal losses, and lose status and social roles more than any population. Within the total aging population are subgroups at particular high risk: ethnic and racial minorities, widows, the poor, the mentally and physically impaired, the extremely old, the elderly poor in inner-city areas, the institutionalized, and the emotionally fragile.[1]

ONE major reason for the vulnerability of the elderly is the lack of a service continuum designed to meet the needs of individuals with varying levels of functional strengths and limitations. A well-designed service continuum provides multiple service combinations with accessible points of entry. It also allows for movement between services. Such a service continuum is not, however, created overnight. It requires planning, commitment of resources, and a philosophy about human services.

Historically, Levindale Hebrew Geriatric Center and Hospital has attempted to use a core of institutional services as the base for constructing such a service continuum. Within the institution there are multiple care levels differentiated by various patterns of medical and nursing care, complemented by a wide range of social, psychiatric and therapeutic services. In addition, in 1970, Levindale pioneered in establishing a geriatric day-care center which is now recognized as a national model for day treatment. Three years later, a community-based group home was begun as another alternative to institutionalization.

The Hurwitz House Group Home was established as a demonstration project to test the feasibility of modifying nursing home service patterns by using supervised group living facilities in the community. It was anticipated that the target population for the demonstration did not require an institutional setting to receive the necessary supervision and care but could be maintained in the community with minimal staff support. This paper presents the results of a study that assesses the effectiveness of the community care approach by comparing the group home with a similar level of inpatient care.

Two Models of Intermediate Care

Levindale's inpatient sections provide four levels of care that correspond to the levels of certified and reimbursable care (through Medicare and Medicaid) in the State of Maryland. These are:

1— Chronic Hospital: for those individuals suffering from long-term medical conditions who require medical and nursing services beyond the level of nursing home care.

[1]Elaine M. Brody and Stanley J. Brody, "Decade of Decision for the Elderly", *Social Work*, Volume 19, Number 5 (1974), p. 545.

2— Skilled Level: for those individuals requiring twenty-four hour nursing care under the supervision of a registered nurse.
3— Intermediate Care Facility "A" (ICFA): for those individuals who require a twenty-four hour plan of care that can be adequately provided by less trained personnel.
4— Intermediate Care Facility "B" (ICFB): for those individuals who suffer from no major medical problem, but require a supervised environment that provides personal care services and continuous general supervision.

The traditional setting for aged persons requiring ICFB level of care is an institution. As inpatients, these individuals become residents in a long-term geriatric setting, structured to replace the community in which the individual can no longer function effectively. Increasing physical infirmities interfere with the ability to perform the activities required for independent daily living. A worsened mental health picture is often observed to reduce further the functional capacity of these individuals.

The second of Levindale's ICFB settings is a group home called Hurwitz House. Located in a residential neighborhood away from the main complex, Hurwitz House has two buildings and a staff of four. The staff includes an LPN, two aides and a handyman who does the heavy cleaning and drives the group home's van. Only ICFB patients are accepted.

The major service objectives of the group home are:

1— to give some care and supervision, but to place an emphasis on self-care;
2— to modify the traditional institutional staffing patterns which tend to reduce the patient's motivation to function as independently as possible;
3— to encourage the residents to function as much as possible as members of the community by having them use community resources including family, professionals in private practices, community-based social agencies, and other social and recreational activities available in the marketplace.

In contrast to the institutional setting, Hurwitz House provides only a semi-protective environment that includes a skeleton of supportive services such as meals, assistance with heavy housekeeping, limited group transportation, and low level nursing supervision. A group home resident must leave the grounds to fulfill his needs for either health-related services or social, leisure and recreational activities.

The Study

The evaluation of the two ICFB settings took place over a three-month period The major research questions were designed to determine the degrees of similarity between the patient populations in both settings, the congruency of service delivery patterns in both settings, and the perceptions of patients' needs by the staff, family members, and the patients themselves. Data were obtained from interviews with nursing staff, family members and patients in both settings. Case records and participant observation methods were also used as an important supplementary data source whenever appropriate.

Seventeen of the 19 residents in the group home (maximum capacity 22 beds), and all 24 ICFB Levindale patients (maximum of 30 beds), were used for the patient comparison

groups. Fourteen family members from each setting (those members reported by staff to have most frequent contact with the patients) were interviewed, and licensed nursing personnel provided the comparative staff perception data. Two residents from the group home were excluded because of their hospitalization. The family group did not include a member for each participant because two families refused to participate and some patients had no families in the Baltimore area. The group home nurse was the most authoritative person for this setting and two RN's and one LPN answered for the inpatients.

Characteristics of ICFB Patients

Analysis of sociodemographic characteristics showed the two groups to be very similar in sex ratio, marital status, length of residence in the setting, type of prior residence, and reasons for seeking admission. These characteristics are compared in Table 1.

