A Community Survey to Identify Rehabilitative Needs in the Home

Marion S. Ryerson

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A COMMUNITY SURVEY TO IDENTIFY REHABILITATIVE NEEDS IN THE HOME

by

Marion S. Ryerson

A Thesis in Partial Fulfillment of the Requirements for the Degree Master of Science in the Field of Nursing

November, 1959
I certify that I have read this thesis and that in my opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of science.

Ruth M. White, M.S., Assistant Professor of Nursing

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ACKNOWLEDGMENTS

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Special appreciation is expressed to the members of the faculty of the School of Graduate Studies at the College of Medical Evangelists for their skillful guidance of this valuable experience and to the typist who so expertly put this report together.

It is my sincere hope that the community groups planning for future rehabilitative services in the Arrowhead United Fund Area will find help and encouragement in the material presented in this report.

Marion Stevens Ryerson
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CHAPTER I

THE ELEMENTS OF THE PROBLEM

Problem-solving methods used in approaching community planning, require accurate knowledge about the community. Such facts and trends may be brought to light through research, where forward-looking leaders can interpret them and translate them into integrated community action.

The community referred to in this study was in the "boot" of San Bernardino County. Although 92 per cent of the area of this county was in the Mojave Desert, the southwestern tip, known as "the boot" had very fertile land. During the years of 1949 to 1959, large crops of oranges, grapes, and walnuts were grown there with the help of irrigation waters. Industries started in these years; steel, metals, chemicals, and textiles, grew and were an additional attraction to an increasing number of workers. The San Bernardino County Board of Trade\(^1\) estimated in July of 1959 that the overall increase in population for the county had been 73 per cent during those ten years.

\(^1\)San Bernardino County Board of Trade, *Population* (San Bernardino: July 1, 1959), mimeographed material.
A part of this fertile valley, the Arrowhead United Fund Area, consisted of three cities and three unincorporated areas; specifically, the cities of Colton, Rialto, and San Bernardino, as well as the unincorporated areas of Bloomington, Highland, and Loma Linda. The estimated population of July 1, 1959 for this area was 169,750 persons or 34 per cent of the total estimated population for the entire county.

I. THE SOURCE OF THE PROBLEM

Requests by telephone. Social service workers in this community took note, soon after the beginning of 1959, that many telephone calls were being received in their offices for services which were not available. Most of these requests were for a person to help in the home during an illness or to substitute for a parent who was temporarily out of the home. These requests were not limited to any one economic group nor to any one stressful situation.

Community organization. Among the more active community groups in the Arrowhead United Fund Area were the Senior Citizens and one sub-committee of that group, titled

2Conversation with the Arrowhead United Fund Area agency representative.

3See appendix A.
The Health Activities Committee. These two groups were a part of the community organization under the County Council of Community Services. It was to the Senior Citizens that the County Council of Community Services went for consultation and consideration of this community problem. Logically, a survey would document the needs of the community in an orderly fashion and for that purpose an investigator was necessary. The Committee contacted the School of Graduate Studies at the College of Medical Evangelists, suggesting that a masters student might be interested in assisting in a survey. One student, who was particularly interested, together with the community representatives defined the problem for study.

The statement of the problem. The problem was to identify and describe the rehabilitative needs of a random sample of persons fifty years of age or over, who were discharged patients of four hospitals in the Arrowhead United Fund Area.

II. THE PURPOSE OF THE SURVEY

The purpose of the survey was to learn the needful trends of a specific community for rehabilitative services

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4 See Figure 1.
5 See Appendix C.
by sampling one major group. The results of the study were
to be used by the County Council of Community Services of San
Bernardino County in estimating the needs for community services
in the Arrowhead United Fund Area.

III. JUSTIFICATION OF THE SURVEY

Felt needs. The initiation of this research was, as is
often the case, the result of felt needs; felt needs expressed
by lay and professional persons in all economic levels living
in the Arrowhead United Fund Area. In addition, doctors,
nurses, and social workers, expressed a belief that homemakers
would be of great value during periods of illness in the homes
of their patients.

Joint planning. "Joint planning on a . . . local basis
can accelerate progress in the fields of ambulatory care,
home-care programs and rehabilitation by (1) enlisting
public interest, (2) studying and evaluating existing
services for ambulatory patients for improvement and
expansion, (3) utilizing presently available personnel,
including general practitioners, and finally, (4) coordi-
nating community services, facilities and resources." 6

Garrett also comments on the successful program by stating
"successful rehabilitation programs depend on integrated

6 Association of Teachers of Preventive Medicine,
Committee on Medical Care Teaching (ed.), Readings in
Medical Care (Chapel Hill: The University of North Carolina
community activity. . . .7 These points are demonstrated in the Arrowhead United Fund Area in the coordination of agencies with a County Council of Community Services. As the trends of this and other studies are evaluated and utilized, it seems quite possible that even further integrated community activity will be demonstrated.

Increasing number of older citizens. "Chronic illness and the elder citizen is increasing"8 and figures used by the National Survey9 for July, 1957 to June, 1958 applied to the estimated population of the Arrowhead United Fund Area10 indicated that there might be as many as 40,740 senior citizens in this area. This number of persons, or 24 per cent of the total estimated population of the Arrowhead United Fund area, seems to be large enough to justify efforts to meet their health requirements.

10See Appendix A for population figures.
Incidence of chronic illness. In 1954 the Commission on Chronic Illness stated that one in six, or 16 per cent of the population of the United States had some disabling or non-disabling physical or mental impairment. In that same year W. D. Bryant's study in Kansas City stated that of 17,000 persons studied, 5.2 per cent were handicapped and of these, 65.7 per cent were rehabilitable. Of this rehabilitable number, 6 per cent were over 65 years of age.

In addition to chronic illness and rehabilitable handicaps, many diseases "plaguing elderly people originate much earlier in life and progress slowly over long periods of time (so) . . . more persons with substantial physical or mental disability now survive to old age due to advances in diagnosis and treatment."

Chronic illness can also originate in the individual who retires without planning for a gradual acceptance of a


12 W. D. Bryant, "Highlights of the Greater Kansas City Rehabilitation Survey and Demonstration," Community Studies, Inc. (Kansas City: September, 1956).

13 Goldmann, op. cit., pp. 163-64.
changed life pattern caused by economic insecurity, boredom, and inactivity. Many times when dependency is seen in the senior citizen it is caused by social isolation as well as physical disability, however, "when a person is vitally interested in life and is active in his living of it, his aging process is slowed." The day care center in New York City demonstrated that these dependencies can be prevented "when adequate medical, social, and other services are available in time." Therefore it seems that not only is this study justified for future planning but there is an urgency about furnishing adequate services as soon as possible to prevent dependencies which lead to even greater rehabilitative needs.

Rehabilitation benefits. The Committee on Medical Care Teaching stated in their report in 1958 that rehabilitation can reduce incidence or recurrence of disease and return a large percentage of handicapped persons to active


16 Wickenham, *op. cit.*
daily living or economic employment. Therefore it would seem justifiable to expect that a successful rehabilitative program would increase the labor force.

**Home care benefits.** A prominent public health leader told nurses in a meeting in San Diego, October of 1959, that care of the aged in their own homes would "help relieve the burden of vital medical rehabilitation. . . . "California," she said, "ranks fifth among the states of the Union that have homemaker services." Older persons respond more quickly to care in their own homes than in institutions. Familiar surroundings give a measure of security, a feeling of belonging.

**Research needed.** Perrow has said that research is needed on the special problems of rehabilitation in the home and that information on conditions at discharge from the hospital "would be most illuminative. . . . There has already been considerable research on diagnosis, days of service, and costs" but all of the studies have been made from the professional viewpoint.

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17 Association of Teachers of Preventive Medicine, op. cit., p. 388.

18 Beverly Beyette, Editorial in *Evening Tribune*, October 9, 1959, p. a27.

A desirable approach. Allan tells his readers, "Although communities can use the results of national or regional studies and apply the statistical estimates to their own population, the possibility for error is considerable and more exact and useful data can usually be obtained by studying and measuring the community's own problem."20 This seemed the desirable approach in this community.

IV. LIMITATIONS OF THE SURVEY

Five limitations. There were five limitations of the survey; two concerned with finances and personnel, two connected with the choice of the sample, and one negative consideration.

Financial limitations of the sponsoring committee dictated the choice of a pilot study which would be less time consuming and require fewer people to put it into operation while lack of qualified personnel to conduct a large study also favored a small study. Individuals in the sample were to be 50 years of age or over. Further limitations of the sample were that each individual have a post office address in the Area, (not that of an institution), and be persons who had sought hospitalization in the selected hospitals. Social status of the sample was not to be included.

The sample was limited to one major group, the senior citizens of the Arrowhead United Fund Area. Perrow justified this choice by stating that small sample analyses can indicate trends which give weight to correct impressions or correct unsystematic impressions.21

V. THE METHOD

The descriptive method was used to present the data secured through personal interviews. The personal interviews assured answers to all of the items of the schedule and the printed interview schedule promoted uniformity in collection of the data. Perrow advocated the use of the descriptive method because as he said it allows for "intensive examination of the data and does not require the elaborate mechanism of control groups."22

VI. THE ASSUMPTIONS

1. It was assumed that the respondent's expression of felt need would identify his understanding of personal need as well as that of his family in the stressful situation following discharge from the hospital.

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21 Perrow, op. cit., p. 37.

22 Ibid.
2. It was further assumed that the expressed needs of the respondent and/or his family was an indication that they would use any service that would fulfill that need, were it available and financial considerations were not operable.

3. It was also assumed that the results of this survey, plus any other study recommendations, could be used for estimating the need for rehabilitative services and their use in the Arrowhead United Fund Area.

4. It was also assumed that nursing homes give rehabilitative care.

VII. SUMMARY

In one small, highly populated area of the large desert county of San Bernardino, the Arrowhead United Fund Area desired documentation of need for rehabilitative services for its citizenry.

