DYNAMIC INTERACTION OF HEALTH SERVICES FOR THE AGED *

by EDWARD E. GORDON, M.D., ABRAHAM I. GIMBLE, M.D., JANET ANDERSON, ETHEL MENDKOFF
Michael Reese Hospital

KATE KOHN, M.D.
Resthaven Rehabilitation Center

REBECCA ROBINSON
Cook County Department of Welfare, Chicago, Ill.

I. AN OVERVIEW

by Edward E. Gordon, M.D.

IN a sense the conquests of modern medicine have created the problem which we are facing today. The sanitary revolution, artificial immunization, and antibiotics have all helped to reduce the importance of infectious disease, which once caused an enormous death toll among the young. For the first time man, at least in the technologically advanced countries, is no longer subjected to the weeding out process exerted by lethal microscopic agents. Larger numbers have come to survive to riper years . . . and also to age-linked disease. On the front of human endeavor there is no rest, as every fresh triumph is prelude to a new battle. It is in this context that the project [1] of health services for the aged was launched. The aged are a growing segment of the nation's population. There are now fourteen million people over sixty-five years of age, and this number is predicted to swell to twenty-one million by 1975.

The term "health services" has been selected with a purpose. We are concerned not only with the clinical aspects of disease in the aged; we must look to the person's mental, physical, and social resources so often impoverished by the "slings and arrows of outrageous fortune." We must look to our community in which he lives.

What is the basic attitude of our community? It frankly rejects the evolutionary doctrine that senescence threatens the survival of the young. It repudiates as barbarous dealing with the aged as did the Eskimos by quickly dispatching the slow; or as do some tribes in New Guinea by relegating them to an encampment of bare survival and squalor. While these crude methods apply to bone and stone cultures, we must admit that residuals exist in our own society, although, in more subtle ways. There are the county poor house, custodial home and other euphemistically named islands of banishment. As Dr. Benjamin Boshes points out, society retires "able men at 65 years of age and, on the other hand, gives social security checks to protect the aging." [2]

To cope with the changing aspect of

* Presented at the Annual Meeting of the National Conference of Jewish Communal Service, Chicago, Illinois, May 19, 1958.

1 Geriatrics Rehabilitation Program Sponsored by the Illinois Public Aid Commission at Michael Reese Hospital, Chicago, Ill., with the participation of the Resthaven Rehabilitation Center and Cook County Department of Welfare.

2 Boshes, Benjamin, "Neurological and Psychiatric Aspects of Aging," *Modern Medicine*, May 1, 1958.

health needs, community resources must be mobilized into a balanced interaction, which in the field of energetics is termed a "dynamic equilibrium." This means the component units are in a state of flux, yet, obey precise laws of relationship to one another and comprise a stable, organic whole. What is required in health services is just this interplay of resources.

It seems to me that a dynamic program of this sort depends upon two requisites: the awareness of what is required to promote optimal physical and social health of the older members of our society; and, second, how to mobilize and integrate these resources.

What it Takes. First, it must be understood that old age is not a disease but a process inherent in biological systems. There are "age-linked" diseases and they are amenable to treatment. We should, rather, speak of disease *in* old age and recognize that basically the same diseases may occur in younger people, with the difference that in the senescent they often assume a bizarre picture. Furthermore, in keeping with the duplicity of symptoms, dementia and psychosis are more often diagnosed than are actually present. Disease often is chronic and leaves disability in its wake; hence, the old-style hospital care is no longer adequate. Provision for longer term treatment, that is, rehabilitation by various services, is essential not only for the patient's sake but for the health of the community. In this regard, the cry "take up your crutches and walk" is neither sufficient nor realistic. Personality, resources innate and external and vicissitudes of life are often crucial in determining the outcome of rehabilitation. It is furthermore a common experience and frustrating to the workers that improvement of functional capacity in a rehabilitation center is often vitiated by the insoluble problems of housing and employment. Finally, the disappearance of the three-generation home from the American scene throws the responsibility of custodial care again upon the community.

Mobilization of Resources. There are many ways of executing a workable scheme, but one way it will not be achieved is by building more giant monolithic hospitals. In England, Sweden and a few cities in this country, hospitals have become diversified in function, catering not only to acute medical and surgical emergencies, but also to the long term patient; affording rehabilitation of the aged and disabled, prevocational training, dormitory services for those still able to function partly independently, and custodial and terminal care for the more deteriorated. Here are concentrated many of the components needed for a comprehensive health program.

