Training may in one case make only the difference between secure and insecure sitting; in another, between safety and danger in going up and down curbs. Other patients may make considerable improvement over a period of time. If these are growing children, it is sometimes difficult to tell how much of the progress was due to training and how much to maturation. But the physical therapist who wishes to do justice to his cerebral palsied patient must have as many balance technics as possible at his disposal.

REFERENCES


The Organization and Development of a Physical Medicine and Rehabilitation Service Within the Framework of a Welfare Agency

Geneva R. Johnson, B.S., Beatrice A. Levy, Jack B. Mohney, M.S., M.D.

Baylor University College of Medicine, Department of Physical Medicine and Rehabilitation, since April, 1954, has operated and maintained a small rehabilitation unit for the indigent and aging indigent, with particular emphasis on the clients of the Houston-Harris County Board of Public Welfare, Houston, Texas.

In April, 1945, the Houston-Harris County Board of Public Welfare opened a convalescent home in the Old Jefferson Davis Hospital building, the former city-county hospital. Forty-five beds were provided on the fourth floor. Medical care was obtained at Jefferson Davis Hospital, the present city-county hospital which is the teaching facility for Baylor University Medical School.

In the fall of 1952, and again in the fall of 1953, unsuccessful attempts were made to establish a Physical Medicine and Rehabilitation Service in the Old Jefferson Davis Hospital. This unit was to serve the patients living in the convalescent home. Money for equipment and operation, including salaries, was furnished by two interested families in the community. Definitive care in physical medicine was offered. These efforts failed due to lack of a firm policy of admissions and discharge in the convalescent home. Turn-over of patients was too slow to make it economically feasible to continue a restorative program.

With the institution of the Department of Physical Medicine and Rehabilitation at Baylor University College of Medicine in January, 1954, it was requested that the unit at Old Jefferson
Davis Hospital be re-activated. In late March of that year, the facility was re-opened. No real change had been made in policies governing admissions and discharges of patients in the convalescent home.

When the unit re-opened, the staff consisted of one physical therapist, one nonprofessional, untrained aide, and the physiatrist, who was available for consultation one-half day each week. Part-time janitorial service, electricity, water, and heat were supplied by the Board of Public Welfare.

Physical space for operation was one room, 20 feet by 42 feet, located on the second floor of the Old Jefferson Davis Hospital building. This was accessible from the fourth floor by self-service elevator, and by elevator or steep, unrailed stairs from the outside. In order to reach the department, it was necessary to pass through a clinic operated by another agency.

Originally, the treatment program was designed primarily for the patients living in the convalescent home. The long range plan was for expansion which would allow extension of service to other clients of the Board of Public Welfare.

Most of the patients initially referred had received treatment in physical medicine and rehabilitation previously. Aims of treatment had not been clearly understood by the nursing staff and the patients. As a consequence, gains made through treatment had been lost. Many of these people had become inactive and some had again become virtual bed patients.

In the early phases, it had been necessary to take all patients referred. Of the 37 patients living in the convalescent home, 8 were selected by the physiatrist as candidates for physical medicine. These represented the usual disabilities of arthritis, cerebral vascular accident, fractures, central nervous system diseases, and spinal cord lesions. The treatment load increased to 14 by the end of the first month of operation and continued to increase gradually. With one exception, the patients were 50 years of age or older. Within six months, the patients first referred from the convalescent home had achieved maximum benefits.

The program consisted of treatment in the department and on the ward with the usual modalities of physical therapy. Diversional activities were encouraged outside of the treatment program and for a time were carried on in the rehabilitation unit and on the ward on an individual basis. These activities were under the supervision of the physical therapist and on the prescription of the physiatrist. As more patients began to participate in this program, it became too time consuming for the physical therapist. Efforts were made to continue with the use of volunteers and later with a part-time crafts instructor. Neither of these attempts proved satisfactory and the program was discontinued as a supervised project.

The nursing staff of the convalescent home, the social case worker, and her supervisor seemed unable to accept or acknowledge the purposes of a treatment program in physical medicine; therefore, no efforts were made to release patients from the convalescent home or to plan for their discharge after maximum benefits had been reached. There were few new admissions to the convalescent home, and as a result, to the Physical Medicine Service.

To prevent the collapse of this carefully nurtured program, a shift in the emphasis of treatment load became imperative. Repeated efforts were made by the physical medicine staff to acquaint the Director of the Board of Public Welfare with the services available to outpatients. In October, 1954, the physiatrist was invited to speak to the entire social case work staff of the Welfare Department about the role of physical medicine in the rehabilitation of the physically disabled. The social case workers had not been aware of the value of early rehabilitative care or of how the Physical Medicine Service could benefit the disabled client being carried on relief status.

