Cooperative Planning for Discharge From Geriatric Institutional Care*

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The community . . . (begins) to see the institution as part of a continuum of services rather than the only and/or final solution to their problems.

The Baltimore Jewish community has long attempted to offer a coordinated service to the elderly. Efforts have been made to offer a continuum of services which would allow the elderly choices among a variety of services as needed and to move freely among the Associated Jewish Charities agencies as their needs require. There is no single point of entry into the system, but once in the system, it is hoped that the client and his family can avail themselves of whatever services are necessary for his well-being. Similarly, we have tried to attain such coordination among the client, his family and the agency that they work toward a common goal mutually agreed upon and in which each member knows his role.

The following project is a description of a coordinated effort between the Levindale Geriatric Center and the Jewish Family and Children's Service.

It has become accepted practice in some communities for the family service agency to perform the intake function for the community old age home. This practice is usually acceptable where the old age home has no social service department of its own. However, it is unusual for a family service agency to perform the discharge function. In fact, until recently, there were not too many elderly patients discharged from nursing homes.

The Levindale Hebrew Home changed its name and function several years ago and became a multi-level nursing home and chronic disease hospital. It also incorporated into its service a rehabilitation unit supervised by Sinai Hospital. The Levindale Hebrew Geriatric Center and Hospital, Sinai Hospital and the Jewish Family and Children's Service are all constituent agencies of the Associated Jewish Charities and Welfare Fund of Baltimore.

A few years ago, the Department on Aging of the JFCS undertook an experimental project and signed a contract to serve as social work consultants to a chain of proprietary nursing homes in the Baltimore Metropolitan area. This chain of nursing homes was employing social work designees in their homes. Most of these employees were also recreational workers and none of them had any experience in social work. Three staff members of the JFCS were oriented to the nursing home system so that there would be adequate coverage during the vacation or illness of any of the three. One staff person was selected as the principal consultant. As a result of these experiences, we learned a great deal about nursing home regulations, staff problems, and attitudes of patients. The nursing-home chain management was so pleased with the service, they hired our staff person to be their consultant concerning issues of "Quality of Life."

This experience also served to prepare the JFCS administration for our next experiment. The JFCS and the Levindale Geriatric Center and Hospital had worked closely together for many years. Board members from each agency were invited to sit on the others' board. Before Levindale changed its function, members of the staff at JFCS were allowed to participate in the professional admission committee meetings.

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With the advent of admissions of the short-term rehabilitation patient, the Levindale staff faced a sharp increase in the need for discharge planning. In the spring of 1976, JFCS and Levindale met to discuss the possibility of integrating a family service worker into the institutional system.

We agreed that introducing the family service worker into the institutional system would offer the client and his family continuity of service. The family service worker may have known the patient and his life style before he entered the institution and may be following him as he returns to the community.

The family service worker meets the patient and his family on the day of admission. This serves to emphasize the temporary nature of his stay. It also emphasizes the need to begin discussing discharge plans as soon as possible. One of the difficulties faced by the family service worker was the difference in time frame. At the family service agency, clients are usually seen on a weekly basis unless there is an emergency. In the institution, it is necessary to see the patient and his family quickly and to gather the necessary psychosocial and medical information as soon as possible since the patient may be staying for only two weeks.

The family service worker is likely to have a deeper knowledge of the community and its resources than the institutional worker because she works intimately with them everyday. She can look at the living environment to which the patient is to return and make suggestions about such things as moving the patient's bed downstairs or removing the scatter rugs or posing the question, will the patient be able to walk three steps leading to the porch. We also found that the family service worker tended to be less protective of the patient than the staff workers in the institution. The former have been more exposed to how handicapped persons have been able to cope with the daily realities of living in the community and know that the struggle to survive can be life-giving.

The family service worker has been able to convince the institutional staff that sometimes the patient should not return to the community because he would be likely to regress. We have seen, on several occasions, patients who have seemed acutely ill make a miraculous recovery in the institution. The security of the institution and having their severe dependency needs met had relieved their anxiety and allowed them to function in a healthier fashion.

Initially we began by assigning one caseworker to this project. She also continued to carry some cases of non-institutionalized elderly. We felt it was important that the caseworker continue to feel part of the family agency staff. She participated in departmental and agency meetings and was supervised by the associate supervisor of the department. At the same time, she was indoctrinated into the institutional setting, attending meetings there and was treated like a staff member. We were fearful that she might begin to think like an institutional worker so we were careful to build a structure that would allow her to remain essentially a community worker.

It soon became apparent that there was a difference in perception about the patient's readiness for discharge between the two agencies. The family service worker having seen handicapped, ill people cope in their own home, was less protective in her attitude. The patient in a hospital tends to take on the "sick role." The patient often regresses emotionally and becomes dependent upon staff. The staff, therefore, tends to see the sick part of the patient rather than his or her health. The family service worker, on the other hand, may see a more independent patient since he may express to her his wish to return home when he is well. In any case, the family service worker was willing to allow the patient to take risks in living which sometimes dismayed the institutional staff.

Although, in the beginning, the two staffs had a number of disagreements about plans for patient's discharge, as they learned to trust each other, both sides began to alter their perceptions to some degree. The family service worker learned a great deal about illness and

its physical and psychological effect upon the patient. The institutional staff learned the specifics of community resources. The institutional staff knew what resources are available in theory, but the family service worker knows exactly what is demanded of a resident in a group home or just how much support system is readily available in congregate apartment living.

The family service worker was able to individualize the patient in the institution and make discharge plans suitable for his life style. She gave emotional support to the family so they were not so fearful about the patient's return home. Families who at first resisted the idea of the patient's return to the community were able to accept the idea when they knew that the family service worker would help share the responsibility and would continue to follow the patient after he left the institution.

As the service grew, it became necessary to introduce another family service worker into the project. After a year, the original caseworker asked to be relieved of her responsibility. She said she was suffering from "burn-out." We decided to rotate the assignment through the workers in the department. It was felt that if everyone was familiar with the institutional system, it would allow for continuity of service and provide for vacation and sick coverage. It became apparent that not everyone was comfortable working in an institutional setting where everyone is very ill. It also appeared that the younger workers suffered less from burn-out than the more mature workers whose parents were about the same age as the patients in the institution.

Despite these problems, the project has worked well. In 1977, there were 86 discharges—71 patients went home, 3 patients went to an acute hospital and 12 others went to nursing homes. In 1978, there were 97 discharges—88 returned home, 4 went to an acute hospital and 12 to nursing homes. Many of the patients who returned home required the support of home health aides or day-care. Many of these patients are still being served by the family agency which offers them and their families counseling and emotional support as well as such concrete services as are needed.

The project has worked so well, we have now signed a contract to supply 40 hours of casework service weekly to Levindale Hebrew Geriatric Center and Hospital.

Of course, there are always problems in starting a new program. The family service worker had to learn to see patients within 24 hours of admission and formulate tentative discharge plans, which of course, frequently did not work out. Families would state they would take the patient home when they had no real intention of doing so. They were often frightened at the responsibility of caring for an aged, sick relative. There were times when the patient grew worse and the family was upset at not being able to have the patient return home. Sometimes the patient had to be discharged within 24 hours and there was no satisfactory plan that could be arranged because of a lack of suitable community resources.

We feel that the project has been beneficial to the patient. It offers a holistic approach to his problems, and offers him a wider range of plans. The community has begun to see the institution as part of a continuum of services rather than the only and/or final solution for their problems. In addition, it has fostered better inter-agency cooperation and added to the knowledge of the staffs of both agencies. We believe that it has resulted in a better coordinated and superior service to the Jewish elderly.