In many communities solutions can be worked out in other ways. Facilities are present in the form of autonomous agencies; what is required is vision to weld the division into a dynamic whole. Sometimes a private agency may take the initiative; at other times, the public health and welfare resources may lead the way. In point, there is the Geriatric Rehabilitation Program, several of whose participants are making specialized contributions to this symposium.

Summarizing in aphorisms:

1. With the conquest of acute diseases, chronic disabilities have come to the forefront.

2. Old age is not a disease but a biological process. Hence one must refer not to disease *of* old age but disease *in* old age.

3. Multiplicity, chronicity and duplicity characterize disease in old age.

4. Inactivity favors regressive changes and hastens deterioration. Mobilize.

5. Friendly interest and sincere concern are often more therapeutic than drugs.

6. Disease in the aged is rightly a public health problem: the total care of any handicapped person, child or oldster, can no longer be handled by a single person but is a community responsibility.

7. Remember the preventive aspects of aging-medical, social, economic.

8. Not division, but vision is needed.

II. THE INTERNIST'S VIEW

by Abraham I. Gimble, M.D.

As Dr. Gordon has asserted, the health problems of older people are an ever increasing challenge to the internist and to his colleagues in medicine. Approximately 17 per cent of people over the age of sixty-five have long term disabilities.

Medical care has mainly been able to manage short term illness and the emergency situations arising in long term illness. Until the means are discovered to cure many of the chronic diseases, physicians must employ measures which will enable patients disabled by those diseases to live as full lives as possible within the limits of their restricted capabilities.

We are not satisfied with therapy based on symptoms alone, we insist that etiology and restoration of function be considered as well. With a threefold emphasis on symptoms, etiology and function, we can arrive at a plan of treatment which yields maximum results. As an example, a patient in our program may have a painful joint. Symptomatic therapy alone would aim at the relief of pain. Therapy concerned with etiology would try to determine whether this was rheumatoid arthritis, gout, lupus erythematosis or some other condition. The treatment based on function would be concerned with the degree of disability resulting from the illness and how maximum function could be restored.

In *hemiplegia,* the physician is interested in the diagnosis and treatment of the acute phase. This interest unfortunately ceases when the threat to life is removed and the convalescence phase is entered. It is in this period when the hemoplegic requires special help as he has to face life with a disability in which the hospital and staff are no longer interested. The patient is regarded as a hopeless, incurable, and irremedial case. Strictly speaking there are few medical conditions which are curable, but most conditions among elderly patients are remedial to a certain extent. In a hemiplegic this can be accomplished in 90 per cent of the cases by the use of appropriate exercises, bracing and muscle stretching. Although there is a possible danger of precipitating another acute episode, experience has shown that older patients are much less fragile than usually considered to be, and they respond well to active therapy.

In the older patient with chronic disease, we find multiple lesions and multiple organ involvement to be a common rather than infrequent problem. *Cardiovascular disease* is the major cause of mortality in the aged. The vascular disease may involve the brain, producing strokes; the heart, producing "heart attacks" (coronary thrombosis) and CHF; and the extremities, producing gangrene. Although not curable, the effects of degenerative vascular disease are remedial to a certain extent.

Chronic pulmonary disease is another incapacitating condition. Although we cannot insert a new set of lungs, we can institute active therapy to maintain what good lung tissue is still present. Newer methods of therapy have done much to improve pulmonary function by acting on the reversible changes in the lungs. Frequently, with improvement of pulmonary function the secondary cardiac symptoms disappear. Treatment of these two problems requires long term continued medical care.

Diabetes is the most common endocrine disease found among the elderly. It is estimated that over five million people in our population have this disorder. In

elderly people with long standing diabetes we see vascular damage to the heart and the extremities. Kidney function is usually impaired. These people develop eyesight problems such as diabetic retinopathy and cataracts secondary to the diabetes. All these must be treated accordingly so that the entire problem is one of viewing the patient as a whole rather than just keeping the urine free of sugar.

Hip fractures are an altogether too-frequent affliction of old people, as is amputation of the extremities. A total approach to these problems may make the difference between a bed-ridden individual and one capable of ambulation and complete self care.

Arthritic patients, specifically those with *osteoarthritis,* comprise a significant segment of the patients in the older age group. Specific medications and use of technique developed in physical medicine can do much to alleviate or eliminate pain. However a symptom of pain in the back or in the hips may be due to a wide variety of etiological agents as we have mentioned before. We do not dismiss the symptoms as being due to osteoarthritis. By the use of good clinical judgment and follow-up laboratory studies we can arrive at the etiology and treat the patient accordingly.

