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A descriptive study of discharge planning for "at-risk" elderly patients at Grady Memorial Hospital

Jenelle Ann Savoy
Clark Atlanta University

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This was a descriptive study of the discharge planning for "at-risk" elderly patients at Grady Memorial Hospital. The researcher also examined variables associated with the discharge planning process. The variables were: 1) efforts of the medical social workers in discharge planning; and 2) presenting factors necessitating help for the "at-risk" elderly patients.

Findings revealed that 73% of the "at-risk" elderly patients had successful post-discharge continuing care placement. Thus, indicating that the medical social workers were also successful in their discharge planning efforts. Of the elderly patients placed, 17% needed
twenty-four (24) hours skilled nursing care, versus 3% who needed intermediate (lower level) care. In addition, 76% of the "at-risk" elderly suffered from multiple medical problems. Eighty percent of the elderly patients had families who were unable to provide post-hospital care; 7% had families who were unwilling to provide post-hospital care, and 13% had no family to provide care. Only 1% of the "at-risk" elderly patients needed continuing care placement due to elder abuse. A significant number (53%) of elderly patients were found to have no impaired mental-functioning, many received medical insurance funding, 47% medicare, 33% medicaid, and 20% social supplemental income.
A DESCRIPTIVE STUDY OF DISCHARGE PLANNING
FOR "AT-RISK" ELDERLY PATIENTS AT
GRADY MEMORIAL HOSPITAL

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

JENELLE ANN SAVOY

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 1992
ACKNOWLEDGEMENTS

I would like to give God the glory for His never-ending love. I would like to give thanks to my family for their love, support, and encouragement in this effort. A special thanks to Dr. Mamie Darlington and Mrs. Kay Holloway for their expertise and guidance. I could not have produced this thesis without their unfailing support. Lastly, I would like to acknowledge all those who believed in me and this thesis project.
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CHAPTER 1
INTRODUCTION

A medicine man once wrote: "It is necessary for the physician to provide for the sick man himself and for those beside him, and to provide for his outside affairs."\(^1\) These immortal words of Hippocrates (450 - 345 B.C.), the Greek father of medicine, embodies a steadfast truth. The truth through rationalization, that the practice of medicine can not exist in a vacuum, rather it must recognize and become responsive to the inflictions of societal ills on victims, who exhibit symptoms.

The Charity Organization Societies (COS), of the early nineteen hundreds, were considered instrumental in addressing the needs and concerns of the poor. The persons primarily responsible for care of the social needs of the patients were called Almoners. Almoners, extracted from the word eleemosynary - meaning alms, were considered to be the first social workers in hospitals.\(^2\)

Miss Mary Stewart of London, England has been recorded in history as the first hospital almoner. Miss Stewart was employed by Sir Charles Loch, secretary of the London Charity Organization Society (LCOS). As a result of her work affiliation with Sir Loch, Miss Stewart was
commissioned to work with the Royal Free Hospital for three months to demonstrate the effectiveness of an "almoner." During her tenure, she was to maintain three objectives: (1) prevent abuse of the hospital by persons able to pay for medical treatment, (2) refer patients already in receipt of parish relief, and such as, are destitute to the Poor Law Authorities, (3) recommend suitable persons to join Provident Dispensaries. In just a few months, Miss Stewart demonstrated to the hospital and the patients, the worth of social treatment for problems that induce illnesses which hinder patients from getting well.

After studying the Almoners Movement in England, Richard C. Cabot, M.D. of the Massachusetts General Hospital in Boston, recognized that treatment all too often dealt solely with the patient's physical ailments, with little regard given to social aspects impacting on the patient's functional abilities. As he himself describes it:

So the doctor's mind is absent from certain human aspects of his patient's lives merely because his attention is so strongly concentrated upon disease.

Dr. Cabot began to rationalize the need to address medical and social problems as an intergrative treatment modality. He also reasoned that this form of treatment approach dispensary. He often called this approach the
three forms of medical social work. The three forms of medical social work were derived from earlier activities performed by almoners. Such activities included:

1. Aftercare home visits to report follow-up recommendations on insane patients in order to detour relapses.

2. Assessments of hospital patients' ability to meet their financial obligations incurred as a result of hospitalization. The focus was to sift-out persons claiming destitution who abuse the charitable systems.

