**ORAL HISTORY VIDEO INTERVIEW WITH**
**GEORGE SOPER**
**JANUARY 9, 2013**
**INTERVIEWER: JENNIE TODD**
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**GS:** GEORGE SOPER
**JT:** JENNIE TODD
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**GS:** Might as well get started.

**JT:** Okay. All right. Well, what we're going to do is we're going to start with me asking you your name, where you're from, and from where you're retired. So we'll just start off that way. So you can just tell us who you are.

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**GS:** Yeah. I'm George Soper. And I just retired from Memorial Hospital in South Bend after 31 years. I was brought to South Bend primarily to build their rehab programs, coming from the University of Iowa where I was Director of Physical Therapy at the time. But I've been in an administrative post here since I came, overseeing a lot of clinical areas, which included all the rehab fields -- which is what I was brought here to do. But also I have had responsibilities for some nursing units and pharmacy and radiology, and a lot of clinical areas that support the care given to patients coming to the hospital. My last five years, though, here I was the Senior Vice-President for Human Resources because in my work with all people in the clinical areas I discovered that, like myself, we didn't really have a lot of formal training in management.

And so I started to bring in programs to help myself and others learn how to be a good manager and leader of people. And so my experience, besides focusing on rehab, has also been to help build leaders to lead people in the healthcare field.

**JT:** That was really good. That kind of addresses some of the things I was going to ask you in the next question, which was: What brought you to Indiana? And how and when did you get into this line of work? So we'll stick with the how and when did you get into this line of work, and then I want to have you elaborate on:

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What was the field of disability human services like when you came to Indiana? And how has it changed? And if you noticed changes between Iowa and Indiana?

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**GS:** Yeah. Good. Well, as I said, I initiated my rehab career at the University of Iowa, where I was particularly interested in working with children with cerebral palsy. That was a passion I had. So all my work on my PhD dealt with a lot of neurophysiology. And so that was my background. So I actually was tapped to go to Mass General Hospital. At the time I was approached by the president of Memorial Hospital to come and help build the rehab programs. And he convinced me that Indiana could use some help in doing that, and I agreed with him at the time. I said there's not much known -- at least nationally -- about Indiana as being a big state that deals with rehabilitation. And so when I came to South Bend, it was mainly to help build that.

And I changed my career, actually, from being an active physical therapist to now administrator over a lot of clinical areas. So when I came to South Bend to Memorial, we had two physical therapists, we had two occupational therapists, and they had just hired a speech therapist. That was all that was here. There was maybe one practicing -- private practicing -- therapist in the community. St. Joe Medical Center certainly had a few therapists as well. But quite honestly, it was a void of people working in the rehabilitative area. And so that was the challenge. And since I was on the National Board of the American Physical Therapy Association at the time I had contacts around the country that I could call and ask to come join me in Indiana to help build these rehab programs. And so that's exactly what happened.

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And we focused on building areas of specialization and people that were strong in orthopedic kinds of disabilities, or neurological disabilities, or cardiopulmonary, whatever -- those are the people I searched out to bring into Memorial to help build the programs. Today at Memorial we have well over a hundred professional therapists that work in home care as well as at the hospital and in two outpatient clinics. So that's kind of how all this really started. There really wasn't much focus on disabilities. In fact, when we decided we wanted to open up a rehab unit that was just specialized to patients with rehabilitation needs, that was a new concept that had to be overcome as well. Because in those days -- and I date myself a little bit, that's back around 1980 -- that I actually arrived in South Bend in the summer.

The administration here was certainly open to it because the President brought me here for that reason. But others were not quite as excited about my rival perhaps the administrator was. And so it took a while to get people to understand that this rehab field was in desperate need of some rapid growth and addressing a lot of need that was here.

**JT:** Do you want to talk a little more about the attitudes or how you and others helped change the attitudes or, you know, what made the difference?

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**GS:** Right. Well, I think one of the things that made a difference for people accepting it were the folks I brought in to head up these different specialty programs had a lot of passion for what they did. And that was kind of infectious. I had an occupational therapist that was very creative, and I assigned her the task of building some very specialized programs more around the occupational side of the therapies. And one of the first things that she noticed was that we had a void in patients having the correct seating devices for their mobility. And so we searched out who some of the best people in the country were that were building rehab seating devices. And in fact, we found a person in Wisconsin and convinced him to come and head up our rehab engineering program. That program was successful from what we were able to do, but it struggled with finding the right funding to support it long term.

And we eventually had to close that program down because we just couldn't find the funding to support these special seating devices that we were building for people. The demand was certainly there, but it took a long time to convince people that in fact, we weren't able to convince them to keep funding it without funding. So we had to close the door on the rehab engineering. Now, those services are still available locally, and those people have started up their own private company. So fortunately, they're still existing in the area. I looked in the phone book the other day to see how many I saw around the surrounding communities, and there was probably seven or eight in there that were still doing some kind of rehab special seating for mobility purposes. But we had quite a ride with that. We had people come in from literally all over the country to see what we were doing at that time.