Dizziness and frequent falling is another problem that we find among the aging population and it requires astute clinical evaluation to determine the exact etiology, some of which can be managed quite successfully. Is there generalized muscular instability due to cerebral insufficiency or the occurrence of multiple "small strokes"? Is there disease of the cerebellum present or of the posterior columns in the spinal cord as we see in pernicious anemia? Does the patient have impairment of the equilibrium mechanism—the so-called labyrinth system of the inner ear? Some of these conditions respond well to drug therapy and the specific drug necessary for the specific disease may be extremely helpful in rehabilitation of the patient.

Secondary problems are frequently overlooked when evaluating and treating the primary disorder. Nevertheless they contribute to the patient's disability.

(1) Long, uncut toenails, corns and calluses and bunions are frequently a cause of much of the foot trouble common to older people. Relatively simple foot care measures can do much to eliminate the disability that these conditions produce. One may think that this type of care is hardly dignified enough to be included in an internist's management of a patient. However, if it permits a greater degree of functional capacity any procedure merits recognition.

(2) Nutritional deficiencies may occur in patients who have had poor dental care or who have lost their teeth, and replacement with dentures becomes an important factor in improving the patient's status.

(3) Failing vision may contribute to multiple falls and subsequent fractures in the aged—this should be remedied by fitting the patient with the necessary eyeglasses.

(4) Deficient hearing may prevent the patient from adjusting to community life—hearing aids may rectify this situation.

The internist must view the "whole patient." He must recognize the existence of social and economic factors and enlist the assistance of the appropriate allied specialists. No one can take upon himself the task of stating at what time in a man's life he may be abandoned to his fate. To illustrate this point, we at the hospital treated thirty-nine so-called "hopeless" patients in the first year of operation of the Geriatric Rehabilitation Program. The thirty-nine included a variety of chronic disabling

diseases: amputees, fractures, diabetics, arthritics, strokes, cardiacs, etc. Many patients, as has been mentioned before, had a combination of diseases. Thirty patients (77%) have been upgraded sufficiently to return to a life in the community. Only 6 patients (15%) were considered failures and had to be returned to nursing homes. All of the patients that we dealt with were 65 years of age and over. The average age was 76.5 years.

So one can see that medical problems in the aged can be handled quite adequately and the majority of the patients can be upgraded sufficiently to return to a life in the community. The foundation of the program and the attitude of the internist should involve a fundamental interest in the aged and a belief in his worth as a human being.

III. OCCUPATIONAL THERAPY

by Janet Anderson

Physical therapy is the non-medicinal treatment of disease by means of electricity, heat, light, massage and active or passive movements. Occupational therapy is any activity directed by an occupational therapist and prescribed by a physician to aid in the recovery from disease or injury. The physical therapist generally initiates the treatment in a passive manner. When treatment has progressed so the patient can actively perform the desired movements, the occupational therapist interests him in an activity such as woodworking or weaving that encompasses those motions. The patient both is mentally stimulated and obtains his exercise. The occupational therapist works through the media of activity, as a doctor works through his medicine, to upgrade functional capacity, to mold attitudes and to motivate the patient toward overall goals of treatment.

In the older age group, occupational therapy is directed at stimulating their minds, keeping them as active and alert as possible, and upgrading their physical function. Although complete restoration of function cannot always be expected, partial restoration may make the difference between an elderly patient being bedfast or being able to putter around on his own.

Patients are initially contacted as soon after admission as the medical condition permits. An active, positive approach and a working relationship are established by evaluating their "Activities of *Daily Living.*" These activities include procedures performed from the time one gets up in the morning until one goes to bed at night including procedures involved in eating, hygiene, dressing, hand and transfer activities. Areas of daily living in which the patient has difficulty are noted and suggestions are made to enable independent performance. Knowledge of wheelchairs, adapted equipment, transfer and self-help procedures are essential.