3. Visiting nurses were responsible for the care of patients who were isolated in the home with contagious disease who found themselves considering the economic and mental difficulties in their work approach.6

These earlier forms of medical social work, identified by Dr. Richard Cabot, were regarded as the earliest evidence of the process we now call discharge planning. For the purpose of this study, discharge planning will be defined as the exploration of patient family problems directly related to post-hospital care and planning and arranging for that care in order to consolidate gains made during hospitalization.7
Statement of the Problem

During the dawn of the 20th Century, the most combative challenge for medical (hospital) social workers was controlling the rate of infectious diseases, such as tuberculosis and syphilis. Since these illnesses had no known cure, the increase in outbreaks had a significant effect on the mortality rate. The average life expectancy in the early nineteen hundreds was 40. The science of modern medicine has not only advance to create vaccinations for such illnesses, but has produced phenomenal new-age technology which can prolong life. Today the average life of expectancy is 71. Researchers predict that by the year 2030 more individuals will be over the age of 65 (23%), than under the age of 18 (18%). Therefore, a new and greater challenge is on the horizon for medical social workers.

The challenge lies in preparation to meet the special needs of this swollen population. It would only stand to reason that, if the aged population is living longer lives, then a great many will incur problems with their health. The aged will be plagued by multiple illnesses and injuries. As a result, a large proportion of the persons hospitalized with chronic medical problems will be the elderly. Many will have diminished family support systems and limited financial resources. They will be labeled high-risk patients for discharge.
To complicate matters further, hospitals have already begun to approach the discharge planning process from a regulated perspective. Diagnostic Related Groups (DRG's), a reimburse payment system, have set forth specific guidelines for medical health care facilities regarding decreasing lengthy hospital stays in order for the facilities to receive maximum financial compensation. Guidelines, such as these, place considerable emphasis on execution of a discharge plan within a particular time-frame. Because there is considerable pressure to stay within these time constraints, medical social workers may often be forced to hurry the process through even at the expense of not adequately meeting the elderly patients' post-hospital needs.

Grady Memorial Hospital, one of the largest hospitals serving the indigent population, has witness the explosion of the elderly population who receives acute medical care. In 1991, 61% of the population serviced at Grady Hospital were age 60 and older. The most common diagnoses among this population were: congestive heart failure, diabeter/end stage renal disease, cardiovascular accidents, and hypertension. Ninety percent of these geriatric patients were black; 85% received either Medicare/Medicaid coverage; and 93% were at the poverty income level. Of the reports published through the hospital on problem placements, 86% of the population were
elderly persons who had little or no family support systems available to meet their daily care needs. As a result, many required institutional placement. Discharge planning for high-risk elderly patients shall require considerable time, effort, and resources to locate maximum support services. Medical social workers who are concentrated in gerontology, will need to examine the discharge planning process very intensely to assess if the medical and psychosocial needs of this vulnerable population are truly being met. Screaming for high risk patients will also require greater effort. Through these methods for evaluation, Discharge Planning will become a more effective and qualitative process for medical social workers when working with the elderly.

Discharge Planning, at Grady Memorial Hospital, is described as a planned program of continuing care in order to meet the patients discharge needs. The procedures utilized for formation of these planned programs include:

1. Identification of high-risk patients upon admissions
2. Notification of proper inter-hospital services
3. Development and coordination of multidisciplinary discharge plans
4. Implementation of discharge plan
5. Actual Discharge
The goal of the discharge planning, at Grady Memorial Hospital, is to provide for the continuity of care post-discharge and to enable patients to perform at their optimum level through services which address the physical, emotional, and social needs of the patient.

