The Ideal Social Intervention for Community Dwelling Elderly; A Policy Analysis

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Abstract:

In the last ten years social isolation has become a hot topic among the literature regarding aging and health. Several studies have seeked to find ways to mitigate the negative health outcomes social isolation and loneliness have on community dwelling older adults. This policy analysis presents a review of the relevant literature and an evaluation of an already existing community based intervention at a facility called *Shilo,* with the goal of providing social support and cognitive stimulation to the elderly residing in a neighbourhood in downtown Haifa. The policy analysis will also be addressing the effectiveness of a novel intervention to be piloted in the same community. The effectiveness of both interventions was assessed through qualitative measures such as direct observation and unstructured interview methods. The findings suggest that the existing intervention was effective in that it was relevant, improved cognition and overall quality of life. The novel educational intervention was also found to be relevant and promoted social interaction, however was limited in proving retention of information, and external validity. Limitations such as language, sampling error and inconsistency of participants hindered the project's validity and reliability. Following the policy analysis it is recommended that the ideal intervention for community dwelling elderly uses principles of capacity building and collaboration in combining socializing, education and discussion to maintain the quality of life and social network of older adults.

Introduction

Among the many critical global health issues that are affecting the world today, one that immediately catches researchers attention is the rapid aging of the population. As the baby boom generation in North America and Europe, as well as Asian and Latin Americans reach older ages than ever previously recorded, this population is projected to be a huge demographic percentage in the coming years. In the next 10 years, those aged 65 and older will reach 236 million, and between 2025 and 2050 the *National Institute of Aging* estimates they will reach 1.6 billion.[1] Although population aging is largely due to the inability for fertility rates to keep up, the increase in this demographic also represent advances in global public health, innovations in longevity, and successful aging[2]. Now, reaching a certain age seems to be less of a concern, rather there are new challenges arising such as the quality of life over longer years, and how this can be maintained through public health interventions. Looking through a socio-ecological lens, these interventions must exist on the individual, community and policy level to mitigate the health risks that exacerbate aging and its negative correlates. There is limited research indicating the significant effectiveness of community level services to improve outcomes, such as social and educational programming, therefore there is a need for investigating on how this level of intervention can make an impact for the quickly aging population and society.

In order to comprehend the severity of a broad global health problem, such as population aging, interventions and policies must be narrowed, and then critiqued using

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[1] He, Wan, Daniel Goodkind, and Paul R. Kowal. *An aging world: 2015*. United States Census Bureau, 2016.

[2] Green, Manfred, "Introduction to Global Health - An Overview".

theory, research and practical assessments. For this capstone, I will be composing a policy analysis of the effectiveness of an existing community based support service working with community dwelling elderly in Haifa Israel, while simultaneously developing and evaluating an educational and social intervention personally designed for a cohort of the population. Integrating material from academic courses such as Developing Community Health Promotion, Research Methods, Theories and Models of Health Behaviours, Health Economics, Global Health Systems and basic Global-Public health competencies and principles, will aid in making recommendations regarding such interventions. Overall the capstone will investigate what the ideal intervention is for this population and where my results fit among the pre-existing literature regarding community intervention and social participation.

The Need for Community Intervention

As the fastest growing population is the elderly and this has tremendous implications for health services globally, trends in the research are indicating that keeping the elderly at home as long as possible can yield cost and health benefits on individual and population levels.[3] There is now a shift from promoting long term care as the site of intervention for the elderly, and now promoting home care and community living as the prefered approach.[4] CBSS, Community Based Support Services are designed to assist community-dwelling seniors to remain in their homes safely by providing services to meet social, medical/health

[3] https://www.huduser.gov/portal/periodicals/em/fall13/highlight2.html

[4]Kimura, Mika, et al. "Community-based intervention to improve dietary habits and promote physical activity among older adults: a cluster randomized trial." *BMC geriatrics* 13.1 (2013): 8.

and other specialized needs.[5] The core component to these programs is the social element. Not only is it the base of how these programs come to exist, bringing similar individuals together daily or weekly, but it also has significant health benefits. Creating opportunities for older adults to interact with one another is especially important as socializing significantly decreases with age. Throughout life, events such as retirement, death and illness among family and friends, health and socioeconomic status, may impede social participation. However, as social interaction is a determinant of healthy aging, it is necessary to maintain.[6] The health benefits associated with social participation are a decrease in functional and mobility decline, depression, risk of cognitive decline, and better self-rated health. Much of the research has confirmed the association of health and social participation. A study conducted by James et al (2011) concluded that the risk of developing deficiencies in activities of daily living (ADL's) decreased by 43% for 5 years in each social activity one participated in, and the risk of mobility issues lessened by 31%.[7] Another study concluded that cognitive decline among older adults decreased by 70% who were frequently socially active over 5 years compared to those who were not.[8]