Eating requires arms and hands that have sufficient strength and coordination to grasp a utensil and lift food to the mouth, lower the hand, and then release the utensil. When this cannot be accomplished various splints can be made to stabilize the wrist, height of tables can be adjusted, and handles of utensils enlarged or attached to the hand by means of cuffs. Hygiene activities include bathing, toileting and activities that revolve around the toilet. When a person cannot get on or off a toilet or in and out of a bathtub adapted equipment can be inexpensively provided to enable the patient to perform independently. Dressing procedures can be greatly simplified by eliminating buttons, suggesting wrap around garments and providing elastic shoe laces and long handled shoe horns. Transferring from one place to another seems to be one of the

greatest problems of the aged. With must patience and clear explanations by the occupational therapist, much can be done. Most old people can accomplish more than they think they can and are able at least to transfer from bed to wheelchair within a week after intensive treatment is begun. Once in a wheelchair, they can propel themselves slowly and adequately.

Activities of daily living form the basic media through which exercise is provided and positive attitudes are formed or awakened. Treatment is begun at the patient's level, whether it be training the person to sit up in bed or to achieve the advanced goal of walking independently. Many times through conversations revolving around treatment, a psychological evaluation can be obtained.

Activities that require a short period of time and gross movements such as rug weaving, large embroidery, sewing, sanding or leathercraft are provided to fill in the hours of boredom when no specific treatment is scheduled. These activities provide a topic of conversation, keep their minds active, encourage socialization and help to break dependence patterns on the staff. With the attainment of even simple goals, the patients gain a great deal of satisfaction. The therapist must have sincere interest, patience and warmth with the patients. All treatment efforts from those of nurses' aides to physicians must be coordinated and consistent.

Social service enables the occupational therapist to learn the patient's home background and personality; psychiatry helps to motivate and evaluate the patient more effectively; physicians, to be aware of the medical condition of each patient; and the nurses, to know their daily status. Only when all these competences are coordinated can the total picture of a patient be known and the patient treated most effectively.

IV. SOCIAL SERVICE

by Ethel Mendkoff

It is an accepted premise that psychosocial factors play an important role in a patient's illness, in his response to medical care, and in his maintenance of improvement. The social worker in the hospital must use all of the generic casework skills and knowledge *plus* particularized relatedness to the specific needs of the aged, chronically-ill person.

We need to recognize some of the similarities as well as the differences which may exist in work with aged people. When ill, all people have fears and anxiety which may become more intense during periods of stress such as hospitalization or placement and which may reactivate past concerns and tensions, and insecurity for the future. With *aged* people, these anxieties and fears may be heightened because the illnesses may have been repeated or there may even have been disabilities and losses in the past. The future, understandably, is even more uncertain for them. However, despite the greater losses in physical, emotional and social resources in the aged patient, at the same time we must be alert to his remaining capacities.

The casework contribution to the whole therapy program is based on the relationship formed with the patient as a *person*. In this directed relationship, the patient finds security, catharsis, awareness of his dependence-independence conflict, and more accurate assessment of his strengths and weaknesses. The patients derive strength and hope from the rehabilitation process and the unified team approach and *can be* helped to relate their inner-most feelings, hopes, fears and self-concepts. Most of the aged in this program have no families or friends, experience little interest from others, and have little hope for the future. Thus the contact with the worker is very meaningful. However, it is more

than interest the aged must feel from the worker; they need to be encouraged to accept the offer of help toward some change.

The caseworker sees each person shortly after admission to begin a relationship as early as possible and to place the worker as an integral part of the total medical program. The worker maps out a regular visit program, explains and interprets hospital procedures, expectations of the patient, and aims.

The initial period of casework contact has as its aim a psycho-social diagnosis. This understanding of the total person is significant in evaluating the patient's ability to make maximum use of the therapy program and to integrate gains or improvements.

The collaborating disciplines must learn to know the patient as a person for the best results in their specialized evaluation and treatment. Collaboration involves individual and group discussion of specific aspects of the patient's psychosocial problems and responsiveness. The worker participates in all conferences, staffings and ward rounds, taking an active role in both the period preceding placement and in the out-patient program which follows.

The hospital social worker interprets the medical thinking and recommendations to the community agencies, relatives, and friends so that the patient's problems are understood and his gains maintained. All of the agencies which knew the patient must be mobilized to work together effectively on behalf of the individual for whom continued observation and care in the community has been provided.

Mrs. S, a 76 year old widow, childless, was almost totally bedridden when admitted to the program after a 6 month stay in a nursing home. She was diagnosed as having ASHD, mild hypertension, and a recent severe dermatitis involving almost her entire body. Although she was alert and gave the impression of being quite adequate, she was basically a very anxious, dependent person. She had been able to function independently in the past only through a close relationship with relatives and friends in situations in which she gave service in return for care.

