

**'TAKING THE HEAT': FRONT-LINE EXPERIENCES
OF DISCHARGE PLANNING**

'TAKING THE HEAT': FRONT-LINE EXPERIENCES
OF DISCHARGE PLANNING

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ABSTRACT

With government pressure to cut healthcare costs, the hospital sector in Ontario has directed increased attention to moving patients out of the hospital as soon as they are deemed not to require acute care. Discharge planning has become a highly measured and managed process facilitated by social workers and Community Care Case Managers. The purpose of this thesis is to look at the experiences of hospital social workers and CCAC case managers and the common (and distinct) ways they experience their discharge planning roles and responsibilities. Information was obtained from two focus groups: one with hospital social workers and the other, with hospital CCAC case managers. Themes from the focus group of social workers emerged that illustrated the ‘heat’ in discharge planning and the implications this pressure had on patients and families, and the role of social work. Two dominant sources of pressure on discharge planning were the provincial focus on reducing wait times and organizational performance markers related to patients’ length of stay. Social workers voiced their concerns about government rhetoric and the inadequacies in community resources for ‘aging at home’, constrained choices and coerced caregiving that had implications for patients and families. CCAC case managers experienced similar pressures to discharge patients quickly while wanting more time to spend with them so that they could arrange the most appropriate services and care plans. CCAC case managers described the unique experience of working in an organization that is not their employer and having to facilitate ‘their’ discharge planning policies. This study looked at the inter-professional relations between social workers and CCAC case managers and how professional identity impacts the role of discharge planning. Social workers associated a certain “character” as needed to stand up against a system that is not always working in the best interests of patients and families.

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Taking the Heat: Front-line Experiences of Discharge Planning

Introduction

Healthcare in Ontario is under considerable pressure at the present time, with governments demanding a range of cost cutting measures. In the hospital sector, increased attention is being directed to moving patients out of hospital as soon as they are deemed not to require acute care. Discharge planning has become a highly measured and managed process, facilitated by nurses, occupational therapists, physiotherapists, social workers and /or Community Care Access Centre (commonly referred to as CCAC) case managers. Currently, health care planning and communication values patient choice and supporting patients to live at home as long as possible. Challenges occur when going home is no longer a straightforward option.

In Ontario, fourteen Local Health Integration Networks are responsible for prioritizing and planning health services and funding for hospitals and CCACs (www.lhins.on.ca/legislation). The LHIN has mandated that hospitals and CCACs work together to transfer patients to the most appropriate destination, be it home or to another setting, once their acute stay is finished. This inter-organizational collaboration has resulted in increased reporting responsibilities and the development of new discharge planning practices. For instance, hospitals and CCACs are now responsible for

tracking and reducing the number of patients who are deemed ‘alternate level of care’ or ‘ALC’. ALC has been defined by Cancer Care Ontario (2009) as:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Care, Mental Health or Rehabilitation), the patient must be designated alternate level of care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient’s needs or condition changes and the designation of ALC no longer applies).

The number of patients designated ALC is captured daily by hospital administrators and reported to all staff, as well as externally to the province and the LHIN. Discharge planning practices are geared towards reducing the number of ALC patients by quickly moving them from the hospital to the community. Elderly patients who need long term care placement or nursing home care are of particular interest because they are typically designated ALC for more days than other groups of patients.

The Ministry of Health and Long Term Care’s ‘Aging at Home Strategy’ (2007) is a key policy and funding stream shaping discharge planning practices. ‘Aging at Home’ promoted the expansion of home care and community support services for the elderly so that they could live at home. From 2008 to 2011, \$700 million was transferred from the province to the fourteen Local Health Integration Networks (LHINs) to implement ‘Aging at Home’ initiatives (www.hnhblin.on.ca). Part of this funding was used to promote the “home first philosophy” which is an imperative to move patients,

specifically elderly patients, from the hospital back to the community to avoid waiting in the hospital for long term care. Brochures and campaigns were launched that educated patients and family on the benefits of living at home, instead of staying in the hospital for unnecessary periods of time.