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But that one didn't survive the financial challenges that it had. But then the next area that we noticed was actually people needing to learn how to drive. And so our next program that we brought in was to -- a person who was really skilled at driver education for the disabled. And we built a very strong program. In fact, at one time we had offices in Indianapolis and in Fort Wayne, as well as in South Bend. The Driver Ed program is still here and doing very well and meeting a big demand for that. And it has people coming from all parts of the state to get that in terms of vehicle modification -- for vans as well as automobiles. And it's in big demand. I do have some literature here, which I'll leave with you, as well before we're finished.

**JT:** That's really good because my next question you pretty much answered it, and I'm going to read to you anyway just to make sure you feel like you got everything. And what it said was, "I understand you were trained as a physical therapist and that you developed one of the first rehab engineering programs, building one of a kind adaptive equipment. Can you tell us more about that? And then was your work with the driver's education a piece of that work?" Which you did address a lot of those things, but if there's anything else that you want to say.

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**GS:** Right. Well, the rehab engineering program had to have its own space, own equipment. And we were able to get some grants to help fund that to get it started. So without the grants that we received from the state, that would have been difficult to really go. But the person that we found was so exceptional in how

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he was able to really design special seating devices that he was really a treasure, if you will, for our program. The person we brought in for the driver ed piece closely integrated with the rehab engineering because the seating devices many times had to fit into vehicles as well. So those programs were pretty much integrated together so they kind of worked in collaboration with one another rather than stand alone.

So when we lost the seating piece, that produced a little challenge for then "How do you help people get into these different seats when they've got special needs to handle?" So that's about all I recall right now. What was the second part of the question?

**JT:** Basically, it talked about that you had the rehab engineering program building one of a kind equipment, and then the driver's ed piece. It says, "So was your work with the driver's ed part of that program?" Which it sounds like it was.

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**GS:** Yeah. Yeah. All the programs that we built in those days -- when I came I changed the way that the structure of the services were built. They were initially designed as a physical therapy department, occupational therapy department, so forth. I changed that and I said, "We're going to call them by what function they do." So the departments were called the Neurological Services Department, which then employed both PTs and OTs and others. The Orthopedic Department was the same. And so it wasn't until many years later that they reverted back to calling themselves as PT and OT departments because they became so large in terms of the services from each discipline that we had to move back into renaming them then Physical and Occupational Therapy.

**JT:** Sounds like an exciting time.

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**GS:** Well, it was. And there was resistance by the therapists in that we were trying to get rid of these disciplines. And I said, "No. In fact, we'll probably need more than you've ever had here." And so those services have grown quite a bit. I do have the exact numbers if you're interested in what that growth number is.

**JT:** Sure.

**GS:** But mind me checking this out. So today -- now, this is just at Memorial so I don't have figures for other facilities -- but we had two physical therapists when we came; today there's 37 physical therapists that work in the rehab areas, both the inpatient and outpatient side.

**JT:** And that is over how many years? [inaudible] 80 [inaudible].

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**GS:** Well, it would be from 1980, when I came and we had two as I recall it -- maybe three -- but two. And then I know we only had two OTs; today there's 25. In fact, there was an attempt back in 1980 to enlist the help of the American Occupational Therapy Association to resist what I was trying to do. But their response back to the therapists that were here at the time was, "No, this looks like a fairly innovative approach; go ahead and stay with the program," which they needed to because I really needed them in key positions. And so today we have 25 occupational therapists. We have 14 speech and language pathology. We only had one when I started. We have ten physical therapy assistants; one certified occupational therapy assistant; four therapeutic rec people; one acupuncturist; one neuropsychologist; and two medical directors.

So that's kind of the scope of where the program has gone. It's very exciting to see it continue to grow and build. And with the aging population, I can't help but think that that's going to be an issue. But when we talk about disabilities, they come in so many forms these days. And some of them are very subtle forms of disability that we have to work with, as opposed to some of the more dramatic…

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JT: Okay. So you were talking about the disability -- that a lot of people come in with different types of disability.

GS: Yeah, sometimes they're so subtle you don't really notice them today. But -- and they can be disabilities that have to do not just with the physical, but with the psychological, emotional, all those disabilities now that really complicate the challenge if you have a physical disability on top of that. And so when we deal with head injury programs, which we had established years ago, that poses a whole new challenge for staff to even deal with those. I mean the physical part is easy enough, but then you add some of these brain injured emotional problems that go along with it, and the behavior of these patients gets to be so challenging that nurses and others really have a difficult time. The other thing that we were able to do when we created this "rehab center," as we called it in those days was first called the Michiana Rehab Institute and they've changed that now to Memorial, I think, Regional Rehab Center.

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But to integrate the nursing component and bring in nurses who were able to deal with those areas as well. So I was also responsible for the rehab nurses that we brought in to the rehab floor. And we then, back in the early '80s, designated a specific floor just for the rehab patients. And then we had a person come in and donate significant money, so we remodeled the whole floor to accommodate the fact that these are patients now that are in wheelchairs and have other problems that you won't find on the regular nursing floor. And so we had to change the real -- the whole outlook -- on how people looked at rehabilitation within the hospitals. I can tell you another challenge that was there that was interesting to overcome, and that was when you bring these patients off the floor out into the rest of the hospital -- that wasn't always viewed with a lot of excitement because they slowed down the lines going through the cafeteria, the wheelchairs were not as easy to accommodate in cafeterias, and so forth.