History revealed that she was a youngest child, having 2 older sisters. Father died when she was 5 years old and mother remarried. Patient lived at home until age of 19 when she came to Chicago to live with oldest sister and brother-in-law. She married at age 22 to a man who had a travelling job. Marriage was a happy one, husband was dependable and good to her. He died suddenly in 1931, when she was 49. Mrs. S returned to Chicago to live with relatives, taking over additional responsibilities during the illness and death of her sisters. She remained with friends until she became ill and unable to care for herself requiring placement in a nursing home. With this change in her living arrangement she began to feel that her friends and niece were not interested in her. She complained that she had always been ready and willing to help others—but that when she was ill, she had no one to help her. Although she recognized that these friends and relatives were really interested in her welfare, she was dissatisfied since she felt she was alone and had no one on whom she could really depend. She had been reluctant to leave the nursing home as she felt she was too sick. The agency worker and the doctor helped her to accept transfer to Michael Reese Hospital.

Because it was known that she was upset about going into the hospital, the worker saw her very soon after admission. She was given an explanation of Social Service function and the medical procedures. The seriousness of her illness and disability, and her harrowing personal experience were discussed. We learned that she saw rehabilitation only as treatment of the dermatitis and that she did not see how she could care for herself away from a nursing home. The interest of the doctors, social worker and hospital in her situation was stressed.

In the developing relationship, it was established that although a dependent, anxious person, she wanted help and would be able to participate. However, she would need to be given a great deal of support and reassurance. She was seen by the worker, both alone and with the team members. She became more relaxed and acceptant of treatment procedures, becoming more of a participant, beginning to walk and care for

herself. The caseworker helped clarify attitudes toward relatives and friends so that the patient was able to recognize that she was really not alone. Repeated emphasis was put on the interest and concern of the hospital team, doctors, worker, and hospital. She was assured that she would not be deserted when discharged from the hospital, but would be followed up afterwards and seen as needed. The task of the social worker was to help motivate the patient toward change.

The members of the team were kept informed of the pertinent facts about this patient and her handling of her dependency needs, so that they could give her reassurance and plan ways to get her cooperation and interest to help herself.

When we began to talk about discharge plans, Mrs. S raised questions about her ability to live in the community, showing continued feeling of helplessness. She had many somatic symptoms which we helped her to recognize as temporary. She was able to see that she was not in need of nursing home care since she had become more independent while in the hospital. In spite of this she was afraid to be alone. The medical group had already recommended Room and Board care in the community and the patient was helped by further contact to decide on such a plan for herself.

In the process of moving toward discharge, she would frequently go back to her old pattern of concern about her physical condition. In conference with the doctor, it was learned that he had given her full information as to the future medical planning and that she had been accepting of these proposals. We felt that though patient was relaxed and accepting of his recommendations with him, she was using the worker to focus on the other side of her conflicts. A three-way conference was arranged of patient, doctor and worker to clarify and to provide needed support on a unified basis. This was done with full and open handling of the person's past, present and future situation. Patient left the conference with a feeling of being understood and accepted, understanding that we were with her to help guide and support her through what we all knew would be a difficult time of adjustment. The preventative aspects of medical care were stressed and she was told that the agency worker would visit her in her new home and would also keep in touch with the medical team.

In the meantime, the agency worker had been alerted to the situation and was looking for a Room and Board placement. She came to see the patient in the hospital to discuss placement in more realistic terms. When a home was found, arrangements were made for the landlady to visit the patient and to talk with the doctor, and hospital social worker. When patient was seen afterwards, she was at first ambivalent but finally able to resolve her conflicts. We had helped this woman develop a sense of confidence and security—knowing that she was not alone but had the medical team and the agency to help her. The social worker's role had been to help this patient appraise reality correctly, and to begin to be able to accept change. The continuity of contact is necessary to reinforce her strengths and partial success in rehabilitation. It is an ongoing process.

The changing concept of rehabilitation for the aged means that we must be alert to individualized goals and aims, valuing small as well as large gains, and enabling a patient to function at his maximum capacity. The community's concept about the aged requires change. They must not continue to be considered second class citizens.

We need to recognize that comprehensive medical care is only one part of total rehabilitation planning necessary for the aged, chronically ill. The community resources must be expanded to include such items as adequate housing, homemaker services, recreational activities, friendly visitors, as well as adequate financial support. The patients need to be stimulated and new interests opened for them. With combined, integrated efforts these people can still be helped to have happy, useful, meaningful and healthier lives. They can be helped to adjust to new experiences.