A descriptive survey was the method of choice to justify the felt needs for rehabilitative services. The estimated size of the senior citizen population and the increasing national prevalence of chronic illness, physical and mental, stimulates community self-analysis. The evidence of successful rehabilitation in other cities gives impetus to any fast-growing community to plan for such services.
The sample used in the pilot survey was limited to those who were 50 years of age or over, who lived and sought hospitalization in the Arrowhead United Fund Area. The results of personal interviews guided by a carefully arranged interview schedule, were to be used as an indication of need for rehabilitation services and use of them once they were established in the Area.
FIGURE 1

ORGANIZATION OF ARROWHEAD UNITED FUND AREA COUNTY COUNCIL OF COMMUNITY SERVICES
ACTIVITY GROUPS, AND PROJECTS AS RELATED TO THIS SURVEY
Individual attitudes. Rehabilitation is not just the responsibility of the community, it is the responsibility of each individual who lives in the community. Many citizens are embarrassed by the appearance of a person in a wheelchair or on crutches. They are ill at ease and cannot accept him as a fellow citizen. They seem to reason that if they look the other way long enough this person and the problem he represents will disappear. These individuals never see the handicapped person who is confined to an institution or his own home and are unaware of the existence of such unless they become a part of voluntary efforts to alleviate these conditions.

Individual concern. Today a new form of handicap is coming to the attention of communities and one that faces each individual; the handicap of chronic illness in old age. It is true, as some wit has said, "An old person is anyone twenty years older than oneself," however, when the individual citizen reaches the age of retirement, as more people have a chance of doing in 1959, than in years before, these problems of chronic illness and aging are all too often
sitting on his doorstep waiting for him. Now each individual has more reason to be aware of the need for rehabilitation since it will concern him personally unless he is an exceptional one person in each six after the age of 65.

The United Public Health Service has estimated that by 1975, 10.8 per cent of the population of the United States will be 65 years of age or over. Those who will be 50 in 1960 will be a portion of that 10.8 per cent in 1975. Thus the younger senior citizens of the Arrowhead United Fund Area by that time will be facing some of the problems now in evidence in those of 65 years of age in 1959.

**National concerns.** A prominent public health nursing leader in the United States Public Health Service has stated that one-third of California's 65 and over population will be in mental institutions and one-half will be in convalescent homes. This she stated is typical of the nation's need.

**National action.** The meaning of any set of figures like these is clear to those concerned with community health. Something should be done about it! Congress took action by

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23 *Association of Teachers of Preventive Medicine, op. cit.*, pp. 47-48.

24 Beverly Beyette, *loc. cit.*
scheduling a White House Conference for 1961 on Problems of the Aging. An annotated bibliography was published for the general public and for those who attend state conferences preceding the national one. This bibliography is worthy of perusal by those planning for community rehabilitative services.

**State action.** California has taken action by setting up two official agencies to deal with these problems; the California Citizens Advisory Committee on Aging and the Interdepartmental Coordinating Committee on Aging. These official agencies have been given the responsibility of providing California's older people with the opportunity to be dignified, secure, and useful citizens. At the time Kuplan wrote the article for *Geriatrics* magazine entitled "California: the State and Its Senior Citizens," there were 70 local committees and several hundred Senior Citizens clubs. The California Advisory Committee compiles knowledge concerning research and action programs in the field of gerontology which is then shared quarterly through a newsletter called *Maturity.*

Many problems in the field of public health, of which

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chronic illness in the aging is one, cannot be identified without the participation of the public. Programs to take care of their problems must be in accordance with their needs, as well as to supply the resources and the types of organizations they are ready to accept. The public needs to be concerned about an identified need and be convinced that the proposed action will solve the problem.

All communities do not react in the same way to preventive public health measures and any rehabilitative program will have to be sold to the public. Measurement of practical possibilities for use of the service as opposed to theoretical belief should be considered in a survey. Thus, although communities can use the results of national or regional studies and apply the statistical estimates to their own population, the possibility for error is considerable, as mentioned earlier.

**Community actions in research.** In the Arrowhead United Fund Area it became evident that a review of literature, studied, should be of the methods used by other communities to learn about their own problems, not just

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28 Ibid., p. 1131.

29 Allan, *op. cit.*, p. 185.
statistics to apply to this community, expecting its problem to be like others.

The one method used in other communities to obtain data which met the above recommendation was the survey by personal contact. Two interview schedules previously used in valid surveys were available. Allan encouraged the local community to organize its own details for a survey on the basis that there is "always some resistance to what the outsider concludes or recommends. There is great merit in a survey and 'plan of our own', tailored to local conditions and needs."31

Rehabilitative leaders' comments. In the opinion of the investigator, another practical review of literature which might well be of value to the County Council of Community


31 Allan, op. cit., p. 181.
Services would be opinions and comments of experienced leaders in the field of rehabilitative work.

One meeting in Ann Arbor in 1953 brought together many of these persons from all over the world. A perusal of their notes revealed some worthwhile items:

The majority of communities who have rehabilitative services do not have comprehensive coverage.

The objective of rehabilitation is to restore the patient to a maximum state of physical, mental, social, and economic usefulness. When we bring the patient up to a certain level of usefulness, we must strive to maintain that level. The success or failure of a rehabilitation program is largely dependent upon intensive medical social follow-up.

If the needs of the small communities are to be met, I believe home care is the only solution. The term 'home care' covers a range of other services (services other than medical) that people need for a period of convalescence, such as someone to help with marketing, clean their rooms once or twice a week, come in once a day to run errands, etc. Recreational support includes day care centers, recreational centers, visiting housekeeping services, friendly visiting.

If we make rehabilitation services available in their homes to people with minimal disability, who may need a small amount of medical care, occasional counseling and guidance, or vocational training or retraining within the limits of their disability, many of our complex cases of disability that require costly rehabilitative procedures can be prevented.

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Nurses can supply many preventive services in addition to those already being offered and should probably be caring for more persons with chronic illnesses. Nurses can do much in the area of chronic illness both in prevention and in rehabilitation. However, this is a more recent addition to nursing service and only the more recent graduate has had an opportunity to learn of it in school. This area should be included in all inservice training programs.

To continue with quotations from rehabilitation leaders:

Confused states are often basic malnutrition. One hundred twenty to 140 grams of protein every day for four weeks plus adequate amount of iron and after this vitamin B... after a short time a number of confused regain their sense of security and insight.

In one situation where the hospital guaranteed that should any medical or sociological reason arise after the elderly patient was dismissed from the hospital, the patient would be immediately readmitted, 25-30 per cent returned to their family units. The family was more willing to assume even greater responsibility than before because of this shared responsibility.

Volunteers have a place in caring for hair, nails, use of cosmetics, etc. but their area must be sharply divided from professional services.

Directing patient's attention from bodily ills to prospective work... lessens the amount of medical care necessary to rehabilitate the patient.
Program (should) be carried out by someone with a philosophy of rehabilitation and a sense of imagination in considering what can be done to help the patient as he progresses. Such direction by the matron of the nursing home, a physician, or a nurse pays off.

In view of the cost, little rehabilitation can be carried out in smaller communities or in public institutions.

Rise in leisure calls for rapid extension of facilities for liberal adult education, such as self expression in fine arts and artcrafts, recreation, opportunity for serving the community and through voluntary activities, to citizenship roles.33

... recent research at Washington University, St. Louis has shown that, when certain physical functions are restored in older people through dietary and hormone therapy, scores on mental tests also improved.34

The cause of premature weariness, boredom, fatigability, loss of confidence, loss of interest in daily living is improper nutrition. Protein, 1.4 gms. per kg. of weight is necessary in later years in addition to adequate vitamins and minerals.35

Recommendations: supplementary feedings for oldsters; teaching of nutrition in medical schools; bi-annual health survey including weight, blood pressure, blood count, blood sugar, urinalysis, x-ray; wider appreciation of prevention of psychoses; and wider dissemination of nutritional knowledge.


Case studies of changes in attitudes and adaptation made by senior citizens as they attended a day care center in New York are noticeably absent of instances of mental senility and psychoses, "... not conclusive but indicative of the value of supervised day care centers for the aged." 36

In the San Luis Obispo County study of the physical and mental needs of the aged in boarding homes, the results indicated that 41.2 per cent of the patients needed additional nursing and mental hygiene facilities. The services which were planned as a result of this study were: meal planning, and preparation, marketing, personal help, bedside care, repair of clothing, general care of the home, and organization of the household so the elderly person could manage in the absence of the homemaker. 37

"All studies show that a significant number of handicapped persons do not know about or are not taking advantage of existing rehabilitative services." 38

"Education of the community at large (is necessary) as to the demand and the need (for rehabilitation) through the media of communications such as the press, popular magazines, television and radio. Stress (should


38Allan, op. cit., p. 20.
be placed on the fact that) the general public can benefit as well as the indigent public with no change in relationship with their private physician."39

**Library services.** Library delivery services are available to shut-ins in some instances with magnifying equipment, ceiling projectors, talking books, or perhaps earphones.40

**Unmet needs.** Unmet needs considered in other studies were medical care and drugs, laundry service, clothing, false teeth, glasses, hearing aids, telephone, household equipment, hospital care, utilities, and housing,41 income maintenance, retirement plans, adult education, recreation, social service,42 housekeeping aid, shopping, meal preparation, and cleaning service.43

**Rehabilitation challenges in summary.** Some of the challenges given by the Chairman of the Rehabilitation Council in his book are given in summary.44


42 Ohio Statewide Conference on Aging, Jan. 16-17, 1958.


The beginning of rehabilitation rests with the medical doctor and his ability to bring medical groups, institutions, and individuals into the planning, teaching, and servicing activities of rehabilitation. Rehabilitation has little purpose without medical guidance and can be a valuable tool for the treatment of the patient. A successful home care program in operation in Canada since 1950 includes the private physician who renders medical care in the home receives his fee from the patient and the other services furnished by the hospital to the patient are paid for by the patient to the hospital. Nursing service is paid directly by the patient to the agency furnishing the service. This successful program offers an administrative procedure worthy of adaptation in other communities.