TABLE 1
Characteristics Common to Both ICFB Groups

	Inpatient (N = 24)	Group Home (N = 17)
	%	%
Sex		
Male	29	29
Female	71	71
Marital Status		
Widowed	71	71
Married	8	0
Other	21	23
Length of Time in Setting		
Less than one year	42	53
More than one year	58	47
Prior Living Arrangement		
Alone	29	35
Share Apartment	71	65
Reason for Application		
Medical	29	35
Social	71	65

It is of particular interest that in both groups, social factors were of predominant importance in the decision to seek admission. The medical problems that ICFB applicants have usually create social problems in that they require the individual to have very close supervision. The problems of failing sight, hearing loss and chronic conditions which reduce ambulation are more threatening to the aged person who lives alone, but living with family members often creates a situation of considerable stress and tension. For the aged person who does live alone, fear of crime and fear of isolation can also create significant social problems.

TABLE 2
Characteristics that Differentiated Two ICFB Groups

Characteristic	Inpatient (N = 24)	Group Home (N = 17)
	%	%
Age		
65–74	33	12
75–84	33	65
85+	33	23
Location of Children		
Adult children in close proximity	33	59
No children in close proximity	67	41
Physical Health *		
Good	25	0
Moderate	75	82
Poor	0	18
Mental Health *		
Good	33	0
Moderate	55	82
Poor	12	18
Performance of ADL *		
Very independent	75	47
Somewhat dependent	8	12
Very dependent	17	41

* Ratings based upon Scales from the OARS Project at Duke University. Good = 1 or 2; Moderate = 3 or 4; Poor = 5 or 6.

Differences between the two groups were discovered in age of residents, location of children, the functional ratings of physical and mental capabilities and activities of daily living. These are presented in Table 2.

Suprisingly, the group home population was notably older and in poorer functional health than was the inpatient population. However, great variation existed within each setting. At Levindale the patients were evenly distributed by age. Hurwitz House was more homogeneous, but there was still more than a 20-year difference between the youngest and oldest residents. At Hurwitz House, all the residents were either in moderate or poor physical health. At Levindale, however, one-quarter were in very good health for their age, and the other 75 percent were in moderately good health. In both settings, the functional performance of activities of daily living varied from totally independent to very dependent. At Hurwitz House, the residents varied from "mildly" to "severely" psychologically impaired. At Levindale, mental health varied from very good to very poor.

The functional diversity of the group home population has several implications for service. Functional differences allow the minimal staffing pattern to work because nursing personnel can give concentrated support to those individuals who are most dependent as the more independent do not require much staff assistance. Additional support for these very dependent people is provided by the direct linkage to the institution if more intensive care is required. Support also comes from outside the staff as helping interactions emerge as part of a group norm with the more independent residents offering support and assistance to the dependent. On the negative side, the mixed population makes formal social and recreational programming exceedingly difficult, if not impossible.

TABLE 3

Type of Contact in Community	Percentage of Residents Reporting at Least One Contact Since Admission: Inpatient (N = 24)	Group Home (N = 17)
Visiting with family	71	82
Leisure activity	54	88
Medical service	17	71
Religious activity	17	41
Visiting with friends	8	12

Community Activity

There are some important differences in types of community contacts the two groups have. Group home residents have a far greater proportion of medical service and leisure activity contacts in the community than do inpatients.

TABLE 4
Leisure Contacts Outside Institution/Off Grounds

	Inpatient (N = 24)		Group Home (N = 17)	
	Percentage	Average Occurrence *	Percentage	Average Occurrence
With family	38	Once per wk.	82	once per wk.
With staff	29	Once per mo.	0	never
Alone	23	once or twice per wk.	35	almost daily
With driver	0	never	100	once per wk.

* Average frequency of activity among those having contacts.

TABLE 5
Service Contacts Outside Institution/Off Grounds

	Inpatient (N = 24)		Group Home (N = 17)	
	Percentage	Average Occurrence *	Percentage	Average Occurrence
With family	0	never	47	less than once per mo.
With staff	46	once per mo.	0	never
Alone	29	once per mo.	35	less than once per mo.
With driver	0	never	6	one patient one time

* Average frequency of activity among those having contacts.

There are significant differences in the patterns of interchange between the community and the ICFB setting. Both groups have two types of contacts, "leisure" and "service". These patterns are shown in Tables 4 and 5.

The family is an essential resource for group home residents for "leisure" and "service" contracts. For some inpatients, families facilitate leisure, but not service, contacts in the community. The group home staff are not involved in facilitating any leisure or service contacts (the driver, although on the payroll of the group home, is not considered by administration to be staff as he does not give any supervision once the residents arrive at a destination). A slightly greater proportion of group home residents reported going out alone for service and leisure than did inpatients. Group home residents also travel a greater distance alone to receive services.