The most impact social programming yields is at older ages and among women, as both groups face the risk of social isolation and loneliness. Social isolation refers to an

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[5] Siegler, Eugenia L., et al. "Community-based supports and services for older adults: A primer for clinicians." *Journal of geriatrics* 2015 (2015).
[6] Novek, Sheila, et al. "Social Participation and its Benefits." *Report prepared for University of Manitoba Centre on Aging* (2013).
[7] James, B. D., Boyle, P. A., Buchman, A. S., & Bennett, D. A. (2011). Relation of late-life social activity with incident disability among community dwelling older adults. Journals of Gerontology Series A: Biological Sciences & Medical Sciences, 66A(4), 467–473.
[8] James, Bryan D., et al. "Late-life social activity and cognitive decline in old age." *Journal of the International Neuropsychological Society* 17.6 (2011): 998-1005.

objective observation of one's social network, where there is a lacking in social contact. Loneliness is more subjective, as it represents a person's perceived connectedness to others in its quality and quantity. Loneliness, in conjunction with social isolation, is a serious social public health issue.[9] There are estimates that 50 to 60% of community-dwelling older adults live in such a state, and there is significant research verifying the negative health outcomes associated. Both these concepts, social isolation and loneliness, are not well researched in regards to their prevalence and direct risk; rather only an association to aging is known.[10] Understanding the theory of association from epidemiological studies, and how causation and its direction is never proven, the relationship between social isolation and loneliness must be critiqued and all confounding factors should be taken into account when making assumptions in the research. Although in the research loneliness and social isolation have been identified to be risk factors associated with poor health outcomes such as physical deficits, cognitive decline and an overall cause of morbidity and mortality, the causal direction remains unclear and a topic of dispute in the literature.[11] Does poor health cause loneliness and social isolation, or does being isolated and lonely lead to poor health outcomes? Regardless of the direction, the most important conclusion the research presents, is the absolute positive affect social participation has on health, wellbeing and quality of life among older adults whether it is preventing significant morbidity or aiding in treatment. The risk of social issues is extremely heightened among the aging population, therefore a critical opportunity exists for policy makers and social services to design programs that promote

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[9] Luo, Ye, et al. "Loneliness, health, and mortality in old age: A national longitudinal study." *Social science & medicine* 74.6 (2012): 907-914.
[10] Grenade, Linda, and Duncan Boldy. "Social isolation and loneliness among older people: issues and future challenges in community and residential settings." *Australian Health Review 32*.3 (2008): 468-478.
[11] http://www.health.gov.bc.ca/library/publications/year/2004/Social_Isolation_Among_Seniors.pdf

social participation.[12] The nature of such programs may vary, but a universal step towards success is the existence of the senior day centre. This is a space where the social community is a focal point to intervention. The centre enables seniors to come together for activities and services ranging from education, arts, and exercise that promote dignity, autonomy and group-based interaction.[13] The benefits of attending such an institution aligns with that of social participation, such that attending programs promotes the maintenance of a social network, improving physical health, and perceptions of self-rated health.

For the purpose of this capstone and understanding the social programs that exist for the elderly, a community-based intervention at a senior centre was chosen for the analysis. The purpose of such a project is to investigate what exists in the Haifa area, and whether modifications are needed in order to develop the ideal program this population. The remaining components of the integrated learning experience will demonstrate the qualitative methods chosen to frame the design and evaluation of this investigation, the results concluded following two months of observation and personal intervention, an in depth reflection on how this program compares to the literature and what policy improvements are possible.

Qualitative Methods

The following section will look at the qualitative methods that developed the research project. Sections have been divided in order to emphasize the process in almost a timeline

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[12] Lee, H. Y., Jang, S., Lee, S., Cho, S., & Park, E. (2008). The relationship between social participation and self-rated health by sex and age: A cross-sectional survey. International Journal of Nursing Studies, 45(7), 1042–1054. doi: 10.1016/j.ijnurstu.2007.05.007

[13] Novek, Sheila, et al. "Social Participation and its Benefits." *Report prepared for University of Manitoba Centre on Aging* (2013).

fashion from the initial research, the various observations, the design of a novel intervention and the evaluation.