This research was prompted by my own experience as a hospital social worker in a busy academic hospital. I, along with my coworkers, collaborate daily with CCAC case managers to create discharge plans with patients and families. Often, the social workers, who are the discharge planners in the hospital, are held accountable for delays in discharges. Yet these ‘delays’ are often due to the lack of community resources and affordable housing well beyond the control of individual social workers. For instance, access to affordable assistive living or subsidized retirement homes is limited for patients in our community. Access is also limited for patients who have psychiatric diagnoses because homes are reluctant to take them due to concerns about managing their mental health needs. Not all patients are able to return home because they do not have friends or family who can assist them with their care needs. Many of the patients we see have complex family dynamics and addiction problems, which make discharge planning more challenging. For patients who need long term care, the wait lists can vary; older, less desirable homes have a wait list of zero to three months, whereas, the newer more popular homes, have wait lists ranging from three to five years. CCAC case managers, who are responsible for arranging homecare services, as well as determining

eligibility for most post-acute care programs such as long-term care placement, convalescent care, hospice and complex care programs, feel the pressure to arrange services for patients who are much sicker, in a shorter period of time. The demand for personal support workers has increased greatly in our community and at times CCAC case managers are unable to arrange homecare services because the service providers do not have any available staff. All of these issues can lead to delays in discharges that are beyond the control of front-line staff.

I began this study with an interest in understanding how hospital social workers and CCAC case managers make sense of their complex everyday worlds and how they manage the pressures to move patients quickly from the hospital to the community. I was specifically interested in understanding how two groups of workers, who come from two very different organizations, negotiate the tensions that can arise between them in trying to discharge patients. The focus groups I conducted with social workers and CCAC workers were rich and provocative. Participants saw questions about the interactions and negotiations between the two groups of workers as relevant. However, the focus groups were much more animated when we spoke about the broader issues of discharge planning, and the tensions and successes in the complex work of transitioning patients out of hospital. Our dialogue led me to shift my focus somewhat –from the relations between the two groups of workers, to the common (and distinct) ways they experience their discharge planning roles and responsibilities.

Literature Review

My literature review begins by describing the origin of hospital social work and how social workers strive to maintain their professional identity in a changing time and health care environment. I then look at our current health care system and the driving forces behind cutting costs and reducing time in hospital. Much attention has been given to standardizing discharge planning yet little time has been invested in addressing the conditions, such as complex care needs and lack of resources that make discharge planning difficult. As there is no specific research on the experiences of CCAC case managers in the hospital, I next draw upon studies that look at the experiences of home care case managers in the community and how they coordinate and provide care under a highly 'managed' program, guided by a neo-liberalist philosophy. I conclude the literature review by examining articles that critically look at case management, with particular interest in the feminist ethics approach that promotes relationships and individualized patient and family care over a standardized, regulatory model.

The Role of Social Workers in the Hospital

The first organized department of social work was created in 1914, at the Massachusetts General Hospital in the United States (Gregorian, 2005). Early social workers focused on public health issues such as cholera, tuberculosis, teenage pregnancy and poverty (Gregorian, 2005). Hospitals were largely patriarchal and male dominated. Social workers were seen as an "instrument" of the physician and assisted

in identifying psychosocial issues that were related to diagnosis and treatment of a patient's medical illness (Gregorian, 2005). As medical technologies improved and people were living longer, the pressure for hospital beds increased (Gregorian, 2005). The hospital environment became faster-paced and more cost-conscious and social workers were seen as vital in facilitating patient flow (Gregorian, 2005). Social workers, as one of the lowest ranked professions in the hierarchy of care, were seen as being responsible for cleaning up 'social messes' or rather addressing psychosocial issues that no other profession wanted to do (Heimer & Stevens, 1997). With increased pressure to move patients out of the hospital, the role of social work transformed from being an extension of the physician to an extension of hospital administration.

