The Changing Focus in Geriatric Care; Role of the Social Worker in Rehabilitation, Restoration, Return to Community*

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WITH the advent of Medicare and Medicaid in our health vocabulary, we are witnessing profound social changes strongly affecting the lifestyle of our increasing numbers of aged and their families.

Acceptance of the home for the aged, or nursing home, as the final residence until the "eventuality" has been replaced by the recognition that alternatives do in fact exist and they offer a fulfillment that is the right of the older individual.

We, the Jewish agencies, having set the pattern of social case work, are required to adjust professionally and personally both to the changes regulated by law and, even more important, to the changing needs of this fastest growing segment of the population.

A reluctance to "rock the boat" too often stops us from moving with the times and creating relevant new solutions.

But the social worker, by definition, is adaptive, interpreting the here-and-now of existing conditions and replacing what was good for yesterday with what's right for today.

Early in the century, when the social worker assumed this professional role, the primary concern was to provide shelter for the aged. We encased them in snug cocoons where they were nurtured with a battery of protective services until their demise. They were judged too fragile to cope with the realities of the open community and no butterfly ever emerged from the cocoon to fly free.

Needs change, institutions and people change, and at JIGC, we are committed to a changed concept of health care: the rehabilitation, restoration of function, and return of certain of our patients to their former environment in the community.

To the elderly themselves and to family members, this approach is as revolutionary in its impact on their lives as the pacemaker or antibiotics.

A complex procedure is set into motion when we say those three R's — rehabilitation, restoration and return. It represents a break with tradition and poses a challenge that has significant implications for the future.

History and Design of Agency

When the Jewish Institute for Geriatric Care opened in March 1972, it drew on the resources and expertise of our sponsoring agency, the Home and Hospital of the Daughters of Israel.

The Social Service Department had functioned as an essential element of a traditional program of care. Its intake division screened applicants. Caseworkers provided on-going counsel and a myriad of special services, and acted in a liaison capacity between agency and family members. The Home flourished in Manhattan for more than 50 years.

As the neighborhood deteriorated and the plant became obsolete, the Board of Trustees and Administration turned their sights eastward to Long Island where the need for comprehensive health services for the aged was most urgent.

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We located on the campus of a major medical center for two reasons: first, through our affiliation with an outstanding general hospital, we would be able to provide our patients with a broad range of special services. Second, the medical community would be brought face-to-face with the patient who historically has been low man, clinging to the bottom rung on the ladder of medical services, and grateful for the minimal interest he was able to generate.

Our 527-bed building literally straddles the border between New York City and Nassau County. This gives us the opportunity to serve an urban-suburban population accustomed to the most advanced and sophisticated methods of treatment and the highest levels of care.

The integration of medical, psychiatric, social and therapeutic services enables us to deliver a two-pronged program of care: long-term for patients requiring on-going services, and short-term for an increasing number of patients who are able to achieve a level of functioning that will permit them to return to the community.

These components were built into the design of the program just as precisely as the architectural design of our modern building was drawn.

Rehabilitation Medicine was planned as a key department in our facility and is housed in a spacious 7,570 sq. ft. area, outfitted with the most modern equipment and staffed by highly trained professionals under the supervision of our in-house physiatrist.

This is a combined department, shared by JIGC and the adjacent general hospital, Long Island Jewish/Hillside Medical Center, with which we are affiliated and connected by tunnel. New methods and therapeutic procedures are constantly being developed for the benefit of geriatric patients as well as those considerably younger.

Methodology of Delivery

With a total staff of 680, all departments at JIGC are involved in shaping an individualized program of care for each patient, an effort that starts at the Admissions interview and continues throughout his stay.

Once the patient is admitted, the social worker on the floor is assigned to the case. Family orientation meetings ease the transitional period for patients and relatives; family clinics bring Medicine-Nursing-Social Service together with patient and relative for periodic evaluation; individual counselling is offered on a continuum to aid relatives in handling the complex problems institutionalization precipitates.