Process of research

After having a prior interest in aging and health outcomes, and noting that Haifa had a very large elderly population, it was apparent that seeking an existing community program for the elderly that would benefit from a policy analysis, would be possible in the selected region Interested in interventions that prevent loneliness and social isolation, a day centre was the ideal place to start. Using the Israeli Google search engine and the key words *Elderly+Centre+Haifa,* and *Day-Centre+Seniors+Haifa,* community day centres were located for the elderly in various neighborhoods. Many hits were variations of nursing homes or cultural centres, both were not ideal populations for the research. Finally *Shilo,* an association for developing services for the elderly in Haifa was found. The organization houses a diverse team of professionals providing social services daily for community dwelling elderly, ages ranging from 65-85, in Hadar, Haifa. Services include transportation to and from home, cognitive therapy, exercise and physiotherapy sessions, meals, crafts, music, group based or one on one computer training classes, weekly lectures, religious and general social activities. Upon contacting the organization the introduction date was set in order to discuss the needs of the organization, and where a student could be of assistance. Following the first meeting it was determined that as a practicum and shadowing student, the weekly lectures and social programs would be observed to inform a new program that could be added as a feature program.

Process of Design

In order to inform what type of intervention could benefit this population it was decided that performing an abbreviated needs assessment was necessary. The strategy used was one that was introduced in the academic class *Developing Community Health Promotion*. The needs assessment consisted of four relevant parts: the social assessment, the epidemiological assessment, the behavioural-environmental assessment, and the administrative and policy assessment. [14] In all of these sections research was conducted to understand the background of the population in Haifa in relation to the specific population at *Shilo.* Statistics and background of the Haifa elderly population specifically, was later combined with the information gathered through interviews and observation. In regards to the needs assessment, the social aspect investigated the social problems affecting the population's life, while understanding the community demographics and neighborhood characteristics; mainly, how the elderly experience living with loneliness and a lack of autonomy in the community.[15] The epidemiological assessment identified the specific health issues of the community and sets priorities as to what health issue warrants urgent intervention. Most of the data indicated that diabetes maintenance and prevention was a health target of interest for the population. In Israel the group with the highest prevalence of Diabetes were those older than 60, at 10.3% and rising.[16] The behavioural and environmental assessment measures how common a behaviour or health risk is in the community, and what factors influence behaviour; inherently the statistics of how loneliness and social isolation

[14] Sznitman, Sharon, "Social Network Theory".
[15] http://publications.jdc.org.il/israelselderly/index.html
[16] Stern, E., Blau, J., Rusecki, Y., Rafaelovsky, M., & Cohen, M. P. (1988). Prevalence of diabetes in Israel: epidemiologic survey. *Diabetes*, *37*(3), 297-302.

could impose negative healthy outcomes. For example, 23% of Israel's elderly population lives alone, this rate is higher among women than men and out of the total elderly population 35% reported actual feelings of loneliness.[17] As research links social isolation to mobility and physical health issues, there is a connection diabetes prevention as well. A study by Colberg et al (2010) demonstrated that one's risk of diabetes can be decreased by 58% with regular physical activity.[18] Lastly, the administrative and policy level identified which policy factors are influencing behaviour, such as funding, or the organization services in place that are promoting or hindering healthy aging and living. The quality of the facility and legislative policies are main concerns during this assessment.

Process of Observation

Following the needs assessment, informal qualitative measures such as direct observation and unstructured interviewing were the methods chosen to evaluate the existing program and inform the design a new program.[19] Two social programs were observed weekly over the two month summer period; educational lectures done twice a month by a nurse both in Hebrew and in Russian, and small group social programs ranging from discussions on cognitively-stimulating topics, to cognitive games such as riddles, jokes, and puzzles. The organization of the program, the response from the participants, and the facility itself were observed. Sitting in on the lectures and programs as an outside observer allowed reflection without interfering with normal routine. For the lectures, the pace of the speaker was

[17] http://publications.jdc.org.il/israelselderly/index.html
[18] Colberg, S. R., Sigal, R. J., Fernhall, B., Regensteiner, J. G., Blissmer, B. J., Rubin, R. R., ... & Braun, B. (2010). Exercise and type 2 diabetes. *Diabetes care*, *33*(12), e147-e167
[19] https://www.socialresearchmethods.net/kb/qualmeth.php

carefully noted, the language used, the subject matter and overall the appeal to the population. As well, retention and attention of the participants throughout was observed. During the smaller group cognitive games and discussions, group interaction was observed, attention was assessed and effectiveness through active participation. All anecdotes and side conversations were recorded and taken into account as well. Simultaneously, as an observer, one-on-one and group based interviews were conducted with the staff and participants to understand how the centre operates and the participant's satisfaction with the program. With this population it was determined following the needs assessment the effectiveness of the programs would be evaluated using qualitative, simple conversations rather than a quantitative survey approach. The unstructured interview, conducted in hebrew, consisted of a few guiding questions which turned into a more free flowing conversation about the centre as a whole. Open ended questions included: why do you attend the centre, what type of programs would you like more of, what do you think about the exercise and computer programs? With the staff questions included: where do you see a need for a public health student, when is the best time to run an additional program, what are the main health risks of the *Shilo* cohort, what is the best method to structure a social or educational program for this group? The facility was also observed and evaluated regarding the quality of the grounds and how this may have affected the attendance and participation of the group.