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So we had to really overcome those attitudes to where patients were not only accepted, they were welcomed into the rest of the hospital because some of these people were out being trained in the hallways and into cafeterias and things. And that was different for people to deal with. But its taken time, but it's certainly there now.

JT: Good. Well, and you're doing such a good job; you're way ahead of me on the questions. So I'm going to read you this next one, and see if you think you've answer it already, too. And what it says is, "From a medical perspective, what changes have you seen in the last few decades in terms of attitudes, procedures, training, and the field in general in terms of progress for people with disabilities?"

GS: Right.

JT: And some of that you've talked about.

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GS: Yeah. You know, in the early '80s, when we knew we had to bring in trained medical directors that were trained in the area of physical medicine, I traveled with another physician to Washington, D.C. and interviewed a physician from Walter Reed Hospital to come and be our first medical director. That person is still here today, as a matter of fact, as our medical director. And we've added others since his coming. But we have two really full-time medical directors now. And what was the rest of the question?

JT: Basically, what changes over the decades have you seen in terms of attitudes, procedures, trainings, in the field in general towards people with disabilities?

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GS: Yeah. I think certainly attitudes have changed a lot in terms of how people deal with disability. In fact, I just had my second knee replacement here four months ago. And when you go through that process, you then are also given the opportunity to have your disability known for your replacement. And they encourage you not to walk long distances on them. And so occasionally I have found that there's more people now that actually have accessible disability identification, either on their license plate or hanging them on their mirrors because people are just more sensitive that disability runs from all ranges -- from severely disabled to those who are more minimally disabled. So I think that's a huge change because I didn't see that back in the '80s for sure.

JT: Well, in terms of young people coming into the field, do you think that in their school training, in their practicums, that sort of work, do you think there's more talk specifically about people with physical disabilities, people with intellectual disabilities? Do you think that that's part of the course curriculum?

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GS: Yes, yeah. It's as far as the training of therapists today, I still teach in the physical therapy program at Andrews University. And I've been doing that now for, gosh, it's going to be close to thirty years, probably not quite thirty. But when I started in physical therapy, the training was really a certificate program. You

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had to graduate from college, and then there's usually one more year. Today that's now moved to where they offer doctorates in physical therapy. So it's three years now, beyond your basic baccalaureate program. And I know that the curriculum has been so expanded to include disabilities from a much wider range than there was time to do in the early days. Gosh, that's been over forty years ago. That's a long time ago. I don't like to think of it as being so long. But, hey, time goes fast. So I do know the curriculums have changed.

There's more acceptance of physicians in the hospitals. That was something I had to overcome back in the '80s when I brought in the first physical medicine doctor into the community. Not all the other medical disciplines were real excited to have that person there. You know, some of the orthopedic physicians weren't sure that they were really needed. They felt that, you know, they could handle that. In fact, in some of the early medical directors in rehab centers were orthopedic surgeons because they did deal with a form disabilities but weren't really specialized in looking at disabilities from a broader range in terms of some of the head injury patients, certainly, some of the behavioral differences you're going to have to deal with, with patients. How do you get families more involved with patients who have disabilities so they can be part of the treatment team? That took some time for that to all mature as well. But even today, now, one of our biggest challenges is trying to find support systems for people that have disabilities.

Oftentimes we see families wanting to almost disown and step away. They're just too much of a challenge. And so hospitals many times are left with patients in hospitals where there's no support family for people with disabilities. That will continue to be a big, big challenge. And I think however the government plays out with Obamacare, it will be interesting to see if they address that in any way because that will be a big challenge.

JT: So you feel like there's still a lot of families that are so overwhelmed by their family member with a physical disability or a permanent disability -- not one that they're going to recover from.

GS: Right.

JT: Permanent, lifelong disability are still being -- feeling like there's not enough support and still willing to walk away.

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GS: Yes. Yeah, we see that. The other thing that is a factor when they are told they are going to have to leave the hospital and go into a skilled nursing or some assisted device area, a great resistance for family members to even want to put them in other facilities other than hospitals because they know the funding is so tight that they don't have the staff there to really deal with people that have serious disabilities, especially if they need a ventilator-dependent support. That's a huge, huge challenge for Indiana. In fact, at one point I thought I heard that Indiana was shipping some of their head injury patients out of state. I don't know if they're still doing that or not, but I know we've always had a head injury program in our neurological portion to deal with them, and we have people who have not only the passion to deal with them, but have the training.

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That's why we brought in the neuropsychologist to be part of our team.

JT: [Inaudible] So then maybe this question -- this may or may not be a good question, but you can couch it however you want.

GS: Sure.