V. PRINCIPLES OF EVALUATION OF REHABILITATION POTENTIAL

by Kate Kohn, M.D.

Evaluation in rehabilitation is directed toward the establishment of the patient's so-called *rehabilitation potential.* The cardinal principle which governs all else

is that the patient is a *person,* not an amputee, not a multiple sclerotic, not a hip fracture. There are three general areas which must be individually investigated. These are: The medical or physical and emotional status of the patient, or as Clark, Case and Furey of Cleveland call it,[3] the "disease activity." Secondly, the functional capacity; third—social-economic status. According to Lowman of New York,[4] the sum total of the evaluations in these three areas equals the *rehabilitation potential.* First, we consider the medical evaluation. Dr. Gimble has described the common diseases of the aged. We are particularly interested in certain aspects. Is the condition stable? Is it progressive? How much of the total patient is affected? Will the course of the specific disease be changed as medication is given? What is the prognosis of the specific disease; on the basis of percentages can one expect the patient to get better or worse? Many of these questions cannot be answered by present-day medical methods. Nevertheless, some attempt at answers must be made.

I will mention only briefly here that no evaluation is a real evaluation without the investigation of the patient's reaction to his role in life, to his illness, and to his disability. Something about his previous behavior and personality must be known. Also important is how he feels about getting better; in other words, his motivation.

Then one must evaluate the specific disability. What part of the patient is involved in the disability caused by the condition from which he suffers. Special disabilities, such as in the patient with chronic broncho-pulmonary disease, give rise to the special question of adequate ventilation. What type of treatment does he need just for this? In these and in the patients with an amputation or a paralysis we really wish to know in what way the disability affects the functional capacity. Is the disability stable? Does the patient have a tremor? If an amputee, is the severance above or below the knee; if there is paralysis, how much of the patient is affected, which side is it, how much functional use of that particular part is left?

In evaluating function, one must first investigate the effect on his functioning of the patient's general condition. For example, if the amputee is blind, one must take this into account in planning his rehabilitation program. If the patient is physically much older than his chronological age, one must investigate this. As Dr. Gimble has stated, the cardiovascular condition is most important in the geriatric field. There is no question but that the aged patient often is more disabled by the general condition of his cardiovascular system than by the specific disability for which he is asking for rehabilitation. In our evaluation of the functional capacity, we are interested first of all in how the disability affects the patient's performance of activities of daily living. What limitation of muscle power is there? How does the paralysis affect the actual functioning of the hand, foot, the leg, or the arm? Then the joints, how much limitation of range of motion is there? How stable is the patient? Is he unstable because of central nervous system disease, or because one of his joints, on which he bears weight, is so painful that he cannot put weight on it and therefore falls? Is he unstable simply because he has only one leg? Then the special senses: is he dizzy because of an affect to the ear? Can he not walk because he cannot see and is therefore afraid to try? Or has he a deficit in proprioceptive power? He may put his foot down where he

[3] W. S. Clark, H. B. Case and J. G. Furey, *J. Chronic Disease,* Vol. 5, No. 6, June 1957, p. 712.

[4] E. W. Lowman, *J. Chronic Disease,* Vol. I, No. 6, June 1955, p. 628.

thinks it belongs, but since proprioceptive feeling is deranged, he does not actually know where it is. Has he anasthesias of certain areas of the skin? This is important, for in conditions which cause inactivity, and loss of the normal protective reflex which would make the normal person shift position and thus save his skin from being pressured in an area too long, decubiti or sores develop which are hard to heal and lead to further complications.

Certain interferences with functioning develop complications or sequelae. In the emotional and intellectual area, there is often mild or even marked depression. Certainly there may be deterioration of intellect. Long inactivation may lead to contractures, to decubiti, to kidney stones and other infections and diseases of the genito-urinary tract, and to bowel stasis, with danger of obstipation and obstruction. Almost all disabling diseases lead to changes in metabolism and poor nutritional status. The patient may be incontinent, not only from paralysis and lack of control of the bladder, but on a psychological basis, from central nervous system affect. Such incontinence then adds to the difficulty in nursing care and may produce fertile field for the development of bed sores. The hip fracture commonly leads to lack of mobility of that one particular part and many of these patients develop necrotic ulcers of the heels. The patient with Parkinson's, having severe tremor of his hands, prefers not to slop food around and therefore doesn't eat enough. These patients are often found to be in a poor nutritious state through lack of appetite on their part because of their inactivity, plus the grave difficulty they find in feeding themselves.