Process of Evaluation

In line with the qualitative framework, and fairly unstructured nature of the research project, the organization as a whole was evaluated in their effectiveness to engage seniors in a social setting, as well as the effectiveness of the new brief educational intervention. This

was done throughout the observation stage and the implementation stage. “Effectiveness” of the organization merely meant in how relevant their programming was towards improving quality of life, maintaining one’s social network, and how it aligns with the existing literature. As well, how they retain participants’ attendance and level of satisfaction. In search of the most insightful form of evaluation and success of the programs, it was decided that in light of cognitive issues the population may face, and the varying attendees weekly, observing the attendance, and again engaging in unstructured “evaluative” interviews throughout and at the end of each session, would be the most reliable. Effectiveness in regards to the newly implemented educational brief intervention related to whether information was being retained, whether it was relevant, if it benefitted population socially, and if it was enjoyable. These questions were to be answered through group discussions following each lecture, and one-on-one interviews with many of the attendees.

Results and Insight

Following the direct observation and unstructured interviewing combined with the background data collected in the needs assessment, all the information was examined and framed to create an intervention that could meet the population of Shilo’s needs. Below is the compilation of interview data that was collected which informed the structure of the novel intervention, prior to implementation. Seven participants were interviewed, all women, and three staff members, all women, were interviewed. The questions are in italics followed by a translated summary of the participants and staff answers. *A personal anecdote and limitation*: All these interviews were done in hebrew and due to the fact that I have

limited intermediate level hebrew many gaps in the responses were later filled because of misunderstanding, or unrelated information, therefore this information was only used as a framework and guideline rather than sound evidence.

Participant Interviews

Q1: Why do you attend the centre?

Majority of the participants mentioned they attended the centre to be social; to talk to friends, to have company and to not feel lonely. Many participants liked the activities offered, where one woman stated: “I wouldn’t leave the house or move all day if I didn’t come here”. Another mentioned, “I get information from the nurse about my health and the programs keep me young”. Further one mentioned, “My daughter doesn’t speak to me anymore, my husband passed and you all are my family”

Q2: How often to attend the program?

Responses included*: “*as much as I can”, “almost everyday if I feel okay to come”, “every day”, “not as much as I would like”.

Q3: What type of programs would you like more of?

A lot of the participants asked for lectures on how to stay healthy, what vitamins to take and which not to take. Many participants asked for question and answer sessions where they can ask about why their ankles are swollen or what exercises to do at home. One women asked just for something fun, where she can talk and learn.

Q4: What do you think about the exercise and cognitive programs?

One women regarded the exercise classes as the only way she will move daily. Another regarded it as being told to move like a baby and it was not her favorite. Another participant loved the environment and moving with friends. “The computer programs make my brain feel healthy, I remember more”, and “ I like the puzzles”.

Q5: What would you be doing if you didn’t come to the centre?

“I would be alone at home”, “I would be watching tv”, “if the bus didn’t pick me up I wouldn’t be able to leave my house”

Staff Interviews

Q1: Where do you see a need for a public health student at Shilo?

The staff agreed that the participants would benefit from another health professional to speak about important health topics, besides the nurse who comes every two weeks. The staff mentioned frequently that the centre is already short staffed and volunteers are scarce, therefore a student would greatly assist with the programming.

What are the main health risks of participants at Shilo?

The most concerning was diabetes, cognitive decline, and mobility issues.

When is the best time to run an additional program?

Before or after the social programs, for less than 20 minutes would be ideal for this elderly population

What is the best method to structure a social or educational program for this group?

The staff agreed that doing a short intervention would be the best for this group. Many participants lose interest quickly or are fatigued during programming. As well,

the group was relatively loud and distractible therefore group sessions with less than 10 participants would be best (especially for a moderate level of hebrew).. In terms of the content, the staff emphasized that simple language and content should be included, at a slow pace that is understandable to the "third age" or the elderly.

As the pre-intervention interview and needs assessment came to a completion, the missing piece was what type of intervention could fit with this population in the two month timeframe? After meeting with professionals in the field of community health promotion and undergoing individual research, the intervention style known as a *brief educational intervention* was chosen as it was relevant and feasible. This is an intervention commonly used in health promotion to improve knowledge over a short time while encouraging health behaviours, and discouraging maladaptive behaviours. The purpose is to motivate those at risk of certain behaviours promoting ill-health, to change their lifestyle choices. This method is often applied to substance abuse however it was adapted to fit this population's needs.