Purpose

There is a lack of information regarding the elderly and the discharge planning process. Because of this oversight, more materials need to reflect this process and the impact it has on this vulnerable population. The purpose of this descriptive study was to review the discharge planning process. Areas included in this review were as follows: 1) efforts of the medical social workers in discharge planning; and 2) presenting factors necessitating help for the at-risk elderly patients. Overall, the researcher studied the discharge planning process of the elderly over the period of 1898, 1990, and 1991 to determine if the post-hospital needs of the elderly were successfully met.
ENDNOTES


6. Ibid.


9. Grady Memorial Hospital. Fulton County.

10. Ibid.
CHAPTER II
REVIEW OF THE LITERATURE

Related Research

In a review of literature regarding the discharge planning process of the elderly within medical health care facilities, three major themes seem to resurface:

1) adequacy of discharge plans for the elderly patient;

2) impact of social work involvement in the process of elderly patient discharge; and

3) degree of patients' family participation in the discharge planning process.

In a study conducted in by Lindenberg and Coulton, findings suggested that of the patients who received social work assistance after discharge, with common diagnoses such as: cardiovascular disease, cancer, orthopedic problems and cerebrovascular accidents, 23 were found to have a high level of impaired functioning where it concerned carrying out basic tasks of daily living. The correlation was attributed to the inadequacy in addressing the patients' post-hospital needs for: financial assistance, social activities, and environmental modification.
Howell, Proctor, and Mui conducted a related study on the adequacy of discharge plans for the elderly patient.² Three hundred and ninety-five (395) older patients, average age 78, were used to determine how adequate the plans for discharge were in meeting their medical and psychosocial needs. All subjects were Medicare insured, and most had a medical diagnosis of either cerebrovascular accident, congestive heart failure, or hip fracture. Twelve social workers participated in the study and were asked to rate on a scale from 1 to 5, to what degree the medical and psychosocial needs of the patients could be met. The findings indicated that factors such as: whether the patients returned home rather than be institutionalized, financial complications, difficulty in working with the patient’s family, and patients who were either confused or diagnosed with congestive heart failure contributed to less adequate results in meeting the medical post-hospital needs of the patients. Variables which produced more adequate results in plans to meet the psychosocial needs were patients who had spouses and/or sufficient care giving network when discharged to the home. Overall, 70% of the plans were rated as more than adequate in meeting the medical and psychosocial needs of the patients, while 25% were rated as less than adequate plans. The authors noted that this placed a large population of older persons at medical and psychosocial risk at discharge.
Since social workers have traditionally been placed with the responsibility of executing discharge plans for in-patients, persons hospitalized, considerable skill, time, and effort are placed in this area. Coulton and Vielhabor concluded that social workers involved more time in considering the patients feelings with regard to discharge plans rather than nurses who were also involved in the process.\(^3\) Twenty-seven percent to 65% of the discharge planning process time revolves around dialogue by the social workers with the patient on this feelings. The role of social workers throughout the discharge planning process has proven effective in reducing unnecessary delays in leaving the hospital.

In some instances, patients may have very little involvement in the Discharge Planning Process, and yet are confident that their needs were met. Of the patients surveyed after their hospital discharged, Wolock, Nicholas and Russell found that the majority indicated that they were pleased with the social work services they received.\(^4\) Although, half were given little to no choice about the plans concerning discharge.

Coulton, Dunkle, Haug, Chow, and Vielhaber decided to conduct a study to determine how patient's perceived control over the decision making affects outcome.\(^5\) The studies population consisted of a sample of 264 hospital patients with an average age of 75 years. The researchers
measured the patients' perception of control over their discharge plans to assess if the patient felt they had control over the plans or whether they believed others were responsible for decision making on their behalf. This was determined on a pre and post discharge basis with most of the patients being discharged to their homes, (60%). The study concluded that half, (50%), of the sample population believed they had had control over decisions that were made regarding discharge. Forty percent of the patients responded that they had some input in their discharge planning, while (10%) felt they had absolutely no involvement. The authors concluded that by allowing patients to participate in decision making regarding their discharge plans could enhance the outcome of care.

Because patient's right to self-determination is such an important component in coordinating an effective discharge plan, social workers have exercised caution not to allow barriers to form which inhibit elderly patients from communicating their needs and concerns. Abramison studied a random sampling of 148 elderly patients from five acute care hospitals in Philadelphia and two in New York. The subjects were comprised of largely women (65%), widowed individuals (40.5%), white (70%), and persons over 80 years of age (35%). Ninety percent have family or significant other persons participating in the discharge planning process. The findings concluded that most of the patients
actively participated in the discharge planning process (71%); however, patients with poor mental and physical conditions participated less. Ninety percent of the patients with family, actively participated in the discharge planning, as well.