One of the most important sequelae is that of pain. If a patient suffers pain, real pain, it is exceedingly difficult to get him to accept a rehabilitation regime. The pain must be investigated, diagnosed, and relieved. Sometimes in hemiplegics, the paralyzed arm will have dragged the shoulder joint into subluxation by its weight against the paralyzed muscles, causing an exceedingly painful shoulder. If the patient is also aphasic, one may not learn of this pain and wonder why the patient is so sensitive to exercise.

The socio-economic phase is the third area of our investigation. Many patients sit around and worry, not only about their physical condition, but about the cost of their care, or whether they have enough money for a prosthesis. They worry about where they are going to live and what kind of work they are going to do. Thus then we have the three areas for drawing up and computing the patient's rehabilitation potential.

The contra-indications for rehabilitation are quite generalized and sometimes very difficult to define. They fall into three major classifications. I shall mention only briefly the first and second. First, does the patient have too much cerebral deterioration so that he cannot learn? Is there too great an intellectual deficit? Second, his previous behavior pattern: has he an emotional deficit enough to inhibit motivation? Was he a drug addict or an alcoholic? In his individual behavior pattern and history, are there indications that certain aspects of rehabilitation technique would not be feasible to attempt?

Thirdly, from the physical aspect, there is one cardinal contra-indication, which is the possibility the rehabilitation techniques will endanger the health of the patient. An example of this is the cardiac in Class III or IV. This patient cannot accept any severe exercises or any great amount of physical activity, without endangering his total health. Therefore rehabilitation techniques have to be carefully tailored, not for the specific disability, but for the patient's general

condition. Another example would be the patient with severe renal insufficiency. He, too, cannot be expected to undergo any really active rehabilitation program. The patient who has had a stroke, and has residual paralysis in one leg, cannot be asked to walk as well or as fast as the patient who has not had a C.V.A. One must protect him against falling in order to avoid such subsequent hip fractures.

An integral part of evaluation or planning for rehabilitation is the estimate of the extent to which one can expect the patient to go. What is his goal? How far can he get? How much upgrading can be expected? One must, above all things, be very realistic and practical. There is no point in expecting a person who did not work before illness to start working after rehabilitation. There is no point in expecting an older person, who because of a heart condition, has not walked up and down stairs for many, many years, to now scale the stairs because he is fitted with a prosthetic leg. Surely we must try to substitute for the disability, to retrain or develop some other part to take the place of the disabled limb, and we must upgrade the patient's physical condition as much as possible, to prevent the sequelae and complications of disabilities, but we still must be practical. I have no time now to go into specific techniques for each level of upgrading, but I would like to give you, as briefly as possible, the several steps or levels that the patient can try to attain. First of all, starting with a completely bedridden patient, one attempts to mobilize the patient in bed; self-care in bed; self-hygiene; so that he can wash himself or comb his hair in bed. If this is achieved, the patient can attempt to become mobilized in a wheelchair and thus to learn transfer activities; how to get from the chair to the bed, from the bed to the chair. How to wheel the chair. After that comes the attempt at ambulation. There are assistive devices, such things as the wheel chair or braces, crutches, canes, pickup walkers or roll-walkers, and with these devices or without them, the patient then attempts to become independent in his activities of daily living. Toileting, walking, sitting, standing, dressing, in and out of bed and in and out of chairs. Having achieved this level, he then goes on to ambulation of stairs. A patient who can climb up a stair can get in and out of an automobile. This, then, would almost, by definition, mean independent living. Can he do enough of his activities of daily living to live alone? Can he cook? Can he buy his food? Independent living then might mean ability to use public transportation and thus to the performance of some form of work, if the patient is so motivated. Shall it be limited work in a sheltered workshop, or part-time work in the business world? The last level, of course, is the independent person, able to live alone, and go to and from a job, full-time with public transportation. This person, then, is completely rehabilitated. One must always remember that all levels are interchangeable, the patient may progress slowly for a time and then faster, or he may regress to a previous level if something occurs. He may attain a much higher goal than was expected at the beginning. Rehabilitation is a fluid process. It is ever changing and must always be carefully fitted to the individual and his specific needs. Now since many of our patients will not attain the final beautiful level of complete independence, but have reached a plateau on one of the other levels and cannot, for the moment, be expected to change, what then for him? What shall he do? Where will he go? Who plans for him? The patient must not be discharged from any rehabilitative program without careful, thoughtful planning for his future.