Gregorian (2005) looked at why some social workers thrive in a hospital environment and others struggle. She identified characteristics, such as a strong sense of personal and professional boundaries and professional self-worth, as needed in order to have a career as a medical social worker (Gregorian, 2005). She stated that social workers that work within the system, by building and sustaining relationships and working within a hierarchical structure, have more opportunity to achieve successes for patients and families, as well as satisfaction in their work (Gregorian, 2005). Similarly, Wilder Craig (2007), a hospital social worker, used the art of story telling to share the complexity of her workday with non-social workers, as well as her social work peers. She was concerned that social workers, who are adept in telling patients' stories, seldom

get the opportunity to share their own profession's stories. As more and more social workers are 'program managed' and not reporting to anyone of the same discipline, she stressed the need to share our collective wisdom with one another, so that social workers can seek to be 'good' social workers and not necessarily 'good' employees of the hospital (Wilder Craig, 2007).

Echoing Wilder Craig's concern about losing our professional wisdom, a study by Phillips and Waterson (2002) examined the role of social work in transitioning older patients from the hospital to nursing home care. They discovered that the rise in managerialism and a focus on administrative tasks, such as needs assessments, took precedence over social workers providing emotional support to patients. The authors were concerned that the interventions of social workers were becoming so routinized that the profession was losing the 'social' that is unique to the profession's identity (Phillips & Waterson, 2002). The authors define 'social' as being therapeutic counseling that helps seniors and their family members cope and adjust to new health conditions and living arrangements (Phillips & Waterson, 2002). Emotional support, not instrumental tasks, was deemed to be the most valuable by patients and families. The authors suggest that there is a needed role of 'social' negotiation or brokerage to help patients and families make transitions from the hospital to long-term care, despite the organizational pressures to do things quickly (Phillips & Waterson, 2002). Spending too much time with patients was seen by management as slowing down the process of

discharge planning; whereas, patients and families felt that social workers played a valuable role in being the “go between” between the hospital and residential care facility (Phillips & Waterson, 2002).

Culture of Fast and Efficient Care

Since the mid-1990s, hospitals have been downsized, restructured, and had their operating budgets cut. Hospital administrators have had to deliver services in a more cost effective way to be seen as viable. As previously mentioned, concerns arise when patients, who no longer need acute care, remain in the hospital. The move from a medical model to managed care model resulted in hospital beds and hence patients, being seen as commodities that need to be “managed” (Aronson, 1999). The emphasis on measurable outcomes such as admissions and discharges; length of stay; wait times and occupancy are used by the government as a major source of evidence about a hospital’s performance.

In particular, the focus on tracking and reducing ALC numbers has had a major impact on the experiences of front-line staff. Rankin and Campbell, in their book, “Managing to Nurse: Inside Canada’s Health Care Reform” theorize how nurses’ work has been reorganized around managing bed flow requirements and ALC numbers, with less and less time allocated to provide direct care to patients (Rankin & Campbell, 2006). Nurses are being taught to “nurse the organization” and not the patients. This work is influenced by an administrative mindset that asserts ALC patients are taking up

valuable acute care resources and thus, should be moved out of the hospital as quickly as possible. Improving access to hospital beds has been reframed as valuing care that is for the 'greater good for all' (Rankin & Campbell, 2006). In contrast, patients who are designated ALC and have a longer length of stay are viewed as less worthy because they are 'blocking' beds for those individuals who need acute care. Although specific to nursing, the effect of reducing time in hospital, increased focus on administrative duties and loss of professional identity can be easily transferred to other professions who work in the hospital. Social workers, as discharge planners experience these same pressures; however, due to their knowledge of systems and building relationships, spend much time 'social working the organization' or massaging the system. Social workers, 'social work' the organization in two ways: they respond to its needs to get patients out quickly and to track ALC patients and they also 'work it' in advocating for patients and families and finding services that will help meet their needs.