The United States Bureau of the Census, (1985) projected that by the year 2030, 22% of the total American population will be older than 65. With implications of an increase in the number of elderly individuals needing care, Cox and Parsons state that facilitation of family mediation by the social worker is essential to creating a mutual satisfactory care-giving plan for the elderly. The authors argue that social workers, particularly those in Gerontology, should attempt to engage the individual family members in participation in the problem solving process. Families who are often in conflict over matters such as: the burden of care-giving responsibilities on a single family member, the lack of financial resources needed to adequately meet the needs of the elderly family member, and the isolation of certain members of the family on care-giving decision, seek to find collective resolutions of these dilemmas in order to arrive at a more effective care-giving plan for the elderly member.

Researchers also note that multidisiplinary team recommendation on the discharge plans of geriatric patients has significant impact on discharge placement and
rehospitalization (Saltz, McVey, Becker, Feussner, and Cohen). These teams are typically comprised of physicians, social workers, nurses, home health care personnel, and the utilization review committee whose primary task is to devise planned programs in order to meet the continuing care needs of admitted patients.

Discharge Planning is considered an essential component of service delivery for many health care facilities. Hospitals, in particular, have developed department services areas whose primary task is to coordinate discharge for its patients. Georgia Baptist Hospital, of Atlanta, has created a department called Quality Resource Management Team. The Quality Resource Management Team is responsible for coordination of internal-external resources services needed to sustain the patient independent functioning in a post-hospital environment. This team is comprised of 9 nurses and 6 social workers all coordinating discharge plans for an average of 100 patients per day. All medical disciplines involved in the patients immediate treatment are responsible for documentation, in the patients medical chart, of any perceived treatment care needs. They then must consult with the Quality Resources Management Team for services. Their goal is to provide quality care at cost-containment for discharge.

Hospitals who handle larger volumes of patients cases, have discharge planning components similar to Grady
Hospital. DeKalb General Hospital handles 300 case volume. The three-person social work staff must evaluate every patient, including infants, for potential discharge needs. This must be accomplished within 24 hours of admissions. The goal of early screening is to identify high-risk patients who have little or no medical insurance, critical diagnosis, vulnerable age group, and little to no family support are recognized as individuals whose disposition may pose a problem and are therefore identified as high-risk. The social workers do provide counseling in addition to the treatment services needed. The discharge planning goal of DeKalb General Hospital is to meet both the psychosocial and physical needs of the patients.

Southwest Memorial Hospital, also of Atlanta, attempts to evaluate every admitted patients within 48 hours of admissions to assess if any discharge needs are present. The two social workers are responsible coordinating discharge plans for a minimum of 60 patients per day. The social workers meet weekly with a interdisciplinary team, consisting of: nurses, doctors, utilization review personnel, dieticians, chaplains, doctors, and a home health care coordinator, to discuss each patients plan for discharge and what services are needed.
Definition of Terms

Elderly: A person 60 years or older.

At-Risk Elderly: Individuals, ages 60 years or older, who either lack personal resources and/or is unable to participate in the problem-solving process due to a physical and/or mental impairment.

Discharge Planning: The exploration of patient family problems directly related to post-hospital care and planning and arranging for that care in order to consolidate gains made during hospitalization.

Continuing Care: Post-hospital care provided to patients returning home after hospitalization through the community services.

Theoretical Orientation

The ecological perspective, suggests that, as social workers, our social purpose is to improve the quality of transactions between people and environments so there is a better match between people’s adaptive potential and environmental qualities.9

It is necessary to understand that much of the discharge planning efforts are to create a goodness-of-fit between the elderly patient and his post-hospital environment in order that he may maximize the medical gains attained through hospitalization. Providing continuity of care, post-discharge enables the elderly patients to perform at their optimum level.
In order for there to be a goodness-of-fit between the elderly and his post-hospital environment, there must first be coordinated efforts between systems which impact the discharge planning process. Hospitals are focused on the application of medical treatment to illnesses. However, in order for elderly patients to sustain the success of the treatment in the post-hospital environment, cooperation must exist between the family and community systems. Hospitals, families, and communities must interact in a collective effort to resolve post-care dilemma which effects the discharge planning of the elderly. If any one system becomes dysfunctional then the supportive transaction which occurs between each system becomes impaired and retards the outcome of discharge planning for the at-risk elderly. If the elderly patient receives treatment for his illness, but is unable to receive post-hospital care from the family to meet his needs, then community care options, such as nursing home placement, becomes the options utilized.