JT: It says, "How have and what changes in state policy and state legislation affected your work?" And that could basically be, you know, what you're talking about now; laws, funding, anything like that if there's --

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GS: Well, certainly Medicaid is the big one that we have to deal with for many of these patients. My wife's an occupational therapist, and she had to deal with Medicaid patients a lot. And that was always the biggest hassle that she had, just all the red tape, the hoops she had to jump through in order to get funding for people on an ongoing basis. It took a lot of her treatment time, actually, just going through the rigmarole trying to get Medicaid funding. That will continue to be a big challenge, I think, for all states but certainly Indiana that will be a challenge. The -- there was something else I was going to mention there. Forgot what it was now.

JT: That's okay. Do you think Indiana is ahead or behind other states in terms of not so much the dedication, but the support and the attitudes? It sounds like South Bend is a wonderful place to be if these are your issues. But as a whole, how do you think Indiana fares in terms of providing good support to people with disabilities?

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GS: You know, I really don't have a good feeling on that overall for Indiana. My guess is we're not ahead of the country in that regard. But I really don't have the data to support that decision. But certainly, funding is going to be a big issue. There are physicians today who won't even take Medicaid patients, and that's probably true across the state. I've had patients walk into my office -- well, when I was still working, not now but -- and say, "You know, my doctor that I've been seeing will not take me anymore because I'm a Medicaid patient; is there anybody that will see me?" And I say, "Well, we do have a family medicine clinic across the street that will see you." And so we still see them in that regard, but private physicians are backing away from government-funded programs because they just don't pay enough.

I think Medicaid pays about maybe fifteen percent on the dollar, fifteen cents on the dollar. And you lose money every time you actually see a Medicaid patient.

JT: And if you could wave a wand and change that, how would you see a change making it better for people that have no money and have no insurance?

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GS: Well, yeah. It becomes is priority issue of all the issues that we have to deal with today. How important is that one versus other things? Because you can't fund everything, so it's a matter of what gets funding and

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what doesn't. And that's where Congress is always stumbling around and trying to address it and then never is effectively as everybody wants certainly. So I don't have any magic bullets for it, but it does become a matter of priorities. So what are we as individuals willing to give up to support people who have less than we have? And that's really kind of the fundamental question, I think.

JT: That's good. This is switching a little bit. And I know you were a recipient of the Franklin Covey Community Service Award in 1999. And is there a way in which your work for people with disabilities has informed your philosophy in leadership regarding community service?

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GS: Well, I think it certainly has because disabilities are a community issue. And so that probably has spurred my interest in being involved in the community. I still am, as a retired, person involved with trying to help. So I think whenever you deal with people who have less than you have and have challenges that are just almost insurmountable that it kind of changes your focus that there's something more out there that we need to do for people than we're currently doing. And so, yeah, I'd say that working with disabled people has spurred more interest in community involvement.

JT: Do you want to talk about the award at all?

GS: Well --

JT: And you have to say the name because they won't know that --

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GS: Yes. Yeah, I received, actually, the Franklin Covey Community Service Award twice. And I even forget the years now that it was. But it was probably in 2005 or 2004 and 2008. I don't remember. But anyway, I can provide you with that information as well. And that was because I took the training of Franklin Covey to the community. I was approached back in the early -- well, actually, probably back in the late '90s -- to "How do we get some of this training in the hands of the youth to help them?" And so we began to explore how we might do that. And we learned that the Franklin Covey Organization actually recognized communities who, as principle-centered communities, who took it to the community, which meant now we're going to be take it to everybody -- cab drivers, disabled -- anybody who would like to know a little bit more about how they can live their own lives more effectively.

And it's a powerful program that I still teach today. I started teaching it in 1992. I took my first class. And I still teach it many places; in fact, even taught it in South Africa at one point to people who were in healthcare and were wanting to know of how they could live their lives more effectively. And South Africa's certainly a country that had just been through apartheid, and they were looking for ways to relook at themselves and how they dealt with life. So great opportunities for people with disabilities to look at these same principles for how do they now look at their lives that have been radically changed. And I can't say that we have actually applied that to that population but it's certainly applicable. I can't tell you the number of people who've gone through the training over the years that have told me that it literally

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changed their lives and how they look at it, becoming more focused, more purpose driven -- which certainly is something that people with disabilities deal with all the time.

JT: That was good. Okay. In looking forward, what do you hope for in terms of support and services to promote the best lives for people with disabilities or -- here's another way to think of that -- what do you see as present and foreseeable trends in these areas, and what is your opinion of those trends?

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GS: Wow. Trends in this area of disability. Management. I think the struggles are going to be still there. I think the more visible we make that struggle known, the better we have of influencing government and other places that will -- could provide some of the support. I think more local support is going to be needed, although I think the challenges there are great. I serve as President of the Board for the South Bend symphony. And of course, one of our big challenges is going out and find funding for supporting the symphonies because, you know, tickets only provide maybe a third of the support needed. And we're finding that's very, very difficult -- more difficult than we've seen it for years. And so I think the challenge is to then apply that over in the area of disabilities is going to become greater maybe.