Although there was evident interest in the work being done in the rehabilitation unit, actual participation by the social case workers did not take place at this time. There had, as yet, been no opportunity to demonstrate the worth of early care or to show how this could save valuable time for the client and shorten the period of welfare assistance.

Soon after inauguration of this unit, the physical medicine staff recognized the potentiality for its growth and service to the community. To increase the usefulness of the unit, an occupational therapist was added to the staff in December, 1954.

In March, 1955, the Executive Director of the Board of Public Welfare, in an earnest desire to offer the best kind of service to his clients, united with the physical medicine staff to plan the first inclusive meeting of supervisory personnel from his department, the convalescent home, and from the physical medicine department. The chief supervisor of social case workers, superin-
tendent of nurses of the convalescent home, the
social case worker of the convalescent home, Ex­
ecutive Director of the Board of Public Welfare,
the physiatrist, occupational therapist, and physi­
cal therapist were present. At this meeting, at­
tempts were made to explain the position of each
group as it related to the patient. The Director of
the Board of Public Welfare was asked to clarify
the purpose of the convalescent home.

Objectives of the physical medicine and re­
habilitation treatment program were defined as:

1. To assist the patient to achieve some mea­
sure of self-discipline,
2. To help the patient to understand his dis­
ability,
3. To attempt to reestablish work habits,
4. To increase work tolerance and endurance,
5. To help the patient to develop as much
physical independence as possible.

Underlying these objectives was the basic phil­
sophy that preservation of human dignity was
equally as important as restoration of physical
function.

The physiatrist asked if beds could be reserved
in the convalescent home for patients who needed
intensive care in physical medicine. A specific
number of beds could not be allocated to this
purpose, but assurance was given that any time
a bed was needed, it would be provided if the
applicant met the Board of Public Welfare
eligibility requirements.

A procedure for referral and acceptance of
outpatients was outlined. Only patients referred
from Jefferson Davis Hospital would be con­
sidered for outpatient treatment, since necessary
medical work-ups, X rays, and laboratory tests
could be more readily obtained for the indigent
patient through the city-county hospital. The
physiatrist also requested that all outpatients have
a tuberculosis and venereal disease clearance be­
fore admission to the Physical Medicine Service.

The Director of the Board of Public Welfare
explained the difficulties involved in discharging
patients from the convalescent home. Many of
these patients had no families or homes to which
to return. Nursing homes were woefully over­
crowded. Age, disability, and past work records
placed many in the so-called “unemployable”
category. The use of foster homes was suggested
as a possible solution for those who required
custodial or domiciliary care. This was accepted
as a valuable suggestion that merited investiga­
tion. The low budget allowed for this kind of
placement, however, does not permit a wide
selection, and desirable and suitable homes for
this purpose are difficult to locate.

Out of this joint conference came the realiza­
tion of the many problems confronting each serv­
ience. Until this meeting, neither group had fully
appreciated the concept of the individual oper­
tation of two related, yet independent agencies.
At this time, it was decided that bimonthly
meetings of this same staff should be held in
order to establish joint policies and procedures.
It was also requested that these meetings should
include discussion of patients who were already
receiving treatment in the rehabilitation unit.
Another request was that the social case worker
whose client was being reviewed be present to
give the social summary and to participate in
the discussion and plans for the patient’s treat­
ment program and eventual termination.

The chief case supervisor was asked to survey
the case load of the Board of Public Welfare to
determine how many clients were receiving aid
because of physical disability. A short case his­
tory was prepared on each of these and this
summary was submitted to the physiatrist. From
this group, he chose a number who should be
sent to Jefferson Davis Hospital for evaluation
and possible referral to the physical medicine
department.

By this procedure, several patients were re­
ferred and accepted for treatment; 4 were lower
extremity amputees, who had been provided with
prostheses by the State Office of Vocational Re­
habilitation. Very little, if any, preparation had
been given before the prosthesis was received,
and no training in the use of the limb had been
provided. Tangible results of concentrated treat­
ment on a few selected patients impressed the
social case workers with its value and inquiries
came about the possibilities of treatment for other
clients. In the course of the following 9 months,
20 outpatients were added to the treatment load.
Of this number, 2 were brought into the conval­
escent home to receive intensive care in the re­
habilitation unit.