Summary

Although much of what has been written regarding discharge planning and the elderly reflects the impact of involvement of social workers, multidisciplinary teams, and families on the outcome of care of the elderly; very little literature outlines the actual discharge planning process
that the elderly patient must incur. The purpose of this study was to describe and emphasize the discharge planning process and the areas of deficiencies and their impact on the lives of the elderly.
ENDNOTES


4. Ibid.

5. Ibid.


CHAPTER III
METHODOLOGY

Research Design

This study is a descriptive study which focused on the process of Discharge Planning of the Elderly at Grady Hospital. The goal of this study was to describe the discharge planning process. The following variables were also examined in the study of the discharge planning process: 1) the efforts of the medical social worker in discharge planning; and 2) presenting factors which necessitated help for the at-risk elderly patient.

Sampling

The random sampling was used. The sample consisted of a population of at-risk elderly patients placed on the Problem Placement Report published by Grady Hospital. The sample of 75 persons selected were all medical patients of advanced age at Grady according to the random number chart.

Data Collection

The data utilized for this study was secondary data. The Problem Placement Report, a compilation of patients who could not be placed immediately due to lack of appropriate
placement, was used to obtain the names of individuals who were in need of continuing care services. The individuals were selected from the report based on identified high risk factors such as: age, diagnosis, reason for placement, and social support system. The study was based on a review of three years, 1989-91, focusing on identified objectives.

Data Analysis

Frequency distribution was used to compile raw numbers and percentages in this descriptive study. A manual calculation of the raw numbers to obtain a percentage was performed. Grady Memorial Hospital Policy and Procedures manual on classification of "At-Risk" Patients was also utilized for identification of at-risk variables for each patient.
CHAPTER IV
PRESENTATION OF RESULTS

This Chapter utilizes the secondary data obtained from Grady Hospital to address the following questions:

1) Are continuing care services meeting the needs of the elderly patient, based on discharge efforts of the Medical Social Workers of Grady Hospital?

2) What criteria is used to isolate the high risk elderly patient at Grady Hospital?

3) What are the presenting factors which may necessitate nursing home placement for the high-risk elderly patient?

Table 1 presents the frequency distribution of the discharge efforts of the Medical Social Worker at Grady in seeking continuing care placement for high-risk elderly patients. The efforts were measured by whether the social workers could secure continuing care placement, as needed by the patient. The findings demonstrated that of the 75 patients, 73% were successfully matched with appropriate continuing care facilities.
Table 1
Frequency Distribution of Discharge Planning Efforts

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful</td>
<td>55</td>
<td>73%</td>
</tr>
<tr>
<td>Unsuccessful</td>
<td>9</td>
<td>12%</td>
</tr>
<tr>
<td>Died</td>
<td>11</td>
<td>15%</td>
</tr>
</tbody>
</table>

Table 2 presents the frequency distribution of Type of Continuing Care Needed. Nearly 17% needed skilled (24-hour) nursing care, while only 2% required general intermediate care. The type of care needed by 80% of the elderly discharged patients was not indicated in the data source.

Table 2
Frequency Distribution of Type of Continuing Care Needed

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled</td>
<td>13</td>
<td>17%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Not Determined</td>
<td>60</td>
<td>80%</td>
</tr>
</tbody>
</table>

Table 3 presents the frequency distribution of Patients with special medical problems that required a major change in their current living arrangements. Major medical problems were defined as multiple diagnosis (3 or more) or Chronic Illness. Nearly 76% had multiple diagnosis or a Chronic Illness. Most had illnesses such
as: dementia, congestive heart failure, strokes, and hypertension. Diagnoses such as these placed the patient at high-risk for discharge.