The Home Care Demonstration Program in a neighboring county also has a program worthy of investigation for features adaptable to the Arrowhead United Fund Area.

The second challenge is that comprehensive rehabilitation coverage and the best facilities for the most patients, should be the aim of community planning rather than specialization.

Third, federal and state programs should be studied. Voluntary agencies should not duplicate services already available, but for the most part the greater the provision
for direct community rehabilitative services for the disabled civilian, the better.

Fourth, recruitment and training of rehabilitation personnel will need to be considered by the community to supply its future needs for growing services.

Fifth, industry will need to be involved in the planning for placement of rehabilitated persons.

Sixth, all public and private agencies will need to be well informed concerning the rehabilitative services offered in the community. A central planning committee is suggested by Allan to help in effecting a common sharing of knowledge of available facilities.

One last challenge summarized here; rehabilitation is the responsibility of all community groups. Handicapped persons need to be accepted in all areas without discrimination. The general public attitude toward such persons can supplement or tear down physical restoration of an individual, if that individual is not accepted outside the rehabilitation center. This attitude toward the handicapped is similar to the attitude toward the aged who are chronically ill. It is in this area of attitude that the enlistment of all community groups to support the community planning for rehabilitation becomes very important. Rehabilitation, when properly understood, should have an appeal to all individuals who
desire a better life for their neighbors. The health team can produce much better results if they have the support of their community.
CHAPTER III

APPROACH TO THE PROBLEM

I. METHOD OF THE SURVEY

In the review of literature, it became evident that needs of the senior citizen, age 50 and over had not been considered as a group in any previous study. Some consideration had been given those age 65 or more.\(^{45}\) In many instances rehabilitation figures were given for total population.\(^{46}\) Studies of rehabilitation needs during and after illness had been considered from the standpoint of the professional evaluation\(^ {47}\) and not the individual's understanding. One of the assumptions of this study was that only as the individual understands his own need, will he be apt to make use of rehabilitation services made available in his community.

\(^{45}\)W. D. Bryant, *Highlights of the Greater Kansas City Demonstration Project* (Kansas City: Community Studies, Inc. 1956).


Description of the method. It was the decision of the Advisory Committee\(^48\) and the investigator to use a descriptive study. Perrow also considered description the best method of presenting a study as it does not involve the use of controls.

Discussion concerning questionnaires brought agreement that this particular age group might not understand how to fill them out or might fail to mail them which would result in a poor return. The personal approach would be more apt to give a uniform response to all the items on an interview schedule.

The selection of the sample. The selection of the sample was based on the age group represented by the Senior Citizens. This organized group in the Arrowhead United Fund Area was composed of persons 50 years of age and over. The Health Activities Committee, a sub-committee of the Senior Citizens, was already engaged in some health education and it was this group that was approached to help implement the study.

Formulation of the interview schedule. The first draft of the interview schedule was drawn up after a review of other

\(^{48}\)See Organizational Chart, p. 13.
schedules used in previous studies. This tool was tested with a group of four citizens picked at random who had been hospitalized within the previous months and who were willing to give the information. During these interviews it was discovered that the number of pages involved was a handicap.

The second draft reduced the number of pages and gave evidence that some items were irrelevant. This draft was reviewed by a sociologist of a nearby university. This interview was arranged by a member of the Advisory Committee. As a result of this interview with a sociologist the schedule was further condensed so that it was accommodated on one page. A final review with the members of the Advisory Committee added two more items but did not alter the one-page arrangement.

The items on the schedule were arranged in groups on the page. These groups gave data concerned with each of nine categories dealing with members of the health team and related services.

About the time this revised interview schedule was ready for testing, the Director of the Visiting Nurse Association invited the investigator to visit with her staff nurses for a day. This seemed to be a good opportunity to test the final draft of the schedule. Permission to conduct these
trial interviews was granted by the Director and each of eight patients. The data obtained during this trial was tabulated without the use of data-processing cards. This pretesting of the interview schedule proved to be satisfactory and mimeographed copies were made up for use in the survey.

II. IMPLEMENTING THE METHOD

Approach to the hospitals. Four hospitals were approached by the investigator with letters of introduction to the chiefs of staff and the administrative heads. Requests were made to use the medical records of a selected number of patients 50 years of age or older, to obtain name, address, case number, phone number, birthdate, birthplace, marital status, hospital days, discharge diagnosis, and date of discharge. These requests were sent by the Administrators to the respective Executive Committees for approval. Three of the hospitals elected to cooperate with the survey and this decision was sent to the investigator through the medical records librarian. In one instance the word was sent to the co-chairman of the Health Activities Committee and was then relayed to the investigator. The

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49 Appendix E
50 Appendix D
medical records librarian then assisted the investigator in choosing patients for the sample.

The size of the sample. Table I shows the total admissions for one year of persons 50 years of age and over. The total average for one month was 511.07 persons. The tentative size of the sample was determined by taking 10 per cent of this number. Discharges over a period of 19 days gave a sample of 56 respondents. This gave a 10.9 per cent sample of the total average of 511.07 patients discharged per month.

TABLE I

HOSPITAL ADMISSIONS FOR ONE YEAR 1958-1959 COMPARED WITH SAMPLE SIZE

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>TOTAL ADMISSIONS</th>
<th>ADMISSIONS 50+</th>
<th>AVERAGE PER MONTH</th>
<th>SIZE OF SAMPLE</th>
<th>PER CENT OF COLUMN 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>6,707</td>
<td>1,673</td>
<td>139.41</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>#2</td>
<td>7,871</td>
<td>2,874</td>
<td>239.50</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>#3</td>
<td>7,987</td>
<td>1,586</td>
<td>132.16</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>TOTALS</td>
<td>22,565</td>
<td>6,133</td>
<td>511.07</td>
<td>56</td>
<td>Avg. 10</td>
</tr>
</tbody>
</table>

*For hospital designation see text.

Approach to the private physicians and the respondents. Letters were drafted with the aid of the Advisory Committee, for mailing to respondent and his private physician. These
letters explained the purpose of the study, requested permission to visit the respondent, and gave an opportunity for each to refuse if they wished. Each letter to the private physician contained a sample copy of the interview schedule and the letter which was to be sent to his patient. The physician's letter was so worded that it was not necessary for him to reply. A time interval of one week, (in most instances) was allowed to elapse before a letter was sent to the respondent. The interval between mailing the letter to the respondent and the interview was an average of five days. None of the selected sample denied the investigator an interview. Two hesitated at the door, but gave the required information following a further explanation of the reason for the interview.

The average time between discharge of the patient and the interview was 13 days. The average time required to administer the interview schedule was 22 minutes.

**Tabulation of the data.** One of the problems which the investigator had to solve was the selection of a data-processing device. The use of data-processing devices was investigated carefully at the time the schedule was prepared. For a small study, the electronic devices were not feasible, however, the Key-Sort System provided a method practical for use without elaborate equipment. Already punched blank cards were
purchased. A special needle and a specially designed punch were the tools necessary for tabulation.

The interview schedule was then coded and appropriate divisions arranged on one of the cards. This form was then printed by a local printing concern. The total cost of the cards, including the printing, was twenty dollars.

In transferring the data from the schedule to the cards, 108 cards were used. Certain definitions were necessary in the tabulating of the data and analysis which are recorded for the convenience of the reader.51 Classifications used are presented in Chapter IV.

III. SUMMARY

This pilot study needed the cooperation of local hospitals and resource persons for its implementation. The approach to and communications with these local representatives were facilitated by the Advisory Council. Requests to use the hospital medical records were considered by Executive Committees in each hospital and permission was granted in three out of four instances. The personal interview, using a prearranged schedule to obtain data, showed trends in the sample made up of fifty-six respondents, 50 years of age and over. Tabulation of the data was done with the aid of data-processing methods. Cooperation from respondents and their physicians was 100 per cent.

51Appendix C
CHAPTER IV

PRESENTATION OF DATA WITH ANALYSIS

From the three hospitals that elected to cooperate, fifty-six patients were discharged and selected over a period of 19 days that met the requirements for a sample. Two respondents died after discharge before the interview could be made. These data were included because the investigator felt it to be representative of the sample and in any projection of these data, the consideration of death rates would have to be included. Information obtained from the medical records was name, address, birthplace, birthdate, phone number, marital status, diagnosis, hospital days, case number, and date of discharge.

I. IDENTIFYING INFORMATION ABOUT THE HOSPITALS

Two of the three hospitals were non-profit and church operated; the third was tax supported. To identify these hospitals in tables and references they were designated as

#1 - non-profit, church operated
#2 - tax-supported
#3 - non-profit, church operated

All percentages are rounded to the nearest tenth in
the following tables. The average number of patients discharged from each hospital was three, as shown in Table II, so that for most of the following presentation of data the individual hospital as a factor was eliminated.

**TABLE II**

**DAYS OF DISCHARGE, NUMBER OF PATIENTS AND AVERAGE DISCHARGES PER DAY BY HOSPITAL**

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>DAYS</th>
<th>NUMBER OF PATIENTS</th>
<th>AVERAGE DISCHARGES PER DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>7</td>
<td>20</td>
<td>2.7</td>
</tr>
<tr>
<td>#2</td>
<td>10</td>
<td>30</td>
<td>3.0</td>
</tr>
<tr>
<td>#3</td>
<td>2</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>19</td>
<td>56</td>
<td>Average 3.0</td>
</tr>
</tbody>
</table>

Table III shows a significant factor in the age group into which the sample fell in each hospital. This trend seemed to indicate that persons in the lower age brackets were more equally divided in ability to pay for their hospitalization but that as age 75 was reached, funds had dwindled until that age group had to rely much more heavily on the tax-supported hospital to supplement their income for hospitalization needs. This is also the youngest age group excluded from Social Security benefits.
### TABLE III

**NUMBER OF HOSPITAL DISCHARGES COMPARED BY AGE GROUP AND HOSPITAL**

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>HOSPITAL #1</th>
<th>HOSPITAL #2</th>
<th>HOSPITAL #3</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>55-59</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>60-64</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>65-69</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>70-74</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>75-79</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>80-84</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>85-89</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>TOTALS</td>
<td>20</td>
<td>30</td>
<td>6</td>
<td>56</td>
</tr>
</tbody>
</table>

**NOTE:** The dotted line divides the age groups into those below and above the age of 75.
II. THE CHARACTERISTICS OF THE SAMPLE

One of the interests in any study is information concerning the major identifying characteristics of the sample. Table IV was designed to compare the marital status, age and sex of persons selected for interview. It is noteworthy that while in 1959 the population at large contained more women than men in this age bracket, 50 and over, more men were ill than women in this sample. The National Health Survey\textsuperscript{52} of July, 1957 to June, 1958 also gives the information that more men 45 years of age and over were discharged from short-stay hospitals.