VI. THE ROLE OF THE PUBLIC AGENCY

by Rebecca Robinson

The public agency which serves the largest number of needy aged through Old Age Assistance has felt the greatest pressure from the problems created by an increasing aging population. There had been no community program to deal with the situation. Because of pressure for beds and lack of interest of medical staffs, acute hospitals discharged aged patients too early, many to nursing homes, for lack of adequate housing or planned care for them. The costs of private physician's care and of hospitalization and nursing home placements grew tremendously. In 1954, the Illinois Public Aid Commission found that 54 per cent of total medical costs in welfare cases were due predominantly to medical care for Old Age Assistance recipients while their hospitalization accounted for another 25 per cent. This, aside from the human costs. It was then that a demonstration program was planned in Cook County to help Old Age Assistance recipients moving into nursing homes, or already in nursing homes for not more than four months, to return to self care in the community.

The first step in rehabilitation is case finding. All applications for nursing homes are reviewed by the caseworker, and the case records read and scheduled. This begins the case study on the basis of which a social diagnosis is made. In the course of the case study the caseworker establishes a relationship with the aged recipient, which is basic to diagnosis and treatment. The case material is then sent in a referral letter to Michael Reese Hospital, giving medical findings, social history, personality structure, motivation, and potential, as well as a tentative plan for community living. The patient is later screened medically by the Research Fellow and evaluated by the Evaluation Board which decides to accept or reject him. At the point where he is ready after medical assessment and treatment, to leave the hospital, the GRP worker works through with him definite plans for housing in accordance with the doctor's recommendations.

The same kind of fears that the patient exhibited at leaving the security of the nursing home is often shown at the point where he must leave the hospital. In the project these fears have to be handled by the Cook County Welfare rehabilitation worker in the community. It is in the community that there is a real test of the gains that the patient has made up to this point. Some aged make excessive demands for care and attention in the "foster" home, which are only an expression of their insecurity in the new relationship, their fears of a new life and new responsibilities. The worker who has found the "foster" home must give a great amount of time at this point to help the aged individual and the landlady work through a satisfactory relationship.

On the basis of the first year's experience, our "foster" homes have proved surprisingly satisfactory in meeting the needs of the aged. The demand for homes is so great that a special worker is necessary to plan and develop all kinds of housing for the aged. We have used the agency standard of $65 per month for room and board plus $10 additional for medical supervision, and a grant for clothing and incidentals to the recipient. We need more flexibility in the amount paid for room and board, especially where help to the patient is required. Some of our aged have applied for public housing, but the waiting lists are long. All Homes for the Aged have to develop the concept of rehabilitation as have a number of the Jewish Homes, if they are to serve the many Old Age Assistance recipients who are coming to them for

admission. At present these Homes will not accept aged with known chronic illnesses and often discharge them when they become ill. Most of them have long waiting lists so that they can be used only for long term planning.

Money plays an important role in the return to the community of an aging recipient. Many recipients of assistance are receiving Survivors' Insurance benefits and the budget can, therefore, be more flexible. Recognizing the psychological meaning that money has for these rejected individuals, it is important to think of a more flexible individual allowance.

The aged who are rehabilitated must be helped to remain in the stream of community life as participating members of society. We try to help them find worthwhile activities in senior groups. It is not enough to talk to the aged about group activities. The worker must stimulate the individual to join one, and then, if necessary, stay with him until he adjusts to the group. Another resource is summer camp. Gradually we are trying to stimulate the aged to help in planning facilities for recreation and activity for themselves; thus one man is helping to organize a Senior Citizens Group in a housing center near his home.

The interpersonal relationships of the aged have not received enough attention. The old person has been left in his isolation, rejected by relatives, friends, and community. Too often the community's emphasis with relatives has been on money contributions rather than the need of the recipient for acceptance and love. He should be helped to carry on his role as a member of the family whether living with them or not, instead of being allowed to withdraw or to express his resentment and hostility through aggressive punishing behavior toward his children. The children must be helped to resolve their guilt and made more comfortable in their relationship with the parent. It has been surprising in this program how children and relatives, when given help, have been able to be more accepting of the older individual and to give him support in his wish to return to the community.

The first year of the Geriatrics Rehabilitation Program has shown that aged chronic sick can with diagnosis, evaluation, and treatment be returned to self care outside of nursing homes and can function successfully when under the care of an integrated program of medical followup and casework service. The Cook County Department of Welfare is now planning to apply the findings to a larger program, including not only Old Age Assistance recipients but those in other categories of assistance.