And so I think if we can't find more private funding, then we're going to have to go back to some kind of government funding to help in that regard. So I don't have a real bright picture because I haven't seen anything that really, you know, lights me up as something that's going to get better. I think it's just going to require a lot more attention given to it. And locally I think people are perhaps going to have to see local governments taking more of an active role in that as well, as opposed to just looking to federal for it.

JT: Do you see any future trends or changes in terms of the field of physical therapy or rehab engineering or rehabilitation down the pipe? Would you see changes or things that you think aren't going to happen?

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GS: Well, certainly with the aging population, the demand to work with disabilities within the elderly or the older population, the population that I'm entering into is certainly great there. So the training, I think, will have to follow where the population goes. And so where the demographics are of the population, the training for therapists is going to have to change and keep pace with that. And I do hear a lot within the field of physical therapy that they say this aging population now that we're going to have to deal with all these baby boomers to keep them healthy and keep them from becoming more disabled, if you will, because of lack of exercise and poor diet and so forth now becomes a challenge for therapists to keep these healthy people healthy. So that's going to have to be a shift as well.

JT: That's good. Okay. And what would you say were a couple of your biggest career highlights?

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GS: In all of my career? I would have to say deciding that I wanted to be a physical therapist was one thing. My coach actually prompted me to that -- track coach in college. After graduation he said, "Sopey, you should look into physical therapy." I said, "What's that?" And so I looked into it and found out that it seemed like

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an interesting field. I didn't know if I could academically handle it but found out that, yes, in fact I could, and I ended up being the top of my class when I graduated. And that began to really tell me I could do more, and so that's where I went on to study more in physical therapy and got my PhD in that area. So that was probably a highlight of sorts.

I think changing fields from being just a physical therapist to now being administrator over a lot of clinical areas -- and particularly rehab in a broader sense -- was probably a highlight for me. I mean, that really changed how I had to focus my own training and my own workings with people. And then I'll have to say Franklin Covey's -- Steven Covey's -- work with the Seven Habits was probably a huge change for me. It changed how I looked at my life, how I help people look at their lives differently, and certainly had to have an influence on how I looked at disability differently than I was looking at it before. That's a big one. And then staying involved as a teacher, I think, at Andrews University was an important part for me.

It stayed -- it kept me into the learning mode. In fact, when I was here at Memorial the last five years, they named me as the Chief Learning Officer, which was a new office position. Because I had been doing teaching for so long at Memorial that they said, "We're just going to make you our Chief Learning Officer, and you can keep working with developing our leaders at Memorial and the community." So that was kind of exciting for me to do. And I continued to read a lot, stay involved with what's going on nationally. Good to see how that's going to influence things. I've been working as an advisor to the school board here in South Bend, trying to help them better focus on what is important for the schools here. And that's been a very good experience for me to help them see their roles differently.

It's a slow process, I'll have to admit. But for the first time they have now come up with very specific goals and objectives with measurable outcomes and timeframes for the Superintendent, which they had never done before. So we'll see.

JT: That was good. You've done a really, really nice job for us.

PH: Listening through, I have a couple questions.

GS: Yes.

PH: You said that you sort of got started in this field with your interest in cerebral palsy. And I was just wondering how that came about -- the interest in cerebral palsy.

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GS: Right. When I started out as a Phys Ed teacher and Science teacher and a Track coach in Cedar Rapids, Iowa. And I went back to graduate school to pursue physical therapy. And the first year I went into get a master's degree in adapted physical education and rehabilitation. And during that time I worked at the school for -- they called it "handicapped" children for the state, where they brought in children from across the state of Iowa to work there. And cerebral palsy was one of the areas that I saw and worked with. And I learned that there were ways you could influence their posture and their walking, and that intrigued me. And so that's where I decided to focus my doctoral work, on understanding their dilemma more.

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Couldn't cure the brain damage being done, but you could influence how they walked and how they handled themselves. And so that's where I decided I needed to learn more about neurophysiology, study some of the people from England that were making great advances and working with cerebral palsy. And that's how all that started.

JT: Do you have another question?

PH: You talked about outpatient services, and I was wondering maybe how I bet there's been a big change from when you first started to where outpatient services are now. And that would include, you know, in-home services.

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GS: Yeah. One of the biggest changes that happened in the rehabilitation field was the -- in fact for hospitals in general -- was the reduced length of stay in hospitals because it was so costly. And so they started to really reduce them. When I started out dealing with people that came to hospitals for total hips and knees and all those kinds of problems, car accident victims and so forth, we could keep them for weeks, months in hospitals. And so that's how that all started. But -- and the outpatient side was not really that important. And so it was all inpatient treatment. Well, that's totally changed today. Today patients come in for total hips and total knees. They're there for two or three, maybe four days and they're gone rather than for several weeks. And so now we had to shift the focus. So how do we take care of these people because they're not really ready to be that independent yet?

And so we had to shift to the outpatient side and really build up the outpatient programs. And so we started doing that back in the -- certainly back in the '80s -- we realized that was changing with the way Medicare was funding rehab. And so now heavy emphasis on outpatient rehab. And you have to extend the hours now, so you have to open up at 6:00 in the morning, be there until maybe 7:00 or 8:00 at night because people work. And so you had to really shift the whole lifestyle of clinicians today and how available they are to take care of people who have these problems. And they're now available, some of them, seven days a week.