# Table IV

A comparison of marital status of respondents with age and sex

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
<th>M</th>
<th>W</th>
<th>D</th>
<th>NEVER MARRIED</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MEN</td>
<td>WOMEN</td>
</tr>
<tr>
<td>50-54</td>
<td>men</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>55-59</td>
<td>men</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>60-64</td>
<td>men</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>65-69</td>
<td>men</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>70-74</td>
<td>men</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>75-79</td>
<td>men</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>80-84</td>
<td>men</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>85-89</td>
<td>men</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>women</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

**TOTALS**  
31 19 2 4 30 26 56
In comparing the marital status of the sample group with the census figures for 1950, Table V shows that the percentages were almost identical. This seemed to indicate that the sample represented the total population, at least as it was in 1950.\(^{53}\)

**Table V**

**Marital Status of the Sample Compared with the 1950 Census Figures**

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample</td>
<td>US</td>
</tr>
<tr>
<td>Married</td>
<td>55.3</td>
<td>55.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>32.1</td>
<td>32.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>5.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Never married</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>99.8</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The scatter map on page 40 also indicated that the sample was well distributed over the Arrowhead United Fund Area.\(^{54}\)

The retirement of the individual respondent in relation to illness seemed to be significant for the male. One-quarter of the sample were males who were retired before

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\(^{54}\)Figure 2.
FIGURE 2
SCATTER MAP OF THE ARROWHEAD UNITED FUND AREA
becoming ill, while another 19.8 per cent were retired because of the present illness as shown in Table VI.

In the sample, three men, ages 52 to 60, were still employed. One was entirely self-employed, one was working in a government agency, and the third combined part-time work in self-employment with employment in a private concern. Their wives were also employed. Of the women respondents, two returned to employment within two weeks of discharge from

TABLE VI

RETIREMENT OF RESPONDENTS IN RELATION TO PRESENT ILLNESS IN PERCENTAGES OF TOTAL SAMPLE

<table>
<thead>
<tr>
<th>RETIREMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before present illness</td>
<td>25.0</td>
<td>3.6</td>
<td>28.6</td>
</tr>
<tr>
<td>As a result of illness</td>
<td>19.8</td>
<td>14.3</td>
<td>33.9</td>
</tr>
<tr>
<td>TOTALS</td>
<td>44.8</td>
<td>17.9</td>
<td>62.5</td>
</tr>
</tbody>
</table>

the hospital, one aged 50, the second, aged 64. The employment pattern is significant, in that none were employed past 65 years of age and of those retired before this present illness none were under 65 years of age.

Those retired because of illness ranged in age from 52 to 77. The illnesses were: 23.7 per cent of the total heart
diseases, 66 per cent of the total gastric and duodenal
diseases, 20 per cent of the total respiratory diseases, 14.3
per cent of the total cancer, 25 per cent of the total meta-
bo1ic diseases, and 20 per cent of the genito-urinary diseases.

Table VII shows that children are represented in this
sample. There were 32 family groups and 4 or 12.5 per cent
of these groups had children in the family circle. Three
parents were in the 50-65 age bracket and had eight older
children, however, one other respondent had three small chil-
dren ages 2 to 6. This sample variation might or might not
represent the population-at-large as this last mentioned male
parent was in the 75-79 age bracket.

TABLE VII
NUMBER OF RESPONDENTS WITH
DEPENDENTS AND SOURCE
OF INCOME

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Male Respondent</th>
<th>Number of Ages of Dependent Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental income</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Aid for Needy Children</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>4</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

If the data of this study are projected for use in
estimating rehabilitative needs, this 12.5 per cent of
families should be considered along with other research data
for families with children. The three children under financial assistance from Aid for Needy Children were receiving rehabilitative services but since this was not the area of this survey this is mentioned only as a social background for the complete picture of the respondents of this study.

**Diagnosis and its implications.** Table VIII gives the diagnoses and average hospital days per respondent. This shows that heart disease was the most frequent cause of hospitalization and that malignant neoplasms were second in this sample. The highest number of average hospital days was experienced for those with upper respiratory disease conditions. Eighty-three per cent of the discharges were of those patients who had stayed less than two weeks in the hospital. Of that number 51.8 per cent stayed only one week or less. Five, or 10.2 per cent were hospitalized just one day. Twenty-six and eight tenths per cent of the discharges were diagnosed as having conditions which ordinarily require long term care after discharge from the hospital. Included in this measurement is one respondent with deformities requiring crutches for ambulation with no prospect at the time of the interview for improvement; one diabetic; one tuberculous patient; eleven heart diseases with additional residual paralysis; and two respondents with terminal cancer.
TABLE VIII

HOSPITALIZED CONDITIONS ACCORDING TO INTERNATIONAL STATISTICAL CLASSIFICATION AND HOSPITAL DAYS FOR EACH

<table>
<thead>
<tr>
<th>DISEASE CLASSIFICATION</th>
<th>RESPONDENTS</th>
<th>HOSPITAL DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Heart diseases</td>
<td>13</td>
<td>23.2</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>7</td>
<td>12.5</td>
</tr>
<tr>
<td>Benign and unspecified neoplasms</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Genito-urinary conditions</td>
<td>5</td>
<td>9.0</td>
</tr>
<tr>
<td>Hernia</td>
<td>5</td>
<td>9.0</td>
</tr>
<tr>
<td>Upper respiratory conditions</td>
<td>5</td>
<td>9.0</td>
</tr>
<tr>
<td>Allergic, endocrine, and metabolic disorders</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>Hemorrhoids, and anal fistula</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Diseases of the gallbladder</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Fractures and dislocations</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Ulcer of the stomach and duodenum</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Mental observation</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Diseases of the sense organs</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Female genital disorders</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Other circulatory diseases</td>
<td>1</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Total Average 12.36
The most frequent diagnosis of the group living with their spouse was heart disease as shown in Table IX. Six respondents represented 46.1 per cent of the number of persons diagnosed with this condition. Two respondents, living with others, accounted for 15.4 per cent of the number of diagnoses of heart disease and five respondents living alone were responsible for the remaining 38.5 per cent of the heart conditions. In Table IX these figures are supplemented with the hospital days and each of the living arrangements mentioned, showing

**TABLE IX**

**LIVING ARRANGEMENTS OF RESPONDENTS COMPARED WITH THE MOST FREQUENT DIAGNOSIS AND HOSPITAL DAYS**

<table>
<thead>
<tr>
<th>HEART DISEASE IN THOSE RESPONDENTS</th>
<th>PERCENTAGE</th>
<th>AVERAGE HOSPITAL DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with spouse</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>Living with others</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Living alone</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>TOTALS</td>
<td>13</td>
<td>100.0</td>
</tr>
</tbody>
</table>

that the married man (and they were all men) stayed in the hospital an average of 16 days. The three women and 2 men living alone were hospitalized an average of ten days, and those living with others, one day.
A further breakdown of the six respondents living with their spouse reveals that four, whose wives were not working, stayed in the hospital an average of 4½ days, while two, whose wives were working, averaged 40 days. These last mentioned, two respondents were both in situations where a homemaker was specifically needed and where such a person would have allowed the respondent to come home sooner than he did. One of the four above specified that a homemaker would have been of great help because the wife also had heart disease. In caring for her husband she became over tired and both man and wife were in need of care in the home by a doctor, a nurse, a homemaker, and a gardener who was hired to care for the yard. The actual listing of needs will be developed a little later but are mentioned in this analysis to explain the wide variation of hospital days. Of those living alone, relatives were living close by or could temporarily live in the home with the respondent, or as in one case, the respondent lived in a residence hotel. Of the two who lived with others, one was moved to a nursing home and the other was taken into custody by the law.

Table X can be interpreted as an indication that the person 50 years of age and over prefers first, to live with his spouse, and second, to live in his own quarters. This is a fact well recognized by all professional workers and probably by most lay persons as well.
### TABLE X

**LIVING ARRANGEMENTS OF RESPONDENTS IN RELATION TO MARITAL STATUS AND PERCENTAGE OF THE TOTAL SAMPLE**

<table>
<thead>
<tr>
<th>LIVING WITH</th>
<th>*M</th>
<th>*W</th>
<th>*D</th>
<th>NEVER MARRIED</th>
<th>TOTAL RESPONDENTS</th>
<th>PERCENTAGE OF TOTAL SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>53.6</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>17.9</td>
</tr>
<tr>
<td>Alone</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>16</td>
<td>28.6</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>31</td>
<td>18</td>
<td>3</td>
<td>4</td>
<td>56</td>
<td>100.1</td>
</tr>
</tbody>
</table>

*M - Married; W - Widowed; D - Divorced
The final item in the interview schedule which has to do with the background picture of the respondents, was that of birthplace. A significant ten and eight tenths of the sample were born outside the United States as shown in Table XI.