The increasing outpatient load immediately
brought certain difficulties. Finally, a form re­
questing necessary basic information was drafted
for use of the social case worker. This form
was sent along with the client when he re­
ported to the hospital for an appointment. The
examining physician could quickly supply the
requested information and add any pertinent
remarks or information, if his evaluation indi­
cated referral to the Physical Medicine Service.
This form was returned to the social case worker
by mail and then delivered to the rehabilitation
An appointment was made for the patient to be seen by the physiatrist. The social case worker made the necessary transportation arrangements and informed the client of his appointment date and time. If possible, the worker came with the client for this first examination. A summary of the patient's hospital chart was prepared by the physical medicine staff before the patient reported for the initial examination.

An outstanding problem was transportation. First of all, the location of the rehabilitation unit was in an isolated section of the city where bus transportation was not within walking distance for the handicapped. The cost of cab fare was prohibitive. Red Cross motor service could provide a limited amount of transportation, but could not meet the needs because of lack of volunteer services. In time this need was made known to Volunteer Community Services, a United Fund Agency, by the Director of the Board of Public Welfare. An effort was made to establish a transportation corps to serve the rehabilitation unit. While this started off well, the corps dwindled to one faithful driver who donated one day a week. A philanthropic group, which became aware of the pressing need, made a regular monthly donation to a transportation fund.

Other difficulties encountered were indifference, in some cases, or refusal of the patient to accept what the long range treatment program meant for him. A long-term disability and a lengthy period of dependence on others to meet his basic needs had destroyed motivation for independence. In some instances, because of heavy case loads, social workers were unable to follow up with frequent home visits.

A valuable standardized form resulted from the need of the physical medicine staff to have immediate basic social information about the referred client. This was to help in planning a suitable program in the unit and for home care. Information was requested about the patient's former employment, his reaction to the suggestion that he be evaluated for possible referral to Physical Medicine Service, and the physical conditions of his home. The latter influenced the type of home program the patient could reasonably be expected to follow. If the client was admitted for treatment, a thorough social service summary was prepared and presented at combined staff conference when the patient was reviewed.

In addition to the problems encountered in treating outpatients, there were many involved in the care of inpatients. When a patient reached maximum benefits in the rehabilitation unit, he could not be quickly dismissed from the convalescent home. Several of these patients were maintained on a treatment program many months past the ideal termination point. The objection to this was that time, space, and staff were not available for a maintenance program. On the few occasions when the patient was discharged and remained in the Convalescent Home, there was a rapid regression to pretreatment level or below.

The difficulties with the convalescent home patients resulted primarily from lack of staff understanding and absence of adequate medical direction. The convalescent home staff consisted of one registered nurse, seven practical nurses, three female aides, and one male porter. Suggestions for self-care ward activities were frequently disregarded as a matter of expediency. The Home was usually filled to capacity. Preparing a patient to meet a physical medicine schedule was an added burden when the staff was unable to see how this would alleviate their load. As patients improved and assumed some of their own care, this attitude began to change, but the change was slow in coming.

Carry-over from the treatment program was further hampered by the physical facilities of the convalescent home. Bathrooms were inaccessible to the patient by wheelchair because of narrow doors, poorly arranged interiors, or a step up or down. Crowded conditions did not leave space for a communal dining room or indoor area for socialization and recreation. A partly sheltered porch garden, which was reached by ascent of a long ramp, and the hallway were the available recreational areas.

In spite of these adverse conditions, from March, 1955 to November, 1955, 4 patients were admitted to the Home from Jefferson Davis Hospital for the express purpose of receiving intensive rehabilitative care. Ten other patients admitted received care when it was indicated. Discharge from the convalescent home continued to be the insurmountable obstacle.

A dramatic change in attitudes and concepts of treatment occurred in December, 1955, with the addition of a new superintendent of nurses. In September, 1955, a trained male social case worker had been transferred to the Home on a part-time assignment. These changes in personnel increased understanding of common problems and made it possible to have a more stable and reciprocal relationship between the convalescent home staff and physical medicine staff.

The common concern of those engaged in the
treatment of patients, and their awareness for
the need of staff medical service, resulted in an
agreement between the Board of Directors of
the City-County Welfare Department and Baylor
Medical School administration to provide such
service. A physician joined the staff of the con-
valescent home in June, 1956, on a part-time
basis.

From the beginning it was realized that a staff
physician in the convalescent home would be the
integral part of the machinery of successful op-
eration. The fortunate choice of a physician who
is vitally interested in the total rehabilitation
process has added immeasurably to the strength
of the whole program.