Table 3

Frequency Distribution of Patients With Major Medical Problems Requiring Major Changes in Living Arrangements

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57</td>
<td>76%</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>24%</td>
</tr>
</tbody>
</table>

Table 4 presents the frequency distribution of patients who had impaired mental functioning. Impaired mental functioning was defined as either having one of the following diagnosis: dementia, alter mental status, or Alzheimer's disease. A little under half suffered from impaired mental functioning which resulted in their placement in the high risk category.

Table 4

Frequency Distribution of Patients Who Had Impaired Mental Functioning

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35</td>
<td>47%</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>53%</td>
</tr>
</tbody>
</table>

Table 5 presents the frequency distribution of families available to assist patients in post-hospital care. The findings demonstrated that a large percentage
(80%) were unable to assist with caretaking responsibilities of their elderly family member because of the level of medical skill care required. Nearly 13% of the elderly patients had no family. While 7% of the families expressed they were unwilling to care for their elderly family member. These factors contributed to the need to seek continuing care placement for the high-risk elderly patients.

Table 5

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Unable</td>
<td>60</td>
<td>80%</td>
</tr>
<tr>
<td>Family Unwilling</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>No Family</td>
<td>10</td>
<td>13%</td>
</tr>
</tbody>
</table>

Table 6 presents the frequency distribution of patients who may have been the victims of neglect, exploitation, or abuse. A mere 1% of the elderly patients were in need of continuing care services based on this factor.
Table 6
Frequency Distribution of Patients Who May Have Been The Victim of Neglect, Exploitation, or Abuse

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Exploitation</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Abuse</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Non-Victim</td>
<td>74</td>
<td>99%</td>
</tr>
</tbody>
</table>

Table 7 presents the frequency distribution of patients medical insurance status. The majority of the patients, according to the findings, received some form of medical insurance. Forty-seven percent (47%) received medicare, thirty-three percent (33%) of the patients received medicaid insurance, and twenty percent (20%), had social supplemental income.

Table 7
Frequency Distribution of Patients Medical Insurance Status

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>25</td>
<td>33%</td>
</tr>
<tr>
<td>Medicare</td>
<td>35</td>
<td>46%</td>
</tr>
<tr>
<td>Social Supplemental Income</td>
<td>11</td>
<td>20%</td>
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CHAPTER FIVE
SUMMARY AND CONCLUSION

The findings were informational in understanding the variables associated with discharge planning. The variables associated with discharge planning were: 1) Discharge efforts of the medical social workers; 2) Continuing Care Needs; 3) Chronic Illnesses; 4) Impaired Mental-Functioning; 5) Family Availability; 6) Elder Abuse; and 7) Medical Insurance Status. This researcher gained a better perspective of the high-risk needs of the elderly and their families response in addressing those needs.

Explanation of the variables are as follows:

**Discharge Efforts of Medical Social Workers**

Based on the research data, it is evident that the social workers were extremely successful in their discharge efforts to effect placement for the targeted elderly population. This is validated by 73% being successfully placed; 15% who expired and 12% remained as disposition problems (unable to locate adequate placement).

**Continuing Care Needs**

From the reported data, it appears that the frail elderly require skilled 24 hours nursing care, which is evident by the 17% who needed skilled care compared to the
3% who required intermediate care (lower-level of care). However, a full analysis could not be determined due to the 80% of patients whose level of care had not been indicated. As predicted in the literature, the elderly will suffer multiple debilitating illnesses as they grow older which will require greater medical attention.

**Chronic Illness**

The research findings indicated that many of the elderly persons are in fact living longer, however many are experiencing chronic and multiple illnesses. Seventy-six percent (76%) of the population suffered from multiple medical problems.

**Impaired Mental-Functioning**

Society has often associated aging with impairment of cognitive functioning. However based on the data obtained from this researcher's study, the evidence speaks quite the contrary, 53% of the patients had not experienced any type of impairment to their mental functioning. Thus suggesting that many of the illnesses incurred by the elderly patients are physically debilitating rather than mentally.

**Family Availability**

Based on the research data collected, there appears to be limited family availability relative to providing post-hospital care for the elderly patient. Eighty percent (80%) of the families of the studies population indicated that they were unable to provide care for their elder
family members; thirteen percent (13%) of the elderly patients had no family; and seven percent (7%) had families who were unwilling to provide care. As reported earlier, many of the elderly will be faced with diminishing family support in growing older. Thereby, placing them at greater risk for institutional placement.