Pope (1991) offers an interesting perspective on how the tracking and management of surgical wait times by the British government gives the illusion that they are doing something to improve time to surgery, yet, in reality, they have not addressed any of the reasons for delay. Pope depicts waitlists as a 'mortlake', meaning a pool of water that collects off the side of a riverbank, to describe how waitlists are set to the side and represent the unmet needs of patients (Pope, 1991). This analogy fits nicely with Rankin and Campbell's work on ALC, as they describe ALC as an interruption in the

flow of hospital beds (Ranking & Campbell, 2006). Similarly, the tracking of ALC numbers gives the illusion that the government is addressing the root causes of why patients are not able to leave the hospital. However, in both these situations, the inability to reduce wait lists and ALC numbers is attributed to inefficient management, instead of inadequacies of community resources (Pope, 1991; Rankin & Campbell, 2006).

A major shift in the handling of ALC patients in Ontario occurred with the release of a study in Mississauga, Ontario by Starr-Hemburrow, Parks and Bisailon (2010). The authors described the inter-organizational collaboration that occurred between three hospitals and the Community Care Access Centre, in order to improve patient flow and access to care. These organizations joined forces to create a bundle of home care services that supported the return of patients home to await long term care placement, rather than staying in the hospital. This collaborative process was deemed the “Home First” philosophy and was cited as being the best option for patients because it increased acute care bed capacity, reduced the risk of hospital-acquired infections and allowed patients to make long term care decisions in their own homes. This concept was embraced in the form of the Ministry of Health and Long Term Care’s mantra of ‘right person, right place, right time’ meaning that patients who no longer need acute care services, need to be moved to the most appropriate place in a timely manner (Starr-Hemburrow et al., 2010). Subsequently, an 80 page manual was created called “Sharing the Practices; Transition Management in Ontario: Home First Implementation

Guide and Toolkit “to assist hospitals and CCAC’s in adopting and practicing this philosophy (LHINC, February 2011). The philosophy and practices associated with ‘Home First’ are topics of debate in discharge planning, as I outline below and as will become visible in the findings section.

Discharge Planning is more than a Checklist

Although the ‘Home First’ philosophy is being presented as a means of supporting aging at home and reducing healthcare costs, the approach does not address the pressures and complexity of discharge planning, or the skills, time and resources needed to do it properly. The Canadian Association of Social Work Administrators in Health Facilities (CASWAHF, 1985) defines discharge planning as:

A complex psycho-social activity which requires use of a wide range of clinical and organizational skills to address the discharge-related needs of patients, their families and the health care system. It is a multi-disciplinary process which may begin prior to admission, and which promotes optimum functioning of the patient, their families and support systems. This process is based on the principal of continuity of care and respects the rights of self-determination for all partners involved in the process.

Dainty and Elizabeth (2009) studied the process of discharge planning for elderly patients and concluded that discharge planning is a multi-disciplinary process that needs to start immediately upon admission to the hospital. Early intervention and assessments were important in understanding the care needs of patients, their social supports and potential discharge location (Dainty & Elizabeth, 2009). The authors created a ‘discharge

planning checklist' to improve communication and understanding of discharge planning for physicians. The items on the list are regulatory and instrumental. There is no mention of any barriers or social conditions that may impede discharge planning. The process is described as elderly patients being "pulled through" the hospital system, so that they do not occupy costly acute care beds (Dainty & Elizabeth, 2009). The authors stress that discharge planning is a neglected skill because it is not taught in undergraduate or graduate programs (Dainty & Elizabeth, 2009). Of concern, is that Dainty and Elizabeth are suggesting that discharge planning is a set of concrete steps or 'checklist' and does not involve any critical thinking or ethical decision making by the professional.

Wells, LeClerc, Craig, Martin and Marshall (2002), addresses the challenges that professionals face in trying to facilitate discharge planning for elderly patients that is ethical and inclusive. They acknowledge that there is a constant tension in balancing the needs of the organization, while trying to balance quality patient care. In order to address this, the authors developed an 'Integrated Model of Discharge Planning' that is patient-centred and encourages decision-making that is based on mutual agreement (Wells et al., 2002). Workers were asked to implement an assessment within 72 hours of admission that was patient- driven and clearly outlined steps so that the discharge planning was not delayed (Wells et al., 2002). The authors concluded that involving

patients and families early in the process and working with them in developing a plan lead to better quality discharge planning (Wells et al., 2002).