Perceptions of activity level differed between patients and their families. It was not possible for subjects to give a specific description of how their activities had changed since admission, but almost two-thirds of the group home residents perceived their activity level as lower. Families, on the other hand, tended to perceive an increase in activity level. This discrepancy was greater in the group home. (See Table 6)

Service Patterns

Differences between the two groups in the frequency and type of community contacts can largely be explained by

TABLE 6
Perceived Change in Activity Level Change

	Lower %	Same %	Higher %
Inpatient			
Resident (N = 13)	39	46	15
Family (N = 10)	9	64	27
Group Home			
Resident (N = 17)	71	12	17
Family (N = 17)	17	33	50

TABLE 7

Type of Service	Percentage of Persons Reporting Receiving Service From Staff: Inpatient (N = 24)	Group Home (N = 17)
Heavy housekeeping	100	100
Meals taken	100	100
Giving medications	100	100
Making personal purchases	17	24
Light housekeeping	100	18
Religious services	63	6
Bathing	54	6
Dressing	21	0
Physical therapy	Unknown	0
Occupational therapy	46	0
Recreation	88	0
Social Worker	77	0
Laundry	100	0

the different patterns of staffing and service delivery in the two settings. Table 7 shows the major differences in patterns of service delivery between the inpatient and group home setting. These differences are intended and reflect the philosophy behind the group home. Group home respondents received very few services on a regular basis except for such things as an occasional recreation program conducted by a community volunteer group, a resident council meeting attended by a social work graduate student, and a ride in the van to some community program.

Satisfaction with Service

The aged subjects in both settings indicate high levels of satisfaction with the services they received. (Table 8) Inpatient staff and families also reported high levels of satisfaction. Group home staff and families were less satisfied. Nursing staff at the group home felt that a greater variety of physical support services could be offered for the more dependent residents. This dissatisfaction on the part of family related to planned social activity and not to the physical supportive services given to patients. There was also a difference in satisfaction with community contacts. The two patient groups indicated almost equal satisfaction, but there was a difference in the family groups. (Table 9) In spite of these dissatisfactions, services were generally considered appropriate by staff, families, and patients. (Table 10)

TABLE 8
Satisfaction With Service

	Inpatient (N = 24)		Group Home (N = 17)	
	Satisfied	Not Satisfied	Satisfied	Not Satisfied
	%	%	%	%
Residents	94	6	82	18
Families	93	7	58	42
Staff	88	12	59	41

TABLE 9
Satisfaction With Community Contacts

	Inpatient (N = 24)		Group Home (N = 17)	
	Satisfied	Not Satisfied	Satisfied	Not Satisfied
	%	%	%	%
Residents	79	21	77	23
Families	71	29	54	46

TABLE 10
Perceived Appropriateness of Current Services

	Inpatient (N = 24)		Group Home (N = 17)	
	Appropriate	Not Appropriate	Appropriate	Not Appropriate
	%	%	%	%
Residents	96	4	94	6
Families	93	7	100	—
Staff	88	12	100	—

Discussion

The results of this evaluation raise several important issues about the philosophy and the implementation of group homes. By reducing the number of staff and the variety of services, Hurwitz House forces the residents and/or their families to assume responsibility for self-care. For the most independent of the group home sample, there is full utilization of those community resources which they themselves consider important. For example, these residents initiate involvement in community social, recreational, and religious activities. The patterns are different for the more dependent residents. This group exhibits greater reliance on their family members for personal care and as their vehicle to community resources. The more dependent residents tend not to

participate in outside community activities.

Hurwitz House is able to provide protection and minimal services to all individuals, but the current structure does not seem effective in developing remotivation among the more dependent. Among those who are admitted without a sufficient level of motivation, the family serves as the major motivating stimulus. In contrast, the inpatient setting is served by personnel who will intervene actively on the part of the more dependent (physically impaired and non-motivated) residents to try to insure that they take advantage of the institutional resources. This type of aged person requires an intensive milieu that fosters remotivation as a form of rehabilitation. Since intensive service is not the intent of the group home, Hurwitz House should be reserved for the more independent and motivated applicants. The admission of moderately dependent people who are not motivated toward independence should be limited to those whose families are available to provide the necessary linkages with the community.

Recommendations

Through the evaluation of Hurwitz House, research staff have identified several issues that have implications for this group home and for the wider field of practice. The group home concept as originally developed helps to insure that the more independent and motivated aged persons will not suffer from "service suffocation". About one-third of the present group home residents are functioning independently in all areas of self-care and making use of those community resources they both need and desire. Another third are doing this on a limited basis, but could be motivated to participate in more community activities. (This would require intensive individual attention to enable them to accomplish a greater level of activity). The remaining one-third are too impaired functionally to be expected to make use of any community resources; they are just able to negotiate the self-care procedure in the group home setting.