**Elder Abuse**

Elder abuse is on the rise, as we face many societal ills - unemployment, substance abuse, mental illness, stress, etc. Many elders are living their latter days while suffering in silence/according to the literature review. However, for the purpose of this study, only 1% were suspected neglect cases.

**Medical Insurance Status**

As anticipated, most of the research reflected that the elderly patients were funded and had insurances of either medicare 47%, medicaid 33% or social supplemental income 20%.

**Limitations of Study**

This study utilized secondary data to obtain information relative to the discharge planning of the elderly patients at Grady Hospital. Because this study used a small sample, the findings cannot be generalized to other elderly populations. Also, a significant amount of data was incomplete, which further limited the study. Lastly, the only available information was obtained from
social workers, and did not represent the information from the families and/or patients who were being directly affected by discharge planning.

Suggested Research Directions

This researcher suggests that this area is under-researched and needs further investigating. Thus, there will be a need to interview social workers, patients, and families who are directly involved in the discharge process. This will allow a diversity of perspectives on discharge planning related to each group. Interviewing social workers would provide positive knowledge and recommendations for improving the discharge planning process. Patients could provide assessments of beneficial and non-beneficial service as it affects their lives. Finally, families interviewed could help to develop community services which would either allow them to provide caretaking services in the home or allow the elderly family members to remain in the home.
CHAPTER SIX
IMPLICATIONS FOR SOCIAL WORK PRACTICE

As we move into the 21st Century, it is clear that service needs and options of the elderly are of paramount importance. Demographics reveal a steady increase in the number of elderly patients. The fastest growing segment of the population is the 75 age group. By the year of 2030, it is projected that acute illnesses will be replaced by chronic illnesses, which further debilitate the elderly.

Concomitantly, as our elders become more chronically ill, health care services will need to be expanded to meet these needs. Grady Memorial Hospital, is one of the largest hospitals serving the indigent population, and has witnessed the explosion of the elderly population in need of medical care for chronic related illnesses. The average life expectancy is 71 years, and illnesses such as: hypertension, cerebrovascular accidents, heart failure, renal disease, and diabetes have debilitated many elderly persons.

Of salient importance is the medical social workers’ response in meeting the needs of our elderly. This researcher’s assessment is that discharge planning from a
social work perspective will need to focus on comprehensive planning for this frail population. Further, society will need to address the growing needs of the elderly with appropriate community supportive services, wherein they may remain in the comforts of their home in a dignified manner.

Social Workers will need to advocate for services and challenge the developmental systems to act in implementing quality services. Social workers will need to interpret the on-going needs and serve as a catalyst. We will need to mobilize ourselves and become prepared with the necessary skills and tools to function most effectively in caring for our elderly and their families.

Often with services in place, there will always remain a group of elderly patients whose social, emotional, physical and medical needs transcend the capability of the family system. For many, twenty four (24) hour nursing home placement is necessary to provide continued medical, social, and emotional support. This population was the focus of this research. An ecological approach to discharge planning is essential if the needs of this special population are to be effectively met.
BIBLIOGRAPHY


Coulton, Claudia J. and David P. Vielhaber, Ruth E. Dunkle, Marie Haug, and Julian Chow. "Locus of Control and Decision Making for Post Hospital Care." The Gerontologist 29 (October, 1989): 627-630.


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Stites, Mary A. History of the American Association of Medical Social Workers American Association of Medical Social Workers, 1955.
APPENDIX
Table XII

Random Numbers

<table>
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<th>Raw Text</th>
<th>Processed Text</th>
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POLICY STATEMENT:

It is the policy of Grady Memorial Hospital that, in accordance with the JCAH Guidelines, each patient will be ensured a planned program of continuing care which meets his/her discharge needs. Facilities and resources will be made available to patients in accordance with their needs as assessed by hospital personnel. Patient discharge planning should include a written discharge, patient/family discharge instruction, prescriptions for discharge medications, appointments for follow-up care and referrals for outpatient support services. Plans for discharge should, whenever possible, be completed the evening prior to discharge. Normal discharge time is 11:00 a.m.