### TABLE XI

**BIRTHPLACES OF RESPONDENTS BORN OUTSIDE THE UNITED STATES**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>NUMBER</th>
<th>PER CENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>6</td>
<td><strong>10.8</strong></td>
</tr>
</tbody>
</table>

#### III. THE REHABILITATIVE NEEDS OF THE SAMPLE

The rehabilitative needs were tabulated from only 49 data-processing cards since seven of the respondents were not interviewed; two because they died between the time of discharge and the planned interview, four because they were discharged to nursing homes, and one who was discharged to prison. This sample was still 9.6 per cent of the average monthly admissions to the hospitals in the survey.

**Classification of needs.** As shown in Table XII needs were classified by the numbers of the health team. It will be immediately noted that the social worker is omitted. This was
TABLE XII

CLASSIFICATION OF THE TOTAL INTERVIEWED GROUP, ACCORDING TO NEED FOR MEMBERS OF THE HEALTH TEAM AND RELATED SERVICES

<table>
<thead>
<tr>
<th></th>
<th>PERCENTAGE OF SAMPLE</th>
<th>UNMET NEEDS</th>
<th>MET NEEDS</th>
<th>CARE HOURS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>40.8</td>
<td>8.2</td>
<td>32.6</td>
<td>...</td>
</tr>
<tr>
<td>Nurse</td>
<td>12.2</td>
<td>1.1</td>
<td>11.1</td>
<td>394</td>
</tr>
<tr>
<td>Homemaker</td>
<td>55.1/a</td>
<td>14.5</td>
<td>40.6/b</td>
<td>2,910</td>
</tr>
<tr>
<td>Foster &amp; nursing home care</td>
<td>14.3</td>
<td>unknown</td>
<td></td>
<td>4,704</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>44.9</td>
<td>44.9</td>
<td></td>
<td>...</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>55.1</td>
<td>55.1</td>
<td></td>
<td>...</td>
</tr>
<tr>
<td>Transportation</td>
<td>53.1</td>
<td>14.3</td>
<td>38.8</td>
<td>...</td>
</tr>
<tr>
<td>Special equipment</td>
<td>10.2</td>
<td>4.1</td>
<td>6.1</td>
<td>...</td>
</tr>
<tr>
<td>Prostheses</td>
<td>16.3</td>
<td>4.1</td>
<td>12.2</td>
<td>...</td>
</tr>
</tbody>
</table>

* Care hours are for the period of two weeks immediately following discharge of respondents 50 years of age and over, from the hospital and includes hours of met and unmet needs.

/a Care which might have allowed these respondents to come home from hospital sooner not estimated.

/b 15 or 30.6 persons had care by relatives who took time from work to care for respondent. They gave full 24 hours a day but only a portion of this time could reasonably be transposed into homemaker hours and are omitted from total care hours given. Might be estimated at 1200 hours.
done because this study was not concerned with the economic background of the respondents and no plans were made to ascertain the need for a social worker. However, evidence was offered voluntarily by respondents that medical social workers were assigned to them. This number represented 10.2 per cent of the sample.

Identification and description of medical needs. Needs for the physician were based on the actual appointments for the interval between date of discharge and time of the interview, an average of 13 days. The total need of the 49 respondents was 40.8 per cent. Two respondents were trying to locate their doctor when he was in Los Angeles for the day and, even though the matter about which they were calling would wait until his return that evening, they considered this an unmet need. The other two respondents seemed to be pressing a need for rehabilitation in being displeased with their medical care. One was expressing his fear of dying alone, even though he was living in a residence hotel. He had had three strokes and feared the fourth one would be fatal. The fourth respondent was able to feed himself but was unable to dress or care for his own hygienic needs. His diagnosis was not one which accounted for his inactivity and he felt that the doctors never did anything for him. He appeared to be more concerned with his inactivity than with his present illness which might have been caused by his inactivity.
Identification and description of nursing needs. Those of the sample who had or needed nursing care amounted to 12.2 per cent of the total sample interviewed and 394 nursing care hours. These nursing care hours represented the total hours needed during 14 days following discharge from the hospital. An even number of weeks gave a more representative total of nursing care hours than an odd number of days because several services were given three times a week. Visiting nursing service was given for 358 hours and an additional 36 hours of care were needed. The respondents were not very familiar with the different types of nursing service and/or thought it was too expensive for them. One respondent thought that nursing service would have allowed her to come home sooner.

Since three went from their home to a type of foster home and four were discharged from the hospital to a nursing home, these round-the-clock hours are included on a two week basis; 4,704 nursing hours. These care hours cannot be considered either professional or non-professional as nursing homes might have one or the other or a combination of worker.

Identification and description of homemaker service needs. Homemaker needs were estimated by the respondents to be 55.1 per cent. Some of these needs, 73.6 per cent, had

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been met by arrangements with neighbors, persons who did housework only, or by relatives. Others, or 26.4 per cent had not been able to make satisfactory arrangements for their need. Half of the respondents would have liked to have had the work load relieved and have had the money to pay for service. The services included in these care hours are bed care of a not-too-ill patient, and daily household duties, such as ironing, washing, meal preparation, shopping, and caring for the yard.

The 2,910 hours in Table XII, or 100 per cent of care respondents had or needed, was divided into hours purchased and hours donated. Of these 2,910 hours, 460 hours, or 15.8 per cent were purchased and 1,686 hours, or 57.9 per cent were donated by relatives or friends who were not working because persons for hire were not available. Thus, 764 hours, or 26.3 per cent remained as a need, half of which could have been paid for had persons been available to provide the service. Donations of services were given by non-professional people with no training, registered nurses, and students of nursing. Those who took time off from their work to give the type of care the homemaker may give were 15 in number. As seen in Table XIII the daughter-in-law gave 46.7 per cent of this time.

These hours were for periods of 24 hours a day and are not added in the total hours "needed" or "had" because of

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the difficulty in figuring accurately the amount of time. It is estimated that 80 hours (40 hours of each week following discharge from the hospital) could be added to the 2,910 hours given for homemaker hours in Table XII. Fifteen persons giving 80 hours would add 1,200 hours.

TABLE XIII
RELATIONSHIP OF PERSONS WHO GAVE NON-PROFESSIONAL HOMEMAKER SERVICES AND TOOK TIME FROM JOBS TO DO SO

<table>
<thead>
<tr>
<th>PERSON</th>
<th>NUMBER PERSONS</th>
<th>PERCENTAGE OF TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter-in-law</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>Sister</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Husband</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Wife</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>15</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Thirteen, or 26.5 per cent of the sample stated that their stay would have been shortened by homemaker service. Half of this number would have been able to pay for the service and half would have been able to pay only a nominal sum. Since the amount of time the stay might have been shortened is unknown and impossible to estimate, no time has been added to the homemaker hours for this item of need, but it would undoubtedly add to the total in actual operation of a homemaker service.

There was also evidence of need for meal preparation and/or shopping. Instruction in special diets was adequate in one
instance and inadequate in another; several men ate with relatives, but one man ate at a nearby nursing home.

Transportation needs identified. Transportation seemed to be a big problem for 7 respondents or 14.3 per cent of the sample. During the nineteen days following discharge from the hospital, 53.1 per cent of the sample made use of one or another type of transportation. Two, or 4.1 per cent were dependent on friends and one, or 2.1 per cent was dependent on a relative to take her to clinic during that person's working hours. Four respondents, or 8.2 per cent owned cars but could not drive; three because they had never learned and one because her license had expired. These three who had never learned wanted to take driving lessons but did not have the money to pay for private instruction. The remaining 12.5 per cent of need was expressed by those who had to depend on taxi or public transportation.

Identification and description of need for special equipment. The need for special equipment included wheel chairs, walkers and a strong magnifying glass, or 10.2 per cent of the sample. Two apartments did not have doorways wide enough to permit the use of wheel chairs and one who could have used a walker did not know how or where to obtain one.
Identification and description of need for prostheses.
The types of prostheses had or needed included crutches, braces, hearing aids, and glasses. Two admitted an unfulfilled need for glasses; one planned to obtain them following an eye operation and the other wanted them but could not afford them. He did not think he was eligible for, or knew about, aid for the partially sighted.

Identification and description of need for occupational therapy. Eight or 16.3 per cent of the sample were not able to leave their home except for a visit to the doctor's office or clinic and then only with great difficulty. Two of that number, or 4.1 per cent would like to have left the house for sociability but watched television or did hand work instead.

Fourteen or 28.6 per cent of respondents did not have friends in; of those fourteen, seven, or 14.3 per cent were content to do nothing more than they were already doing, however, the other 14.3 per cent expressed a desire to watch television, do handwork or mend, have books and records to play, have talking books (blind respondent), and one respondent wanted very much to be re-employed as a carpenter but complained, "All the bosses say I am too old." One woman also wanted work and thought she would like to be a homemaker.
Identification and description of the need for physical therapy. Most need for physical therapy is based on the activities of daily living. Of the total sample, eleven or 22.4 per cent, were unable to carry on all the activities of daily living. All were able to feed themselves, even though some were slow and awkward. Six or 12.2 per cent were unable to dress themselves. Six more were ambulatory with the aid of crutches, canes, or a wheel chair but were unable to care for their daily hygienic needs. Only one respondent was sure of what a physical therapist was or could do for him.

Only one respondent was having difficulty with his speech and according to his wife it was improving without therapy.

The composite picture of the sample respondent. We have seen from the data that the respondent stayed in one of the three hospitals for an average of 19 days and if he was seventy-five years of age or over he was in hospital #2, the tax-supported hospital. That he was more apt to be a man than a woman, be married and when he went home he was living with his wife. If he were over 80 years of age, he was widowed. He might equally well have lived in any of the Arrowhead United Fund Area. If he were under the age of 65 he would probably

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have been retired because of the present illness, if over 65
he would have been more apt to be retired before the present
illness. He would have been only one in fourteen respondents
if he had children at home, or had never married.

The most frequent diagnosis was some type of heart
disfunction (20 per cent) or cancer (12 1/2 per cent).

