From rehab to home — making the transition

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Greater MetroWest CARES, the Committee Addressing Resources to Engage Seniors, is coordinated by Jewish Federation of Greater MetroWest NJ and brings together leaders from Greater MetroWest agencies to promote independence and support vitality among older adults. Throughout the year, Greater MetroWest agencies have the opportunity to address critical eldercare issues in this column. This month's article on transitioning from a sub-acute rehabilitation facility to life at home is presented by Daughters of Israel.

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Today, there is an increasing population of those 60-plus who are opting to have elective surgery such as a hip or knee replacement and subsequently require post-surgery care at a sub-acute care facility. In addition, there are patients who require sub-acute rehabilitation following a hospitalization due to cardiac surgery, medical illness with deconditioning, fractures, complex wounds, strokes, and other complications.

The length of a stay at a sub-acute rehabilitation facility varies, depending on the individual's health, insurance coverage, and other factors. A social worker assigned to the individual in conjunction with the interdisciplinary team, will develop a discharge plan to ensure that the resident has a safe and comfortable return home.

However, upon being discharged from a short-term rehabilitation facility, the individual and/or his or her family may feel overwhelmed. Regardless of the discharge plan — which typically includes prescriptions for medications and medical equipment, and skilled homecare services — there are still many day-to-day responsibilities that can be difficult to handle. For instance, a newly discharged patient may feel too emotionally or physically overwhelmed to schedule the appropriate follow-up doctor appointments, pay bills, and more. Perhaps the patient could use a companion to help with grocery shopping, meal preparation, and laundry. Such tasks can become particularly challenging if there is no family member close by to help.

There is a growing field of outpatient geriatric care managers who provide referrals for many of the services needed and who monitor these services to ensure optimal outcomes. These care managers coordinate with local and out-of-state family members and can also assist in securing government entitlements such as Social Security, Supplemental Security Income, and Medicare. There also may be local benefits for which they are eligible, which in the Greater MetroWest NJ area may include Kosher Meal on Wheels, specialized services for Holocaust Survivors, and volunteer companions.

Here in Greater MetroWest, two agencies are collaborating to assist patients and their families in making transitions. Jewish Family Services of MetroWest NJ has just partnered with Daughters of Israel to create *Transitions*, which is made possible by a generous grant from the Jewish Community Foundation of MetroWest NJ. *Transitions*, which is a partially subsidized program, enables those being discharged from the Rehab Center at Daughters of Israel to work with experienced JFS MW geriatric care managers. These care managers provide information on what resources are available, how to access them, and the associated costs.

To learn more about *Transitions*, its offerings, and fee structure, please contact Daughters of Israel Social Services Office at 973-400-3306. ■

Renee Glick is the director of public relations and marketing at Daughters of Israel, the skilled nursing facility located in West Orange whose mission is to provide a continuum of health-related and social services to the Jewish elderly and others in need.