With statistical data collected from a literature review of the Israeli elderly population, in addition to the qualitative data collected through interviews and meetings with professionals, it was decided that a lecture series with a theme focussing on diabetes management and prevention would be relevant and beneficial for this population. The implementation of the program would span three weeks, where a three-part lecture series was created. The lecture details such as language, pace, length, and style were specifically tailored to Israeli men and women age 65-85. Research indicated that topics such as foot health, exercise, and nutrition would be critical for this group in improving knowledge and

self-care strategies. The lectures were designed to have 10 minutes of straight content gathered from two sources: The Israeli Diabetes Association, and a health promotion government website named www.efsharibari.gov.il. Five minutes was allocated to question and answer sessions.

Successes and Limitations of Results

Two sets of results were developed in the investigation of what the ideal community health intervention should entail; one evaluating the effectiveness of *Shilo* in providing good social programming, and another determined if the lecture series supplemented programming and social needs. The insight into this matter was inferred by the observations collected throughout the two month duration, the unstructured interviews pre-intervention and the feedback from staff and participants post intervention.

The *Shilo* program was observed and evaluated, in regards to the social programming designed to improve cognition, based on its' ability to create social connection, provide relevant material, and maintain attendance. As well, the lectures on health topics that the nurse conducted biweekly were evaluated on whether thei were relevant, their design and the participation. For the social programming, in relation to the criteria I have set for the evaluation, and reflecting the interviews from participants, *Shilo* has created effective programming that has the potential for mitigating the effects of social isolation. The program exercised their cognitive capacities while encouraging them to work together to solve problems. Also the open discussion gave the members an opportunity to speak freely

and learn. Many of the participants' interviews stated that they would not have left the house if it weren't for these programs as they are alone most of the time. Despite some being critical of programs, overall they understood the benefit socially and how it affected their health. The Nurse's programs were also effective in that relevant topics were chosen to engage older adults such as learning about how to self-measure blood pressure, which meats are healthy and an introduction to antibiotics. It was observed that the hour long duration of the lecture may have been too long as some participants began to lose interest after 30 minutes. As well, there was little time for discussion during these lectures as the nurse had a lot of content to cover, therefore this program was more educational than it was socially stimulating. Throughout both the sessions full attendance was almost constant. It was observed that patients were less likely to attend when the weather was incredibly hot and that participants were more likely to leave a program early or not be engaged if the air conditioning was not working well in the room. The centre was often full with participants eating meals together, and socializing in the hallways, almost to a point of crowding; hallways and rooms were often busy and seats limited when attendance was at a high point. For programming, almost all participants were engaged in the program by answering questions and nodding in agreement to the content being discussed. Although the social programming content was not directly related to health it was apparent that these programs were creating a social, comfortable and supportive space for the participants, that was yielding health benefits.

Regarding the novel educational intervention I designed and implemented, the criteria of evaluation was set at whether the information was retained, relevant, enjoyable

and had social benefits. The results were broken down into successes and limitations in the programs effectiveness. A success of the intervention was that subject matter was determined to be relevant. Based on the needs assessment, it was decided that themes related to diabetes management and prevention would be beneficial for this population. Although only 2 participants out of the 7 in my cohort had diabetes, the rest were still considered to be at risk and the lectures emphasized knowledge and self care strategies critical for prevention. Following each lecture, feedback from participants indicated that the topics were easy to understand, interesting, and they enjoyed learning from a student in public health. The topics stimulated health related questions and encouraged participants to gather more information from their physician at their next visit. For example, in regards to foot health, participants were encouraged to receive annual foot checkups for sores and blisters if their are any neurological deficits, in order to avoid severe foot complication such as amputation. A noted success was the social aspect. The program was in a small group therefore participants were able to feel comfortable around one another and speak openly. Many interesting discussions were sparked as a result of the health topics and this further demonstrated the open and supportive space of Shilo.

Insight into Shilo as a Social Space: A Reflection

An important realization was made during the execution of the small group health lecture series. This realization was of the social and communal environment that *Shilo* has created for their participants. It was a common theme throughout the lectures that participants would interrupt and ask questions. Before even beginning to answer the

question as a professional, fellow participants would introject. Some questions were incredibly personal or just curiosities, however regardless of the type of questions, the participants were able to receive and provide emotional and instrumental support to one another. Some questions stimulated conversations unrelated to the health topic at hand but provided me with incredible insight into the participants deepest worries, experiences with physicians, and curiosities of the public and social services they are entitled to. One participant was not aware that she was entitled to a social worker and to volunteer services to assist at home, when she is not participating in the community centre itself. Soon the intervention changed from the participants learning from a lecturer and the lecturer learning from the participants. A true sense of community was emanating from this group. What dawned on me as a junior researcher was that I was now exposed to the elderly person not as a frail, sick person who needed help, but as a person who has a voice and in need of a space to express themselves. This demographic is often underestimated and abused in ways of neglect, all of which promote loneliness and social isolation. With all the emerging research that exists linking social issues to negative health outcomes, more spaces need to foster support and conversations such as the ones observed. It was not shocking that some of these side conversations were completely off topic, however they still allowed the person to have autonomy and feel heard. These conversations had much deeper health benefits than just knowledge; improvements in self confidence, self worth, while learning new information and helping their peers were observed.