The purpose of the convalescent home was
analyzed and restated. Criteria for admission
were established and an admission board ap-
pointed. To be eligible for admission, applicants
must meet these requirements. Discharge poli-
cies have been reorganized and executed. Patients
eligible for pensions—those who are blind, who
receive old age assistance, or are totally disabled,
must be placed in another facility as they are
no longer eligible for welfare assistance.

This new interpretation of the purpose of the
convalescent home has brought about a change
in its name. It is now called the Convalescent
Ward and thought of as an extension of service
of Jefferson Davis Hospital, even though there
is no administrative connection.

Before admission to the Convalescent Ward,
a patient is evaluated for referral to the physical
medicine department. This makes institution of
early treatment possible and results have been
far superior. All patients in the Convalescent
Ward have had a medical workup since June,
1956. Reports are available in the Ward office.

In October, 1956, the social case worker was
assigned full time to the Convalescent Ward.
Social histories have been completed on all pa-
tients and are also available to the staff. The
social worker now has time to prepare the pa-
tient to accept discharge from the physical medi-
cine department and subsequently from the Con-
valescent Ward.

Each week the entire patient load of the Con-

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CHART I

DISTRIBUTION OF PATIENTS BY AGE GROUPS
(April, 1954—November, 1956)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
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<tbody>
<tr>
<td>Total</td>
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<td>10</td>
<td>24</td>
<td>44</td>
<td>20</td>
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<tr>
<td>Total</td>
<td>105</td>
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</table>
CHART II
DISPOSITION OF PATIENTS TREATED IN REHABILITATION
UNIT
Between April, 1954, and November, 1956

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Number</th>
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<tr>
<td>To employment</td>
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</tr>
<tr>
<td>Maximum benefit. Discharge to home*</td>
<td>15</td>
</tr>
<tr>
<td>Discharge to home care*</td>
<td>14</td>
</tr>
<tr>
<td>Maximum benefit. Discharge to Convalescent Ward*</td>
<td>10</td>
</tr>
<tr>
<td>Failed to report (Transportation, lack of interest, etc.)</td>
<td>9</td>
</tr>
<tr>
<td>Discharged to home*</td>
<td>5</td>
</tr>
<tr>
<td>Transferred to other facility*</td>
<td>5</td>
</tr>
<tr>
<td>Discharged from Convalescent Ward*</td>
<td>5</td>
</tr>
<tr>
<td>(Pension, failed to return, needed bed space, disciplinary measure)</td>
<td>5</td>
</tr>
<tr>
<td>Discontinued treatment. Illness*</td>
<td>3</td>
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<tr>
<td>Maximum benefit. To Vocational Training*</td>
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<tr>
<td>Deceased</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
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On Treatment Program

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>105</strong></td>
</tr>
</tbody>
</table>

* Being Maintained by Board of Public Welfare.

Multiple problems have been encountered and some remain. In the Department of Welfare these center around lack of trained social case workers, lack of knowledge about medical problems and disabilities on part of the workers, lack of funds to assist with a program of expansion, and heavy case loads which prevent adequate home follow-up by social case workers.

In the Convalescent Ward there are problems of untrained personnel without proper understanding of rehabilitation aims, unsuitable living quarters, inadequate staff to care for patients and also supervise activities of daily living, and slow discharge of patients who have reached maximum benefit.

In general the program is hampered because of limited funds for necessary equipment, such as braces, wheel chairs, splints, bed boards, foot boards, over-bed bars; cramped treatment area with no space for private examination or quiet treatment, office space, waiting room, or dressing rooms for patients or staff; lack of transportation for patients.

This has been a rewarding and worthwhile project which can serve as an example to other communities, regardless of size. Resources in this community have been utilized to provide a select group of disabled persons with an opportunity to lead productive lives. Assistance has come from the following sources:

1. Private
   a) Baylor University College of Medicine.
   b) Thrift Shop.
   c) Citizen groups.
   d) Goodwill Industries.

2. State
   a) Office of Vocational Rehabilitation.
   b) State Crippled Children.

3. Community Aid—Red Feather Agency
   a) Jewish Guidance Service.
   b) Community Volunteer Services (Community Council).
   c) American Red Cross.
   d) Speech and Hearing Center.
   e) Visiting Nurses Association.

4. Social Agencies
   a) Board of Public Welfare.
   b) Catholic Charities.

A rehabilitation center to serve the nonpaying and part-paying patients of Harris County should be the natural outgrowth of this established nucleus.