55.1 per cent needed or had homemaker services
55.1 per cent needed physical therapy
53.1 per cent needed transportation
44.9 per cent needed occupational therapy
40.8 per cent needed or had medical care
16.3 per cent had or needed prostheses
14.3 per cent had foster or nursing home care
12.2 per cent needed or had nursing care
10.2 per cent needed special equipment
CHAPTER V

OVERVIEW OF THE SURVEY

I. PROBLEM

The problem was to identify and describe the rehabilitative needs of the individual, 50 years of age and over, who lived and sought hospitalization in the Arrowhead United Fund Area.

II. SOURCES

The felt needs of citizens of the Arrowhead United Fund Area became evident through telephone calls to various community agencies seeking services which were not available at that time. The County Council of Community Services took these observations to the Senior Citizens. This group had a sub-committee already active in health education, known as the Health Activities Committee. The Health Activities Committee secured the help of a masters student from a local college to conduct a pilot study and appointed an Advisory Committee to advise and assist in community contacts.
III. METHOD

The problem and the method were agreed on by the above interested persons at the beginning of the year 1959. The descriptive survey, a 10 per cent sample, and the personal approach using an interview schedule, were justified by previous studies of home care programs and counsel of a statistician in the local college. The study was completed in September of 1959.

The sample. A sample of 56 respondents was interviewed and the data tabulated according to Key-Sort processing methods. The respondents were discharged from three hospitals in the Arrowhead United Fund Area and were interviewed within an average of 13 days after they were discharged. The sample was 11 per cent of the average monthly discharges of patients who were 50 years of age and over, from the hospitals selected for the study.

IV. CONCLUSIONS

Although this survey was done in one small area of the United States and the reader is interested in the way in which it represents that area, it is also interesting to note a few ways in which it seems to be representative of the national picture in similar groups.
First, the scatter map shows a well distributed picture of the visits made. Second, the sample was made up of more men than women which is also true of the sample in the national survey completed in June, 1958, of discharges from short-stay hospitals. Third, the marital status compares favorably with the 1950 overall population and with the marital status of the group 45 years of age and over in the same national survey. Fourth, the most frequent diagnosis was heart disease which disease is also the leading cause of death in the United States.

**Composite picture of the respondent.** The composite picture of the respondent as indicated by the data was that of a man, 67.6 years of age, married and living with his spouse. He owned his own home and might equally well have lived in any part of the Arrowhead United Fund Area. He was more apt to have been retired before the present illness and to have heart disease. He stayed in the hospital an average of 13 days.

**Rehabilitative needs.** The greatest expressed needs of the respondent or that of his family in connection with his illness were homemaker service and physical therapy, each 55 per cent. His second greatest need was for transportation; third was for occupational therapy. Fourth, was his need for his physician, either at a regular appointed time or for some emergency situation. Needs for prostheses, foster home care,
nurse, and special equipment for the home came next and in that order.

The national trend mentioned earlier in this description for one-third of the nation's population to be in mental institutions did not have a parallel in this study. None of the 65 and over age group were being observed for mental illness. This may indicate that other arrangements were made for this type of patient in special hospitals and that they did not come within the scope of this sample.

The demonstration unit in Los Angeles County of a home care program, as a neighboring community project, should be considered for study as plans are made for long term goals in the Area. A home care plan utilizes all the members of the rehabilitation team and all the medical services of the community.

A comprehensive rehabilitation program includes a home care plan and, although homemaker service, seems to be the greatest present need among the senior citizen group of the Area, it is a part of more comprehensive rehabilitative care. Comprehensive coverage seeks to assist the individual to reach a level of maximum physical, mental, social, and economic usefulness but many disciplines are required to accomplish this goal. Homemaker service is only one, if an important one, of the home care plan. Experience in rehabilitation has shown that overall planning should be for a long term goal and made
without consideration of available finances. The auxiliary services, no doubt, have to be considered and made available one at a time and the evidence of this survey seems to indicate that homemaker service is the one most urgently needed. It has also been observed that the members of the Health Activities Committee have increased their understanding of, and interest in, home care during the year.

The need for physical therapy was not expressed as a need for a physical therapist but as a lack of ability to carry on the activities of daily living. Prevention of some of these inabilitys might be accomplished by nurses but the physical therapist will be the team member who will be able to help the greatest number of persons. From the data in this study, the families were receiving no assistance in meeting their needs for independent living, whereas a high percentage of homemaker needs were being met in one way or another, even if by non-professional lay persons. On the other hand, it was not within the scope of this study to determine how many of the expressed needs for independent daily living were capable of being met. Many Visiting Nurse Associations employ a physical therapist to assist nurses, patients, and families in meeting their needs for the demands of daily living.

The third service in percentage of need was that of transportation. However, the percentage of those who had solved their own problem seems to minimize this need considerably. The community is already offering such a service through the Red Cross and utilization of this service for the percentage of unmet need might well be a solution to this need.

The expressed need for occupational therapy came fourth in the list of needs. Again this is a need which is unmet. The respondents were unfamiliar with the resources already available in the community and didn't seem to have any concept of the meaning of this type of service.

The need for the physician was well met. In the 20 percent of expressed unmet need it was rather obvious that this percentage of respondents did not know of other available services and could only express their dissatisfaction with their situation in terms of the person they had been most closely associated with, the physician. Other members of the health team in the home might well have perceived and referred the needs on to the physician who, in turn, could have provided the needed orders.

The unmet need for prostheses was mostly an ignorance of community services available for help in the case of need, combined with lack of finances. Again observation in the home by a nurse or other member of the health team, referred on to the
physician would have been sufficient to set processes in motion to supply these needs.

In the original plans for this survey, it had been thought that the need for nursing home care need not be considered. However, as the investigator chose the sample, it became obvious that those who were discharged to nursing homes might represent a need of a representative group in this sample. Later, as visits were made to homes, respondents were found to be in, or planning to go to, foster or nursing homes as a result of the plans made by the family. Thus, the factor of foster and nursing home care became evident. Some of the respondents were not interviewed as indicated previously. However, where the respondent had been in his home for a time, before he went on to a foster or nursing home, his needs for that period were ascertained from the family and included in the needs of the total sample. The need for nursing and foster home care is represented by 14 per cent of the sample.

The need for nurses was not expressed by respondents in but 12 per cent of the sample. This low incidence may indicate a lack of referral of the respondent to the service or, his thought that a visiting nursing service was too expensive for him to request. The official public health nursing service is limited to the indigent, so that within a large portion of the Area, there are many of the people who may not avail themselves of this valuable service.
The use of wheel chairs was limited by the width of doorways in the homes of the respondents in need of them. Types of wheel chairs made to go through the standard doorway did not seem to be available to them on loan. In one instance, repair of a privately owned wheel chair would have prevented a serious accident. While there had been funds originally to purchase the chair, funds were, at the time of the study, depleted so that purchase of repair services was not possible.

V. RECOMMENDATIONS

Recommendations and their application to the Arrowhead United Fund Area. Rehabilitation is not limited to the needs of the senior citizen and the above conclusions do seem to have implications for the entire Area.

In short term planning, it would seem, from the data, that a homemaker service should be the first consideration. However, the need for physical therapy is such an equally urgent need, that the Visiting Nurse Association may wish to consider the employment of a qualified physical therapist to assist the nurses, patients, and their families to learn the methods involved in maintaining independent self care of the older person in the home.

Present public health nursing services in the Area should be encouraged to include more chronic disease care. As patients are discharged from hospitals, referrals could be more
adequate in meeting needs of the patient as he goes home.
Nurses, in turn, who see the patient in his home should relay
their observations of need on to the physician or to other
proper resources.

Preventive measures are very important and can be
included in short term planning to advantage. They help to
keep the rehabilitative needs from increasing quite as fast
and there are persons already available who could contribute
to this prevention. They are nurses in the hospitals, nursing
home operators, the Visiting Nurse, the Public Health Nurse,
industrial personnel, and training personnel in vocational
programs.

Nurses in the hospitals can be responsible for learning
the needs of the patient before he leaves the hospital and
making the necessary referrals to proper resources; nursing
home operators, through proper nutrition, positioning, and
range of motion exercises can return many patients to their
own homes with the aid of homemaker services; the Visiting
Nurse and the Public Health Nurse can do much to continue the
education of the patient in his own care and independency once
it is established; industrial personnel can help by organiz-
ing plans for gradual retirement of their employees; and the
vocational program can contribute much to happy activity for
the active, yet bored, individual.
Sheltered workshops have been of use in many communities by furnishing occupation for the handicapped. Rehabilitation centers have been established around an already existing rehabilitation service. The experience of the Goodwill Industries, the Conference of Rehabilitation Centers, and other similar organizations could be utilized in planning for the long term goal of the Area.

Since half the age group over 65 in the nation will be in nursing homes, it seems reasonable that the plans in the Area should include some arrangement for an increase in this type of care. Perhaps the utilization of rehabilitative services for the patients in these homes would increase the availability of these beds. As rehabilitated patients were able to return to their own homes, either to a family group or with a homemaker service, additional beds would be available for other patients in need of nursing home care.

The development of supplemental feeding for senior citizens living alone seemed to have possibilities. One respondent had met his need for this service by arranging with a nursing home operator to supply his meals three times a day. Other nursing home operators might be willing to prepare special

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60 Beyette, loc. cit.
diets or regular diets for senior citizens living alone in their neighborhood. It seems possible, also, that homemakers might assist in such a program by helping in the home during the meal-time rush. Where several homemakers would be needed in individual homes to prepare meals; one, as an assistant to the nursing home operator, could service more people with less expenditure of time. Another phase that might be explored would be church participation in some phase of this program.

Transportation problems were real but by a better understanding of existing services, these problems could be met. The expressed need for driving lessons might be met by a senior citizen who needed something to do, who would be willing and capable of teaching such a course in the adult education program.

It was the observation of the investigator that more needs were evident for physical therapy and occupational therapy than were expressed by the respondents. These needs would probably be recognized by the respondents if information about these services and the personnel to furnish them, were available.