The group home population should be reviewed to determine which individuals have the potential for a greater level of community involvement. Based upon the results of this evaluation, families and representatives from the Jewish Family and Children's Service and the Jewish Community Center should develop ways to help remotivate and reorient residents to the use of community facilities and programs. Many of these people have been socially isolated for many years prior to admission and do not have a basis for this pattern of participation.

Admission criteria and procedures should be developed to insure that admission to the group home will be limited to persons who can profit from this setting. The check list such as the one in Figure 1 is a useful guide for determining which ICFB facility is more appropriate for a given patient. The list includes activities of daily living as well as social activities that may be important to an aged individual. A determination should be made about which of these needs the individual has the capacity and desire to meet for himself. A similar determination should be made of which needs can be met by the family (or family surrogate). The combined resources of the individual and the family should then be matched with the services available in both the group home and inpatient settings. If there are needs unmet by either the individual, the family, or the setting, one of two choices is available. First, the individual can be placed in the group home with the awareness that certain service elements are ab-

FIGURE 1
ICFB Admission Check List

Life Activity Areas	Individual Resources	Family Resources	Setting G.H. I.P.
Dressing			X
Cooking			X
Light cleaning			X
"In-house" therapy			X
Laundry			X
Bathing			X
Light shopping			X
Recreation			X
Religious activity			X
Transportation to medical services			X

sent. For example, if there is an absence of religious or recreational activities and the individual is satisfied to live without these services, then the group home remains a viable placement. If the missing component is crucial to the health or safety of the individual, the group home is the wrong placement. The second alternative is placement in the institution where all of the service components are provided or consideration of other group living arrangements available in the community (i.e. foster homes).

Regular and formalized case progress reviews should be completed for each resident. The Admission Check List would provide a framework for the ongoing assessment of changing needs and resources. This assessment should be interdisciplinary.

Finally, thought and planning should be devoted to the management of group home residents with temporarily increased dependency. For example, a broken arm causes problems with most physical care functions, and causes the person to require additional assistance. This type of problem could be handled through shifts within the group home or by short-term admission to an inpatient facility. Either way, this type of contingency should be planned for.

Fact and Opinion

SAMUEL SPIEGLER

The Red Mogen David

THE Israeli equivalent of the Red Cross is the Mogen David Adom, or Red Star of David, just as the Eastern European and Moslem equivalent is the Red Crescent and the Iranian equivalent is the Red Lion and Sun. But, despite a quarter century of trying, the Mogen David Adom has been refused international recognition and Israel's Mogen David Society therefore is not eligible for membership in the League of Red Cross Societies, to which all the other nations belong.

Israel has resisted pressure to accept the Red Cross as its emblem, contending that the symbol has religious connotations, as indeed the insistence of Moslem and other non-Christian countries on devising their own distinctive symbols testify.

Recently, a campaign for recognition has been stepped up, under the auspices of Operation Recognition, a world-wide effort. Its American Section has Senators Jacob K. Javits of New York and Abraham Ribicoff of Connecticut as national co-chairmen and the support of many diverse American Jewish organizations. Its headquarters are at 1 East 42nd Street, New York, 10017.

It now appears that success in the struggle for recognition of the Red Mogen David may be in view. This April, a three year diplomatic conference on Reaffirmation of Humanitarian Law will hold its concluding sessions in Geneva, and before it will be a proposal for recognition. There is hope that the proposal will be adopted.

A Ray of Hope Through the Fog of Gloom

Out of the miasma of gloom and doom that pervades the contemporary view of the Jewish future comes a bearer of glad tidings: In the year of the Bicentennial of American independence, American Jewry may be "about to embark on its golden age."

Thus spake—or, more precisely, wrote—Professor Henry L. Feingold, of the City University of New York, in the 1976 edition of the *American Jewish Year Book.*

American society has allowed full play for the energies and talents of American Jews, observed Professor Feingold, and "The portents are that American Jewry may generate sufficient cultural energy to carry Judaism forward."

The receptivity of the United States toward Jews and Jewish culture is reflected, Professor Feingold noted, in the acceptance of Jews in America's representative assemblies. Jews "have a share of power," he added; and "singling Jews out as a target becomes increasingly unlikely."

The professor thinks, moreover, that America is producing quite a bit of praiseworthy Jewish scholarship. "The mantle of scholarship worn for centuries by European Jewry," he wrote, "has been successfully transferred not only to Israel but also to America . . . American universities are witnessing a proliferation of courses in Jewish history and culture, and in some cases of entire Jewish-studies department," indicating "that a substructure is being