These services then become the foundation for the ultimate responsibility of the Social Service Department: discharge.

The team approach utilized in all phases of patient care is crucial here and the function of the Discharge Committee will be explained more fully later.

At a time of crisis, one way the family copes is by selective listening and often at the initial admissions interview, they choose not to hear the word discharge.

Not only is this a time of severe trauma to the patient but the family is often engulfed in a period of emotional stress. Their parent may have suffered a recent stroke, a fall, Parkinson's, or other disability and resolving this immediate problem takes precedence over any other consideration.

The discussion of admissions criteria and guidelines for eligibility by the social worker is meticulously followed by an explanation of our discharge policy. Families invariably concur whether or not they comprehend it.

Afraid of jeopardizing their parent's admission by questioning our approach, they may assume that this couldn't possibly apply to someone past eighty, anyhow. Tuning out becomes a simpler expedient than facing this reality with all its implications and potential demands on them.

Conversely, it is important to note that there are family members who react very positively to the discharge policy, finding in it a reassurance that independent functioning can be resumed which will be truly gratifying to all concerned. They motivate their relative to participate in the therapeutic program to the fullest of his capabilities. Although these individuals represent a minority, we are convinced that their numbers will increase substantially as the public becomes educated to this new phase of health care.

Family Orientation

An essential link in our carefully-forged methodology leading to discharge is the family orientation meeting held within two weeks of admission. Seated around a conference table, relatives hear their hopes and fears echoed by others as the talk centers on their expectations for the rehabilitation of the patient.

Often, they are sadly unrealistic and it then becomes the responsibility of the social worker to bring into focus what the Institute can and cannot deliver.

We are particularly concerned about enlisting their support in setting realizable goals since if we can accomplish this we will minimize serious disappointment and depression both to patient and family later on.

Within the context of this open meeting, the discharge policy becomes less threatening and can be viewed as a viable alternative, at least for some. Others challenge us to define its parameters:

> How can you talk discharge when my father is paralyzed?
>
> What will my mother be discharged to? Her apartment is gone and I have no room.
>
> How can you expect a woman of eighty-eight to learn to use an artificial leg?

Rather than discuss specific cases at this premature point in time, our emphasis is to communicate that we have a goal and whenever possible our program of care is directed toward achieving it.

Assessment of Patient

An assessment of the patient's physical and emotional condition proceeds over a two to eight week period during which the full resources of our Institute are brought into play. In addition to evaluation by the Medical Department, Physical Medicine and Rehabilitation, Psychiatry, Ophthalmology, Dentistry and Podiatry participate in the assessment of his needs. If other consultants are required, specialists at Long Island Jewish/Hillside Medical Center are available to us through our affiliation agreement.

Even during this preliminary period, we begin to make some determination about the potential for discharge. We take our cues from the patient's disability, his motivation, the family's readiness to become involved, and the supportive services that can be utilized in the community.

As a course of treatment is developed, family members may question certain aspects of the diagnosis or prognosis and it's not unusual for different members within one family to bring opposing viewpoints to us.

The Family Clinic was devised to help resolve situations like this but it serves also as an opportunity for staff to clarify any on-going problems it may be experiencing in relation to a particular patient.

The staff physician, nursing coordinator and social worker join with family members to share their mutual concerns. This has proven to be a most effec-

tive way of imparting information and at the same time conveying the genuine interest that staff has in successfully implementing an individualized program of care.

We've found that negative attitudes often change dramatically after we've demonstrated our awareness of the patient as an individual and as a member of the family unit. The benefit to the patient is obvious since it results in a closer partnership between staff and relatives, each more understanding of the problems of the other.

Discharge Process

Ideally, this sequential communications program starting at the admissions interview will connect with the final link in the chain when the staff physician advises the Discharge Committee that his patient is ready for discharge. At the subsequent Committee meeting, all disciplines report on the patient's status and recommend the level of care he will require after leaving the Institute. If the Committee then concurs with the physician's recommendation, a letter is sent to the family requesting them to attend a meeting at which the discharge will be discussed.