JT: Are there things that we haven't asked you that you think would be important to make a record of? Anything you want to talk about? Personal stories, anything that comes to mind?

GS: Can you give me just a minute to think?

JT: Sure can.

[ Pause ]

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GS: Well, in terms of maybe some closing thoughts on this whole field, particularly as it relates to some of the areas I'm most familiar with where I see disability being dealt with, insurance and government funding has been the primary basis for reimbursement for those services. And insurance companies basically are there

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to make money. I mean, that's their basic motive. Although their advertising is there, they're there for a different purpose; they're really there to make money for their organization. And there's nothing wrong with that, actually, unless it gets to be where that's so prevailing that they lose sight of the mission of what we're trying to do in the country, and that is have a healthy country.

So I would guess that funding will always be a challenge. I tell therapists today that they need to find ways that their services can be affordable without it having to be through insurance or government funding. And a lot of that might be to help people stay well, as opposed to damage their bodies in such a way that they can't live independently anymore. And there's so many signs of that. Probably 80% of what we deal with today is lifestyle abuse in hospitals. And so I think more emphasis on people taking care of themselves early on can do a lot to prevent strokes, heart disease, a lot of things that people end up with disabilities in that are so expensive to deal with that they have to then go to insurances and the government to help pay for it; otherwise it will bankrupt them if they have to pay for it themselves.

So I think more emphasis on lifestyle, helping people stay healthy, taking interest in their own. And I do see changes coming about in that regard where companies today are saying, "You know, employee, you have to take some ownership in your own health. And we're going to give you benefits on premiums if you can demonstrate that you in fact are doing that." And today companies are taking -- running profiles on their employees -- to find out where's the risk involved and providing coaches to help deal with that to prevent themselves from damaging their bodies so seriously. And also on their mind. I mean, there's ways you can stay active with your mind. I mean, telling people they need to retire at 65 I think is a mistake. I was 73 when I retired, and I'm still not really retired because I want to keep my mind active so that I can put off some of these other disabilities that affect Alzheimer's patients and things.

That's just a horrible, horrible thing, which is another form of disability that really seems to be not disappearing but maybe growing even. So if we can stay healthier all through our lives, I think we can reduce the demand for having to deal with disability down the road. And maybe that's an answer that we need to spend more time on, helping people understand that. So those would be some thoughts.

JT: That's good.

PH: You mentioned Alzheimer's, have you had much work with Alzheimer's patients who have come through the rehab at all?

[00:47:48]

GS: Well, certainly when they have other problems like strokes and so forth, then definitely we would be dealing with Alzheimer's patients -- not as the primary reason they're there to see us necessarily but because it's a complicating factor, which always then is more difficult to work with them on their physical side as well. And certainly, dementia is a part of that, that whole field of brain health is an issue that we have in fact opened an institute called Brain Works part of Memorial, to help educate people on how to keep healthier brains, keep them more active. And just another part of trying to stay ahead of the game, going further upstream to help people manage themselves better, and not just abusing themselves like many of us do.

[00:48:54]

And I have to admit there are things I still am not as good about as I need to. But I'm better today than I used to be because I've seen the results of what happens if people misuse themselves.

PH: We pulled into the Brain Works. Remember, we saw that building that said "Brain Works." We pulled around -- we pulled in, turned around. I was wondering what that was.

[00:49:22]

GS: The other thing that -- and this is about Memorial, not necessarily related but maybe -- is that, oh, probably six, eight years ago our CEO felt that we have to be more innovative on how we approach some of these problems that we're dealing with. And so we have a center downtown. It's called the Pfeil Innovation Center. It's part of Memorial's programming, but it's funded by a private individual here locally. And they have people come in from literally all across this country to learn "How do you build more innovation into how you deal with issues in the healthcare field or in any business you might be in?" but we're focused mainly on healthcare. And so we've had a lot of hospitals come in, as well as non-healthcare organizations to learn "How do we apply these principles of innovation to looking at different ways of approaching these problems?"

And certainly, when it comes to disabled we're going to have to be more innovative on how we approach these, as opposed to just going back and doing it the same way with the same kind of funding, etc. All those things are ripe for new ideas to come forth. And you might want to send a team through the center to learn about these people who are involved with disability, even from the state level to learn about, "So how could we look at these problems differently?" And it's a very affordable program, by the way.

JT: That's a good point.

GS: Yeah, it's a two-day full intensive program. It's $150 for two days. You get all your material, your meals while you're there.

JT: Do you have some literature you can send us back?

[00:51:16]

GS: I will, I will. We had Florida Hospital come up from -- they're part of the Disney World organization. I don't know if you're familiar with Florida Hospital or not. But it's trying to become the hospital of the future. And they came through and picked up a lot of interesting ideas as well. But I'll send you the information on that if you'll take a look at it. We just had a group come through Wednesday and Thursday, and I'm among their faculties so I teach one part of that.