Volunteers would have a place in the planning for rehabilitation services. They could care for the hair and nails, do mending, write letters, and furnish a friendly visiting service. These little details of daily living are sometimes
overlooked but they are important to the handicapped person who already feels that a minimum of his care is a burden to an overworked member of the family.

The librarian also enters into the rehabilitation program by furnishing books for the shut-ins and to senior citizens limited in their activity. Ceiling projectors have their place with the handicapped person in bed, as have talking books for the blind.

VI. NEED FOR FURTHER RESEARCH

Rehabilitation is a service needed by all age groups. The interview schedule, with slight revisions, could be used to identify and describe rehabilitation services needed by any other group in the Area if needed.

While these conclusions and applications are only those of one person, and "the survey approach to problem-solving is not essentially forward-looking,"61 this study may provide data which will have additional meanings to forward-looking community planners.

BIBLIOGRAPHY

A. BOOKS


B. PUBLICATIONS OF THE GOVERNMENT, LEARNED SOCIETIES, AND OTHER ORGANIZATIONS


San Bernardino County Board of Trade. Population. San Bernardino: July 1, 1959. mimeographed material.


C. PERIODICALS


Lane, Harriett C. "Rehabilitation Nurse," Nursing Outlook, Vol. 6 (March, 1958), pp. 157-159.


D. UNPUBLISHED MATERIALS


E. NEWSPAPERS

APPENDIXES
APPENDIX A

ESTIMATED POPULATION OF THE ARROWHEAD
UNITED FUND AREA FOR JULY, 1959*

<table>
<thead>
<tr>
<th>Location</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Colton</td>
<td>19,490</td>
</tr>
<tr>
<td>City of Rialto</td>
<td>17,840</td>
</tr>
<tr>
<td>City of San Bernardino</td>
<td>94,270</td>
</tr>
</tbody>
</table>

Unincorporated areas

<table>
<thead>
<tr>
<th>Location</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington Township</td>
<td>18,950</td>
</tr>
<tr>
<td>Highland</td>
<td>12,500</td>
</tr>
<tr>
<td>Loma Linda Area</td>
<td>6,700</td>
</tr>
</tbody>
</table>

Total estimated population       169,750

*Composite Estimate by Board of Trade, Registrar of Voters and Planning Department, San Bernardino County Board of Trade, July 1, 1959.
## APPENDIX B

**DETAILED INFORMATION IN CONNECTION WITH THE INTERVIEWS**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of Visits</td>
<td>July 20 through September 15, 1959</td>
</tr>
<tr>
<td>Average Length of Interview</td>
<td>22 minutes</td>
</tr>
<tr>
<td>Total Travel Time</td>
<td>45(\frac{1}{2}) hours</td>
</tr>
<tr>
<td>Mileage</td>
<td>485 miles</td>
</tr>
<tr>
<td>Average Interval between Discharge and Date of Interview</td>
<td>13.13 days</td>
</tr>
</tbody>
</table>
APPENDIX C

DEFINITIONS

Chronic illness. Comprises all impairments or deviations from normal which have one or more of the following characteristics: are permanent; leave residual disability; are caused by nonreversible pathological alteration; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation, or care.¹

Cooking. For the purpose of this survey, cooking included all kinds of nutritional aid, from the preparation of a simple meal to consultative service from a dietitian.

Disability. "A disability is a condition of physical or mental defect or impairment, congenital or acquired by accident, injury or disease."²

Homemaker. In general, that person who gives service in the home where assistance will keep families together and the ill person in the home. For the purpose of this study, the following needs were tabulated under this heading: cooking, shopping, custodial bed care, daily household chores, and minimal care of the yard.

Nurse. For the purpose of this study, the Visiting Nurse is the only one whose services are included in this category, unless otherwise specified.

Physical therapy. "Physical therapy is the art and science dealing with the prevention, correction, and alleviation of disease and injury by employing manual and other physical means and devices according to the prescription of a physician."³


Physician. Need for the physician was considered to be only those services needed during the 13 days average time between discharge and the time of the interview.

Prostheses. For the purposes of this survey, prostheses were considered to include aids to rehabilitation for the individual respondent; such as glasses, hearing aids, braces, arm or leg substitutes.

Rehabilitation. "Rehabilitation is the restoration of the mentally and physically disabled to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable." 4

Retired. For the purpose of this survey retired individuals included those men no longer employed full time or part time in the occupation which produced their major income during their lifetime. For the female respondent it was considered to include the woman no longer able to care for her own home, or the woman who was living with others and assuming little or no responsibility for the care of the house.

Senior citizen. Any adult 50 years of age or over at the time of the survey; July 7 - September 15, 1959.

Social work. "Social work is a professional service to people for the purpose of assisting them, as individuals or in groups, to obtain satisfying relationships and standards of life in accordance with their particular wishes and capacities and in harmony with those of the community." 5

Special equipment. For the purpose of this survey, special equipment included all types of hospital equipment which could be used in the home for the purpose of rehabilitation such as walkers, wheel chairs, crutches, canes, special beds, orthopedic swings, etc.


Vocational rehabilitation. Vocational rehabilitation is centered on rehabilitative measures to restore function, prevent further deterioration and help the disabled individual make optimum use of his remaining capacities. For the purpose of this survey, recreational, vocational, and occupational therapy were considered as one discipline and were referred to as occupational therapy.

---

Dear Doctor:

A study is to be conducted by the San Bernardino County Council of Community Services. This study will describe, identify, and classify rehabilitative needs of a sample of patients, 50 years of age and over, who have been discharged from four hospitals in the greater San Bernardino area. As a graduate student at the College of Medical Evangelists, I am conducting the research for this study as part of the requirements for my masters degree.

The results of the study will be used by the County Council to help determine the needs of the community for rehabilitative services.

The Executive Committee of the Loma Linda Sanitarium and Hospital has approved the use of the hospital records for the purposes of the study. Now I would like to obtain your permission to visit a selected few of your patients who might be discharged on the days chosen for the study. No patient will be interviewed without his or her consent, neither will any question be asked other than those on the enclosed schedule. Diagnosis and prognosis will not be discussed with the patient and all information will be confidentially respected. A copy of the letter which will be sent to the patient to explain the purpose of the interview is enclosed along with a copy of the interview schedule.

I will be starting this study within the next few days and will include your patients in my list unless I hear from you to the contrary. Any comments you may have will be appreciated and, if you wish, a summary of the findings will be available to you.

Sincerely,

Mrs. Marion Ryerson, R.N.,B.S.
Research Collaborator with the Health Council
Dear Respondent:

Your community is interested in knowing if your needs have been met adequately since coming home from the hospital.

In order to find out whether or not the community resources are meeting the needs of those who are convalescing from illness, I am conducting a study in cooperation with your County Council of Community Services and with the consent of your physician.

You can help by telling us what services you have needed or made use of since coming home from the hospital. Any information given will be held in confidence.

Anticipating that you will be able to cooperate in this study, I will call at your home within the next week. If, for any reason, you will not be at home or you wish to arrange for another time, you can leave a message at one of the following numbers:

TUrner 9-0111, extension 481, or PYramid 6-2555.

Sincerely,

Mrs. Marion Ryerson, R.N.
Representing the Health Committee of the County Council of Community Services
July 20, 1959

Sister Mary Cyril, Administrator
St. Bernardine Hospital
2101 Waterman Avenue
San Bernardino, California

Dear Sister Cyril:

The purpose of this letter is to inform you that the Health Division of the Senior Citizens Committee of the County Council of Community Services is very much interested in seeking your cooperation with a study pertaining to some of the rehabilitation needs of older patients who have been discharged from your hospital. This study is being conducted by Mrs. Marion Ryerson, a competent experienced nurse who is now working on her Masters degree in Nursing from the College of Medical Evangelists.

This is to introduce Mrs. Ryerson who will discuss this study further with you and tell you how you can cooperate with her in this small but significant study. Loma Linda Hospital has already been contacted and permission has been granted for her to use their medical records for purposes of this study.

Mrs. Ryerson's findings will be reviewed and discussed by our Health Division and of course the findings and implications will be shared with you and others who will collaborate in the study. We will appreciate your cooperation in this matter.

If there is need to discuss this request with the Executive Committee of the Medical Staff, please let me know as I would like to meet with them in person to answer their questions. Or, if you have questions I would appreciate an opportunity to talk with you by phone or in person.

Again, thank you for your consideration of this request.

Sincerely,

Julius Zelman, M.D., Chairman
Health Division
Senior Citizens Committee
George L. Pelkey, M.D., Chief of Staff  
St. Bernardine Hospital  
2101 Waterman Avenue  
San Bernardino, California  

Dear Dr. Pelkey:

The purpose of this letter is to inform you that the Health Division of the Senior Citizens Committee of the County Council of Community Services is very much interested in seeking your cooperation with a study pertaining to some of the rehabilitation needs of older patients who have been discharged from your hospital. This study is being conducted by Mrs. Marion Ryerson, a competent experienced nurse who is now working on her Masters degree in Nursing from the College of Medical Evangelists.

This is to introduce Mrs. Ryerson who will discuss this study further with you and tell you how you can cooperate with her in this small but significant study. Loma Linda Hospital has already been contacted and permission has been granted for her to use their medical records for purposes of this study.

Mrs. Ryerson's findings will be reviewed and discussed by our Health Division and of course the findings and implications will be shared with you and others who will collaborate in the study. We will appreciate your cooperation in this matter.

If there is need to discuss this request with the Executive Committee of the Medical Staff, please let me know as I would like to meet with them in person to answer their questions. Or, if you have questions I would appreciate an opportunity to talk with you by phone or in person.

Again, thank you for your consideration of this request.

Sincerely,

Julius Zelman, M.D., Chairman  
Health Division  
Senior Citizens Committee
William L. Cover, M.D., Chief of Staff
San Bernardino Community Hospital
1500 West 17th Street
San Bernardino, California

Dear Dr. Cover:

The purpose of this letter is to inform you that the Health Division of the Senior Citizens Committee of the County Council of Community Services is very much interested in seeking your cooperation with a study pertaining to some of the rehabilitation needs of older patients who have been discharged from your hospital. This study is being conducted by Mrs. Marion Ryerson, a competent experienced nurse who is now working on her Masters degree in Nursing from the College of Medical Evangelists.