Where do the interventions fit within the research?

Drawing on pre-existing literature, theory, and results from the *Shilo* project, it is apparent that one's social network plays a crucial role in an individual's quality of life, especially for the elderly. Social Network Theory can be defined as how individuals interact with others around them, through which they create a network. It is important to note that is it not only about the number of people in one's network, yet more of the "quality of the relationships" one has, and the type of social support received and provided.[20] Quality of life (QOL), sometimes described as a vague health indicator, is an important element to healthy aging. The *World Health Organization* described QOL to be one's perception of their position in life, reflective of their culture and values, which can span across sensorial functioning, autonomy, social participation, death/dying, intimacy and family.[21] Most importantly, when analyzing social networks, one must be aware of which types of networks yield the highest health benefits in relation to the elderly. According to Gouveia et al (2016), networks provided through friendship and neighbourhood-centered relationships, were found to have the most positive effect on the health of the elderly, more so than family ties, due to the voluntary nature of the relationship. The proximity of the social networks and how it impacts the frequency of interactions is also a factor impacting quality of life. In relation to the population in *Shilo*, it was shown that this organization plays a large role in forming the participants social networks. As most are widowed and separated from family by

[20] Sznitman, Sharon, "Social Network Theory".
[21] Gouveia, Odília Maria Rocha, Alice Delerue Matos, and Maria Johanna Schouten. "Social networks and quality of life of elderly persons: a review and critical analysis of literature." *Revista Brasileira de Geriatria e Gerontologia* 19.6 (2016): 1030-1040.

distance, the friendships and frequent interactions the day centre provides, is critical to promoting successful aging in this population. Through group discussions it was apparent that participants were providing each other with emotional, informational and appraisal support. Support such as empathy, advice, and encouragement, are all forms of support observed throughout duration of the project, and have shown to be linked to improving quality of life in regards to life satisfaction.[22] Another point is that the homogeneity of the group members, meaning most members being of similar age, culture and social class, is also a factor that contributes to an effective social support network.[23] Linking the literature, theory, and the *Shilo* project's findings, it is apparent that social support and interaction stems from friendships and relationships with those living in close proximity successfully exists at this day centre. These findings have a significant impact on one's health in regards to quality of life, and the *Shilo* population is a prime example of an intervention that promotes such interactions.

Limitations

There were many limitations interfering with the execution of the project. The first is the language. Having only intermediate conversational hebrew significantly hindered the success of the project. It affected my ability to conduct organized and thorough interviews, communicate with staff and design the lecture series. The research and lecture design took almost double the time. In spite of the challenge, the lecture series was executed effectively

[22] Young, Kim Wan. "Social support and life satisfaction." *International journal of psychosocial Rehabilitation* 10.2 (2006): 155-164.
[23] Berkman, Lisa F. "Assessing the physical health effects of social networks and social support." *Annual review of public health* 5.1 (1984): 413-432.

and was understood. Further, the evaluation was flawed and did not portray validity or reliability. Due to the nature of my expertise, in combination with evaluating a population with cognitive issues, it was very difficult to determine whether there was retention of the lecture material and implementation in everyday life; the inherent goal of the program. Careful attention was placed so that the lectures were structured based on various types of communication strategies for such an audience. Important information was repeated and emphasized, the scientific recommendations were translated into jargon, and the hebrew was simplified. Despite the modifications, determining whether the participants were learning and applying the information to their everyday life was impossible at this level of a project; I was not present frequent enough to monitor such progress. Also, the attendees varied from week to week, so some participants were not even included in the three part series to test any retention or overlap. Another limitation commonly brought up in the research methods of projects such as these, is the sampling error and selection bias of the population. The methods in this analysis in relation to how the group was selected, may indicate that the findings are not be representative of the entire community dwelling population of older adults in Haifa. There is significant sampling error; the participants were not chosen randomly. The group was chosen based on attendance; if they attended the program they were part of the research project and this sometimes varied week to week. Those who did not attend the centre were automatically not included in the results and could have altered the results or execution of the project. The cohort who participated in the lecture series was very small in number which also biased the results to be less externally valid. To reduce the

effects would be to choose a larger sample, at random, to more likely be representative of the entire population and yield valid results.