JT: Thank you.

PH: Just one more thing about the Driver's Ed.

GS: Yes?

[00:52:02]

PH: It's a program -- how long -- so people would come here with, say, their vehicle and then they would get training? Is that part of it, too, or [inaudible]?

JT: In terms of do they just do the adaptations of the vehicle, or [multiple speakers]?

GS: Oh, they do the training.

JT: So they were taught how do drive their new vehicle as well as the vehicle that's fitted?

GS: Yes. Our program even has one that deals with visual -- people who have difficult visual problems.

JT: So they don't need to start that all over [multiple speakers].

GS: Let me acquaint myself with the program as well.

[ Pause ]

[00:52:54]

PH: I worked with a guy who had physical disabilities. And he had a van equipped. And then one day he told me to take it somewhere to get something, and I'm trying to figure out driving and not having foot controls [inaudible].

JT: Right, right.

GS: This says in here over fifteen years. I can tell you it's been over twenty years that we've had the program, probably closer to 25 years or even more.

JT: So should we just start -- let me just do a conversation about that. Okay.

GS: Yeah.

GS: So what we'd like you to do -- and you've done some of this before -- but basically talk about the program. People come in, they're fitted in their vehicle, they might be taught how to drive or how to use the vehicle. And then as you were talking about the people with visual impairments.

[00:53:48]

GS: Yeah. Our driver rehab and training program is probably over 25 years old. It started in the very early part of the '80s when we were putting together a lot of our specialty programs. But people come here from all around the state actually. And they're assessed for their current level of driving ability. They go through a training program with a person who is certified and licensed to do this. We work closely with the Driver's Ed bureaus for the state so they recognize our program as one that is qualified to do this. In fact, we even have clients that come who have visual problems, and we're able to work with them on helping them with

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special glasses and so forth come up with driving ability. That's a little bit more challenging because people see this as a form of being more independent.

And so they get very concerned because sometimes we have to tell people that they just aren't safe to drive. It may be a stroke patient who has some psychological problems that go along with that, that might be more of a problem than their physical abilities. But all of that has to be evaluated by somebody who understands these processes. And the person we have in there right now has been there for, I know, over fifteen years and is very qualified. But they do use the bioptic telescopic lenses with patients, which is pretty unusual. There aren't many in the state of Indiana I don't believe. You should be interviewing her because she knows this stuff. And I should have interviewed her before I sat down here. But they work with, of course, spinal cord injuries; muscular dystrophy; multiple sclerosis; post-polio syndromes; brain injuries; stroke; learning disabilities; cerebral palsy; spina bifida -- those are all kinds of the patients that would go through our Driver Ed program.

And it's just -- it's an exciting program that gives people at least the sense they can still be independent to some level of -- and that's important, especially as people get older. They're afraid of losing that independence by having to give up their driving ability. I don't know how I will handle that, but I'll have to deal with it at some point myself. And some insurances cover it. Some is covered by, I think, Voc Rehab. And I don't know about Medicaid, if that handles that or not. But anyway, people come, here and we have to assist them in finding housing while they're here. We used to have an apartment that we had on campus for that, but that's long gone with all of our campus expansion. But that is a key program for people with disabilities.

JT: Sounds wonderful.

PH: So how long would they take for them to get through the [inaudible]?

[00:57:17]

GS: That's a good question, how long would it take? It could take probably a week. It depends on the individual client in terms of how quickly they are able to deal with it. Local people, of course, they have a place to stay but when they come in from out of the area, that poses a challenge. We used to take our program to other cities. I don't know if they still do that or not -- they may -- and we could certainly find ought that information as well.

JT: Do you happen to have any pictures, maybe old personal pictures or pictures in your library of some of the things that you've talked about?

GS: I'm sure we do. I asked the guy who used to be the director of our whole rehab program for what they had currently. And so that's what he gave me. What I can go back and do now is say, "So what do you have in your archives that would show some of this stuff?"

PH: Nice to have some pictures of the early days of rehab [inaudible].

[00:58:27]

GS: You know, I do have some of those old photos that I've found. In fact, there are some -- when I retired I went through my files to throw out stuff, and I kept a lot of the old rehab stuff. So let me go back through that, see if I can get you more copies of that, and we can make copies and send it down to you.

JT: It would be really nice to have some visuals along with the talk.

PH: Let me ask [inaudible] you mentioned Voc Rehab, what their experience has been with Voc Rehab?

JT: We can. We know that they've done some vehicles.

[00:59:09]

GS: Yeah. Well, in the early days Voc Rehab was very instrumental in our getting a lot of these programs going, these special programs. And I don't have a lot of current information about that. I just know that that's one source of funding for a lot of these programs. Again, I can probably find that out, but I don't know it today. But they were instrumental in how we got started with some of these programs.

JT: There's a couple people that we know that have vehicles because of Voc Rehab.

GS: Yes.

JT: But they've have them for quite some time. So I, like you, don't know if they're still doing that.