Again, it's the staff physician, nursing coordinator and social worker who inform the family of the changed status of their relative and discuss the appropriate environment for him now.

If he can return to his own home or that of a relative, the discharge plan usually follows an orderly and predictable course. The social worker maintains close touch with the family as together they provide the tangible and intangible supports the patient requires at this time. When the satety of familiar surroundings and routine is withdrawn, he may become overwhelmed and fearful of his ability to cope outside, especially if the period of institutionalization is longer than six to eight months.

But what happens when he has no place to go?, a not uncommon quandary, as mentioned earlier.

We struggled with a particularly difficult situation a few months ago. An 82 year old patient, who had successfully learned to use a prosthesis after the amputation of her leg, was ready and eager to leave us if only a suitable home could be found.

Home, in this case, would be a ground floor apartment fairly accessible to her family where she could realize her dream of functioning independently. Despite intensive efforts with the Housing Authority, the Department of Social Service and private resources, it was months before an appropriate apartment was located. The prolonged wait was demoralizing to the patient who became depressed and embittered. When she finally left, it was a triumph for her, and she has returned to meet with other amputees, inspiring them "to try harder" so they, too, might one day return to the community.

Throughout any discharge procedure, the social worker acts in a liaison capacity, contacting agencies such as the Department of Social Service, homemaker services, Jewish Association for Services for the Aged and Visiting Nurses Society in order to effect the smoothest transition from JIGC to home or other institution.

Inadequate supportive services in the community however create major problems for the would-be dischargee and often impede the discharge process. The insufficient number of homemakers available, to say nothing of their high cost, is a serious deterrent. Families unwilling to cooperate present another roadblock, and when health related facilities and nursing homes refuse to accept Medicaid patients, an undue hardship is imposed on patient and family who find themselves separated by excessive distances.

Staff's participation on local boards and coordinating agencies will contribute toward generating the interest and action necessary to ameliorate these conditions. But this won't happen overnight.

Community Education

It's essential therefore to reach out directly to the public, involving them in a community relations program that seeks to establish a bridge of understanding between agency and community.

Where do we begin?

With the media, of course, to publicize the positive aspects of discharge and convey news of advances in the medical and psychosocial care of the aging.

With organizations like Hadassah, sisterhoods, local groups of all kinds that may program "The JIGC Story" at a membership meeting and then follow it up with a tour of the agency.

By maintaining a close working relationship with public and quasi-public agencies involved directly or indirectly in the health and welfare of the elderly.

With special events that draw the community into the Institute, giving us an opportunity to "show and tell" the difference between our agency and the stereotyped facility.

With a women's auxiliary concerned not only with service and fund raising but education and social action in the field of geriatrics.

...and with a vital added dimension — education for the lay community. An adult education course titled "An Aging Parent" was developed by our Community Relations Office, and accepted by four Long Island school districts as a pilot program. Lecturers were professionals on our social service and medical staffs and the classes were held at JIGC, again to expose the public to an "inside view" of a skilled nursing facility.

By exploring the medical and social problems of the elderly, we underscored our conviction that aging too can be a dynamic time of life and thus reinforced our commitment to discharge and return to the community.

Statistical Information

While our statistical data is necessarily limited, a numerical breakdown on planned discharges is pertinent.

During the little more than one year of the program's implementation,

46 patients returned to their own homes
25 returned to the homes of relatives
12 were transferred to a health related facility
8 were transferred to nursing homes providing less intensive care
3 returned home after short term skilled nursing care in our Extended Care Unit which opened last fall

for a total of 94 planned discharges.

Statistics become a very unsatisfactory measurement when human lives are involved. Each of those ninety-four discharged patients demonstrated — to greater and lesser degrees — the viability of a changed concept of care. They were the pioneers who proved it was workable and with their families translated our philosophy into their reality.

From the knowledge and insights gained, it should be possible to move ahead in directions not yet charted that will bring to us as professionals and as individuals with our own stake in the future a real sense of fulfillment and hope.