The last limitation was the structure of the project. The organization was very unorganized and my involvement was not determined from the start, therefore the design of this program occurred almost backwards. It was very difficult to structure the findings from a very inconsistent population and relate it to existing research. As well, due to time and the variation of participants there was no formal post intervention interview, rather feedback discussions following each session. Ideally, the program would have been designed to create a questionnaire, follow the participants for more time in the centre and at home, and have a stronger post-intervention evaluation.

Future Recommendations: Moving Forward

As the methods and analysis comes to a close, the pertinent question now at hand is: what needs to occur to create an ideal intervention for community dwelling adults, to reap the most health and social benefits. With the results in mind four solutions are proposed to answer this question from fiscal, legislative and policy perspectives. The first possible solution would be to create a better facility. With an increase in funds, the building and programs could be updated with a more comfortable (ie. Air conditioning and heating update), spacious atmosphere (ie. less individuals in the hallway, wheelchairs/walkers blocking), and adding more employees to run a variety of programs. Added programs could add more rooms for physical activity programs such as yoga and tai chi, or an art studio. The benefits of this recommendation would be to increase the participant's satisfaction with the

facility, where there could be a variety of programs, and a comfortable atmosphere. Older adults, who are more sensitive to changes in temperature and are easily fatigued would benefit from this change. The limitations to such an approach would be a high cost; funding a building operation would be costly and it is not feasible over a short period of time. As well, it does not guarantee improved the social and health benefit. Also, facilities such as these are already short staffed, therefore adding trained professionals to the team would be challenging and unrealistic.

Another approach could be to maintain services regardless of whether participants are physically able to attend the centre or need to stay home. Ensuring that volunteers are on call to run programming in the homes of these individuals would guarantee this possibility. Volunteers would to provide the elderly with cognitively and physically engaging activities in the comfort of their own home. As well, these volunteers can go over nutritional shopping and cooking plans practically with the individual and recommend safe walking routes in the community; all of these aspects are already theoretically covered at Shilo. A positive to this option is that this intervention will include all in the community whether they are able to make it to the centre or need to stay home for whatever reason. As well, it will reduce social isolation in the home by providing companionship. A significant barrier to the success of such an intervention is the shortage that exists of trained staff and volunteers. Shilo is actively searching for volunteers so to guarantee such a service will be draining on their resources and may not be consistently feasible. Another limit is that participants may

become too dependant on this service and actively choose not to attend the day centre; losing many of the health benefits and social rewards.

Another solution to the problem facing community dwelling elderly would be to increase coordination and collaboration between the organizations providing services for the elderly, and with the participants themselves as well. It is apparent that in Israel there are many different organizations that play a part providing services to the elderly. In relation to day centres and supportive community networks alone there is the Ministry of Social Affairs, Eshel, country wide nonprofits and other commercial business that are involved in creating the basket of services that the elderly are eligible to receive and this excludes the numerous ones involved with home care.[24] Both the pre-existing literature and the results of this policy analysis indicate that community dwelling elderly are not aware of all the services that exist for them to utilize in order to better their health. This may be due to the segmented nature of services, where elderly must make numerous stops to gain information, and enroll in certain services over a lengthy time. This is incredibly difficult for those with limited mobility especially. For example, according to the Nursing Law of Israel passed in 1988 those living in the community who have difficulty performing ADL's are eligible to receive up to 16 hours/week of help at home (shopping and cleaning).[25] According to some of the discussions sparked during the lecture series, it is apparent that many participants are not aware of this law as they have little to no assistance and are eligible. What is being proposed is a more extensive joint program between the social service organizations and the community, where representatives from the ministry are housed in the day centres and can

[24] http://www.euro.centre.org/data/1256027560_36114.pdf
[25] http://medicine.jrank.org/pages/939/Israel-Social-services.html

provide the information directly. The benefit of this would be to create a centre where the participants can receive all their health information and social programs. This would also coordinate resources so there would be less overlap and waste across segregated organizations. A mishap that could occur could be political conflicts between governmental ministries, nonprofits and private enterprises that may cause the 'butting of heads' in creating a more unified locality of services.

The last proposed solution would be to provide resources to *Shilo* to better their programs from a health information and social gratification standpoint. With the research collected regarding what programming works (cognitive games, healthy lifestyle discussions, social service inquiries) it would be beneficial to create a curriculum or set of programs covering all these subjects to pilot at *Shilo* and then see if it would be relevant for other day centres to implement. A benefit of this approach is that it promotes capacity building; a term greatly emphasized in the realm of public and global health. Rather that making big changes above the employees, that have significant costs, this approach would provide the workers with the capacity to execute the ideal intervention. By making it their own and executing it in a way that meets the needs of their participants, which they know best, it will be more accepted and relevant. A set back to this approach would be how to ensure it is carried out without significantly having to intrude or becoming too political with regulations as a public health professional or social service worker.