PROCEDURE:

Discharge planning will begin immediately upon admission. Discharge planning shall involve:

1) Identification of high-risk patients
2) Notifying proper services
3) Development and coordination of multidisciplinary discharge plan
4) Implementation of discharge plan
5) Actual discharge

1) Identification of high-risk patients:

A patient will be considered "high-risk" if he/she has a catastrophic or life-threatening illness or accident, multiple congenital anomalies, end-stage renal disease, addiction at birth, lead poisoning, psychiatric disorder, severe decubitus ulcer, AIDS or ARC.

Other high-risk patients are patients who have problems with:

a) Home environment
b) Placement
c) Transportation
d) Neglect or abuse
e) Substance abuse
f) Non-Compliance

2) Notification of Proper Services:

When a patient is identified as high-risk, Social Services should be notified as soon as possible. Consults from other services should be requested as necessary for timely discharge.
3) Development and Coordination of Multidisciplinary Plan for Discharge:

The head nurse will be responsible for planning weekly multidisciplinary rounds and/or consultations involving physicians, nurses, dieticians, Social Services and other ancillaries as appropriate for the patients' needs.

4) Implementation of Discharge Plan:

Each department will be responsible for ensuring that its functions are completed and in order that patients are discharged in a timely manner.

5) Actual Discharge:

a) Physicians will, whenever possible, write Preliminary Clearance orders for patients by 1800 the evening prior to discharge.

b) It will be the head nurses' responsibility to ensure that all orders, including prescriptions, are filled before discharge.

c) Physicians will write may-goes by 0900 on the morning of discharge.

d) The head nurse will be responsible for ensuring that the patient has been properly instructed regarding post-hospitalization care.
The discharge planning outline being presented represents a composite of the guidelines of the Joint Commission, "the Patient's Bill of Rights", a review of various quality assurance programs, and the applicability of such knowledge to this particular setting. Discharge planning is an essential part of the hospital's program of service to patients, and social work is an integral part of the team designed to facilitate a smooth and orderly discharge from the hospital.

Ideally, every patient who enters the hospital should have a team effort directed toward planning their discharge. However, cost containment and staffing limitations dictate that our discharge planning efforts primarily focus on certain groups of high risk patients. These patients can be identified in one of several ways as follows:

1. Referrals directly from Admissions
2. Referrals from the medical staff
3. Referrals from Utilization Review
4. Self-referrals (either the patient or his family)
5. Regular area team conferences and/or rounds (social worker would accompany physicians)
6. Casefinding or screening by social workers

Review of several current publications and experience in this setting have helped with identifying certain high risk patients. Whenever any of the following conditions or criteria exist, discharge planning should be initiated within two (2) working days after admission. Criteria is as follows:

(1) Ages (70 or over) and living alone

(2) Transient patients (patients from Salvation Army, the Mission, etc.) and patients unable to provide information

(3) Patients admitted from another institution, (nursing homes, prisons, etc.) foster homes or boarding homes

(4) Patients with no source of income

(5) Patients with recurring admission (two or more admission within a six month period)

(6) Patients with impaired decision-making capabilities
(7) Child abuse or neglect

(8) Failure to thrive

(9) Pediatric cases of delayed development

(10) Specialized prosthetic and medical equipment needs

(11) Obstetrical patients who are adopting, are abortions under 16, or have had no prenatal care

(12) Hysterectomy patients of child bearing age (under 39)

(13) Patients with high risk admission diagnosis:

A. Gangrene
B. Multiple fractures
C. Sub-dural hematoma
D. Spinal cord injuries
E. Suicide attempts
F. Cancer
G. Burns
H. Coma
I. Stroke
J. Open heart surgery
K. End Stage Renal Disease
L. Terminal illness

Social work intervention with any of the above patients should ideally begin immediately upon admission, and definitely should occur within two (2) days. Social workers must make all other team members aware of these high risk patients for their assigned areas in order for them to assist with casefinding. Social work intervention is thereby expected on all patients who met the conditions mentioned above, and documentation of such in the medical record is expected within a two (2) day period.