This is to introduce Mrs. Ryerson who will discuss this study further with you and tell you how you can cooperate with her in this small but significant study. Loma Linda Hospital has already been contacted and permission has been granted for her to use their medical records for purposes of this study.

Mrs. Ryerson's findings will be reviewed and discussed by our Health Division and of course the findings and implications will be shared with you and others who will collaborate in the study. We will appreciate your cooperation in this matter.

If you have questions I would appreciate an opportunity to talk with you by phone or in person.

Again, thank you for your consideration of this request.

Sincerely,

Julius Zelman, M.D., Chairman
Health Division
Senior Citizens Committee
Mrs. Virginia Henderson, Administrator
San Bernardino Community Hospital
1500 West 17th Street
San Bernardino, California

Dear Mrs. Henderson:

The purpose of this letter is to inform you that the Health Division of the Senior Citizens Committee of the County Council of Community Services is very much interested in seeking your cooperation with a study pertaining to some of the rehabilitation needs of older patients who have been discharged from your hospital. This study is being conducted by Mrs. Marion Ryerson, a competent experienced nurse who is now working on her Masters degree in Nursing from the College of Medical Evangelists.

This is to introduce Mrs. Ryerson who will discuss this study further with you and tell you how you can cooperate with her in this small but significant study. Loma Linda Hospital has already been contacted and permission has been granted for her to use their medical records for purposes of this study.

Mrs. Ryerson's findings will be reviewed and discussed by our Health Division and of course the findings and implications will be shared with you and others who will collaborate in the study. We will appreciate your cooperation in this matter.

If you have questions I would appreciate an opportunity to talk with you by phone or in person.

Again, thank you for your consideration of this request.

Sincerely,

Julius Zelman, M.D., Chairman
Health Division
Senior Citizens Committee
San Bernardino County Council of Community Services  
548-A Sixth Street - Phone TURNer 9-9771  
San Bernardino, California  

July 20, 1959

Arthur E. Varden, M.D., Superintendent  
San Bernardino County Hospital  
780 East Gilbert Street  
San Bernardino, California

Dear Dr. Varden:

The purpose of this letter is to inform you that the Health Division of the Senior Citizens Committee of the County Council of Community Services is very much interested in seeking your cooperation with a study pertaining to some of the rehabilitation needs of older patients who have been discharged from your hospital. This study is being conducted by Mrs. Marion Ryerson, a competent experienced nurse who is now working on her Masters degree in Nursing from the College of Medical Evangelists.

This is to introduce Mrs. Ryerson who will discuss this study further with you and tell you how you can cooperate with her in this small but significant study. Loma Linda Hospital has already been contacted and permission has been granted for her to use their medical records for purposes of this study.

Mrs. Ryerson's findings will be reviewed and discussed by our Health Division and of course the findings and implications will be shared with you and others who will collaborate in the study. We will appreciate your cooperation in this matter.

If you have questions I would appreciate an opportunity to talk with you by phone or in person.

Again, thank you for your consideration of this request.

Sincerely,

Julius Zelman, M.D., Chairman  
Health Division  
Senior Citizens Committee
**APPENDIX E**

**CODE USED IN TABULATING DATA FROM INTERVIEW SCHEDULE**

As mentioned in the letter you received a few days ago, the County Council would like to have your help. You can help by telling me what services you have needed or made use of since coming home from the hospital. For instance,

<table>
<thead>
<tr>
<th>A. What services have you needed</th>
<th>B. Did anyone take time off from their job to help you?</th>
<th>C. Would any service above have let you come home sooner?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>If yes, what is their relationship to you?</td>
<td>If yes, which one?</td>
</tr>
<tr>
<td>Nurse VNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transprt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardener</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other protheses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Do you or would you like to:</th>
<th>E. Are you able to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>leave the house?</td>
<td>get out of bed alone</td>
</tr>
<tr>
<td>have friends in?</td>
<td>dress yourself?</td>
</tr>
<tr>
<td>watch television?</td>
<td>help yourself when eating</td>
</tr>
<tr>
<td>do handwork?</td>
<td>walk alone?</td>
</tr>
<tr>
<td>have records?</td>
<td>go up and down stairs</td>
</tr>
<tr>
<td>have books to read?</td>
<td>get into a chair with help</td>
</tr>
<tr>
<td>study a special subj.?</td>
<td>propel a wheel chair?</td>
</tr>
<tr>
<td>go to school?</td>
<td>other?</td>
</tr>
<tr>
<td>other?</td>
<td></td>
</tr>
</tbody>
</table>

F. Would you have preferred to remain at home for your care, if your doctor had agreed? yes no

G. Do you have dependents? H. Are you retired? Due to illness?

I. Comments: Talked with interviewee alone family alone both

J. Int’v’ee lives alone, in own home, aphasic Other
CODE USED IN TABULATING DATA FROM INTERVIEW SCHEDULE TO DATA-PROCESSING CARDS

**Code Used For Schedule A.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Code</th>
<th>Needed</th>
<th>Had</th>
<th>How Many x/Wk.</th>
<th>How Many Hrs/Day</th>
<th>Found Unavail</th>
<th>If Not Utilized, Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>110</td>
<td>210</td>
<td>120</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Nurse VNA</td>
<td>210</td>
<td>220</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRN</td>
<td>230</td>
<td>240</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVN</td>
<td>250</td>
<td>260</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other health personnel</td>
<td>270</td>
<td>280</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td>310</td>
<td>320</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td>410</td>
<td>420</td>
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<td>Bed care</td>
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<td>370</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Transprt.</td>
<td>510</td>
<td>520</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>330</td>
<td>350</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Gardener</td>
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<td>390</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Special bed</td>
<td>610</td>
<td>620</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>630</td>
<td>640</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheel chair</td>
<td>650</td>
<td>660</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other equipment</td>
<td>670</td>
<td>680</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Glasses</td>
<td>710</td>
<td>720</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>730</td>
<td>740</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prothes</td>
<td>750</td>
<td>760</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Code Used For Schedule B.**

1. Daughter or Daughter-in-law
2. Friend
3. Husband
4. Mother
5. Neighbor
6. Sister
7. Wife

**Code Used For Schedule C**

1. MD
2. RN
3. Homemaker
5. Trans.
7. Prothes.
8. Occupation

**Code Used For Schedule D.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you OR would you like to:</td>
<td></td>
</tr>
<tr>
<td>1 leave the house?</td>
<td>1 D</td>
</tr>
<tr>
<td>2 have friends in?</td>
<td>2</td>
</tr>
<tr>
<td>4 watch television?</td>
<td>4</td>
</tr>
<tr>
<td>7 do handwork?</td>
<td>7</td>
</tr>
<tr>
<td>10 have records?</td>
<td>10</td>
</tr>
<tr>
<td>20 have books to read?</td>
<td>20</td>
</tr>
<tr>
<td>40 study a special subj?</td>
<td>40</td>
</tr>
<tr>
<td>70 other?</td>
<td>71</td>
</tr>
</tbody>
</table>
Are you able to:

got out of bed alone? yes no

dress yourself? 2

help yourself when eating? 4

walk alone? 7

go up and down stairs? 10

get into a chair with help? 20

propel a wheel chair? 40

other? 70

Card punched for YES answer only.

Card punched for YES answer only.

Card punched for YES answers only.

alone 1

family alone 2

both 3

alone 1

in own home 2

aphasic 4

other 7

married 1

widowed 2

divorced 4

male 7

Loma Linda Hospital 1

San Bernardino County Hospital 2

St. Bernardine's Hospital 3

"M" punched only for those born in U.S.A.
<table>
<thead>
<tr>
<th>AGE</th>
<th>PERSONAL</th>
<th>HOSPITAL DAYS</th>
<th>CARD NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units</td>
<td>Tens</td>
<td>Status</td>
<td>Units</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
COLLEGE OF MEDICAL EVANGELISTS
School of Graduate Studies

A COMMUNITY SURVEY TO IDENTIFY REHABILITATIVE NEEDS IN THE HOME
by
Marion S. Ryerson

An Abstract of a Thesis in Partial Fulfillment of the Requirements for the Degree Master of Science in the Field of Nursing

November, 1959
The purpose of this pilot study was to find trends of needs of senior citizens which would be helpful to the community in planning for rehabilitative services. These needs were identified and described from data secured by personal interviews of 56 respondents, using a prearranged schedule. These respondents were 50 years of age and over who lived in and sought hospitalization in the Arrowhead United Fund Area. They were interviewed an average of 13 days following discharge from the three hospitals selected for the study.

The average respondent was found to be a man, 68 years of age, married and living with his spouse. He owned his own home which could very well be in any part of the Area. He was more apt to be retired before the illness which caused the hospitalization at the time of the survey, and his diagnosis was more apt to be some form of heart disease. He stayed in the hospital an average of 13 days and his greatest needs following discharge were expressed as a need for homemaker service and observed as conditions which physical therapy is most often able to correct. The remaining needs were expressed in degree of need in the following order: transportation, occupational therapy, physician,
prostheses, foster and nursing home care, nurse, and special equipment.

From the analysis of the survey data, it would seem that the community would want to consider the establishment of a homemaker service and physical therapy first.

Second, it seems possible that a greater measure of prevention of chronic illness and disabilities in the elderly might be considered with existing personnel and that increased efforts through all channels of communication might be made to inform the public of existing facilities.

Third, that whatever services are established, be made available to citizens of all economic levels.

Fourth, that in considering long term goals, a study be made of the neighboring county's demonstration of a home care plan for applications to the rehabilitation coverage in the Arrowhead United Fund Area. Comprehensive rehabilitation seeks to assist the individual to reach a level of maximum physical, mental, social, and economic usefulness and many disciplines are necessary to accomplish this goal.