In my opinion the last recommendation is the most practical and feasible approach in creating the ideal intervention for community dwelling older adults. Funds are increasingly

becoming limited for the elderly population and legislation needs to be modified to create a more comprehensive basket of services, however in terms of a cost effective, least political and short term approach towards improving the quality of day centres, option four will be the most effective. Capacity building is very important in order to make stronger communities that can sustain past the moment of external assistance. By training and providing resources that are relevant and qualitatively proven, it is likely to be an effective approach for this specific population. Once it is trialed, along with further needs assessments, this framework can be applied to other day centres in the long term. It is important that community dwelling adults are provided with opportunities that encourage cognitive and physical stimulation, autonomy, self-worth, and relevant health information in a social setting. Instead of speaking to this population, it is necessary to speak with them and advocate for their needs, so they can get the full health benefits of a social and educational program. Lectures are not enough; interactive discussions are crucial to the success of these programs. Literature found by a leader in the field, Barbara Stender, the Coordinator of Senior Well-Being Programs of Greater Trenton New Jersey has stated that, "Surprising new evidence reveals that discussion programs for seniors are far more beneficial than we had realized. Seniors need to talk for their mental health".[26] This statement is exactly it. Seniors need a balanced program. By choosing option four as the immediate choice, I choose it without disregarding the validity of many of the other options, especially option three, as at this moment option four, from a bottom up approach, is beneficial for short term trials and is feasible. This does not ignore the immediate need for top down action, in terms of policy

[26] http://www.peopleandstories.net/programs/partner-sites/seniors-programs/

changes, advocacy and a uniformed execution of programs; it is another significant issue that needs to be tackled as well.

Integrated Competencies:

Throughout the duration of the integrative learning experience five competencies from the IMPH program were integrated in this project, and were underlined in the context in which they relate to the policy analysis presented. These competencies, outline fundamental processes and theoretical tasks pertinent to work in public health. In this project all these competencies demonstrate key applications from the IMPH program integrated into a practical work setting in health promotion. The first competency that was integrated was the underlying goal of the analysis; to design an effective population-based program or intervention (9). In doing so it was necessary to outline a framework through which to collect data, analyze the results and evaluate the significance of the intervention. The use of another competency such as a needs assessment (7), a tool commonly used throughout health promotion, added to the design of an intervention specifically tailored to the population at *Shilo.* In developing such an intervention, a lecture series covering various health topics in relation to diabetes prevention and maintenance, different communication strategies (18) were utilized to effectively communicate to the elderly population and the staff involved at the centre. Slow, simple speech, and repetitive language was necessary for the older adults throughout the lectures and interviewing process, whereas with the staff members, concise, more intellectual and assertive language was appropriate.

Another competency integrated was the ability to propose building stronger partnerships and coalitions (13) between the day centre and important political circles such as Eshel, integrated in the making of this project was advocating (14) for the need and importance of social programming for the elderly of *Shilo*, and as a larger scale population through legislative and political improvements, and through capacity building. All five of these competencies make up the core of this policy analysis and render it significant and relevant to the public health and global health administration of community dwelling older adults.

Conclusion

As the demographic trends escalate towards an increasingly aging population, as are the negative health outcomes associated with aging. Social isolation, one of the negative correlates associated with aging, is a significant health risk that is being tackled in the literature and through intervention. As aging and how it is related social isolation is a popular topic among gerontology and public health researchers, I too sought out to understand what interventions exist that are mitigating the effects of social isolation, in promoting successful aging in Israel and globally. After immersing myself within an intervention at an organization named *Shilo*, and attempting a personal project to improve knowledge and socialization, I was able to extract data relevant to such a global problem. It was apparent that an organization such as *Shilo* has created a space for older adults to feel safe, supported, and cognitively stimulated. It has created social programs that encourage camaraderie and the transfer of social support. *Shilo* has also provided a forum where older

adults are free to discuss and speak their minds, while yearning for attention and emotional support. The intervention also has shed light on the gaps that exist between community programs, social services, and legislative policy, needing to be filled with collaboration and coordination of services. After combining data discovered through direct observation and the evaluation of my lecture series, it is apparent that a discussion-based educational program that promotes cognitive stimulation is the ideal program for community dwelling adults in Haifa. In regards to such a significant problem that is facing the fastest growing demographic worldwide, the information extracted from this research project is an interesting start to the future of community intervention and legislative policy towards promoting healthy aging.