[00:59:50]

GS: Don't know what the funding is for that today. That would be the big thing. Funding got changed so much. Certainly when DRGs came in -- diagnostic-related groups -- for funding of hospitals, patients and hospitals, rehab because it was a different type of patient was exempted from the early days of prospective payment. And they were probably exempted for maybe eight, maybe even ten years. And then finally, Medicare came up with a way of developing a prospective payment for rehab patients, which then allowed for patients to stay a longer period of time but required a lot more documentation about the progress of the patient as well. So funding can really change the whole direction where some of these services go, no question about it because they're not inexpensive and it requires trained people to work with many of these folks.

JT: Again, they have to be available [inaudible] needed.

GS: Exactly. Yeah. Yeah, it's -- the need isn't going to disappear. And hopefully local people will find ways to help support that.

JT: Well, I wrote down one thing that you were talking and I didn't get it all. I don't know if it's even relevant, but you were talking -- when you were talking about the Franklin Covey highlights, when you were talking about the highlights and you said something about disability and that really changed the way you thought. And since this is a disability history project, is there anything that you might have been thinking about that you would want to elaborate? I'm not even sure I got it down correctly.

[01:01:590]

GS: Well, let me tell you why I think the initial work that I did with Franklin Covey made a difference on how I looked at things, including the area of disability. The fundamental habit of the Seven Habits is to be proactive and stop being reactive and how you looked at things. It was a choice that we all have in terms "Are we going to be a player in a game, or are we going to be a victim in the game?" And if you can get people to understand that they have a choice, they can be a player -- regardless of what their situation is, what their color is, what their disabilities are, what's going on -- they have a choice. If they choose to be a player, then they can go ahead and they begin to plan a life, which is habit two: "How do you build a mission a vision for yourself?" But if you don't want to be a player, no sense in having a vision because you're just going to be a victim.

And so the next thing is so what's your vision for yourself? And then we help people build a vision. And then we say, "Now that you've got the vision, how you going to make it happen?" That's habit three. Habit three is, "How do you put the things first in your life that will make your vision become a reality?" And we help them on how they sort out how they spend their time. And they say if you can do those three things, you now have private victory over yourself. You now can be an independent person. But you need those three habits. But now you're not an individual by yourself; you play in a world. So how do you play in the world? And we say, "Now with you need to play with other people on a win-win basis looking for mutual benefit." And if we can get people to understand that -- even people who aren't disabled -- now we've got people who can start to look at "How do we help people who don't have as much we have?

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How do we find a mutual benefit to include them in that as well?" And so if you're looking for a mutual benefit, then people want to collaborate. And that's by collaborating you seek first to understand. What's the other person's view before you make your view known? Well, now you're starting to build some collaboration with people because now you're going to be exchanging ideas to see if you can build better opportunities for everybody. And if you can do that, and you're successful, now you've reached synergy, which means your idea and my idea together if we build upon them, can actually be a better idea than what either one of us had together. That's habit six. That's synergy. And then we say, "Now, how you going to keep all this going in your life?" That's habit seven, sharper the saw on the physical, mental, social-emotional, and spiritual basis.

And so you have to keep working on yourself in those four areas. If you do, you'll be a complete person, and you'll sustain yourself and be highly successful in life. I mean, the principles are so simple, they're beautiful. And if people adopt those -- I've always said if I can have people who integrated the Seven Habits in their lives, I'll have an unbeatable team.

JT: Well, thank you.

GS: So that's what I think about when I think about community service: How do we help people embrace those simple -- and they're all based upon life principles that are found in, I think, every religion in the world.

[01:05:49]

JT: That was really nice. Can we think of anything else?

GS: Okay. When we were talking about bringing into the school curriculums things that would help people begin to understand the issues of disabilities, when they started to mainstream more children into the school systems was a good beginning at, I think, trying to help people accept them as just part of the society. I mean, they are just as good as anybody else and as productive. When I started out at the School for Handicapped Children in Iowa City, all the children were bussed in from around the state and it was a residency. And it was felt like they had to take them out of the schools and put them in a facility. Then that changed, and everything got pushed back to the communities to try to deal with the challenges in their own schools.

[01:06:55]

My wife is an occupational therapist, and she worked for the school systems here. And she had to travel from school to school to work with the teachers and with students who were -- that needed occupational therapy support while they were going through training. That begins to establish people with these challenges -- physical and emotional challenges -- by trying to keep them in society, a part of society but helping them be successful in that process. And so that's a good part, I think, that has started already. And if we can even strengthen the curriculum so that it's dealt with, I think, more overtly than it is today -- it still isn't talked about as much as I think it needs to be and can be in the curriculum.

But at least there's a start. And it's going back in the right direction, trying to mainstream kids back in the world. Because if they have it when they leave school and become adults, then there's more of an opportunity for them to try to figure out, "So how do we help these people exist in this world that seems to be focused around normality?" -- whatever that is.

[01:08:02]

JT: Well, I've enjoyed our conversation.

GS: Well, like I said in the beginning, I didn't know quite what you were wanting or needing, and hopefully you got something there that would be helpful.

JT: We got a lot of good information. And you are our third interviewee, so.

[END OF INTERVIEW]