The literature that supports discharge planning that begins when the patient is admitted to hospital seems to assume that issues identified early in the process of care can be 'resolved' by the time the patient's acute care needs have been addressed. However, not all issues can be resolved quickly such as chronic health conditions and multiple comorbidities, complex family dynamics, financial issues and addiction problems. A study of three large urban hospitals in Montreal showed that psychosocial issues, such as financial concerns, were leading causes of longer hospital stays (Lechman & Duder, 2009). The authors suggest that social workers are needed to assist patients with psychosocial needs, yet, unfortunately, with system pressures to discharge patients quickly, they are not granted the time to use their professional skills to help patients manage these problems (Lechman & Duder, 2009).

Focusing on the psychosocial needs of patients in the context of discharge planning involves an assessment of 'risk' to determine whether or not a patient has the capacity to manage and direct his or her own care needs, as well as whether or not there are appropriate resources to assist with these needs. In a climate that values patient choice and the need to reduce time in hospital, the evaluation of risk can be compromised. Ferguson (2007) looked at how the transfer or risk is moving from the state to the individual under the pretext of patient choice. The imperative to move

patients home as soon as their acute care is complete can result in patients not being fully assessed regarding their cognitive and functional capabilities. Any refusal of care or services can be interpreted or framed as patients exercising their right to choose - instead of their inability to truly appreciate and understand their current life situation or what it will be like to be at home and trying to manage their own care, or simply their desire to get out of the hospital and back home. A patient with complex care needs may be sent home with no support on the premise that he or she has the right to make a bad decision. Paternalism or the need to protect and help patients has been reframed as a negative practice; whereas, choice and consumerism are considered the preferred way to provide service (Ceci & Purkis, 2009). These issues can cause moral dilemmas for care providers because they do not want to be seen as limiting patients' right to self-determination; nor do they want to be seen as standing by and failing to act when patients make 'choices' that put them at risk.

Social workers have had a lengthy history in helping physicians and other professionals in understanding the psychosocial needs of patients and in helping patients transition from the hospital back home or to another destination. With the current pressures to cut costs and reduce patients' time in the hospital, discharge planning has received a great deal of attention. Organizational pressures to reduce the number of ALC patients has resulted in hospitals adopting the 'Home First' philosophy that encourages patients to return home as soon as their acute care stay is complete.

Going home is not always an option due to patients' care needs, limited finances and lack of adequate community resources. Social workers struggle with the organizational mandate to improve bed flow pressures and advocating for patients who are not able to safely leave the hospital or who do not have any place to go. Much of social work's role is to 'social work the organization' or massage the system so that it can meet patient and family needs.

Managing 'Care' From Hospital to Home

The role of homecare case managers in the hospital falls under the domain of the Community Care Access Centre. This organization was set up in 1996, across the province of Ontario, as a single point of contact for publicly funded services provided in homes. The original purpose of this organization was to provide extra help to clients so that they could maintain their independence at home and to support clients and families in making arrangements for long term care placement. The role of CCAC case managers has greatly expanded over the years, to include determining eligibility for most post-acute care programs, such as convalescent care, complex care, long-term care and hospice care, in addition to arranging home care services. They work in the hospital as well as the community. CCAC case managers come from a variety of professional backgrounds such as nursing, occupational therapy, physiotherapy and social work. For those case managers in the hospital, the pressure to arrange services quickly fits in with the neo-liberal agenda of fast and efficient care.

As noted earlier, because there is little research about CCAC case managers in hospitals, this review draws on studies of case managers' roles and experiences in community settings. Ceci (2006) explored the ethical struggles that homecare case managers experience in trying to exercise their professional skills while being constrained by organizational practices and policies. By using an ethnographic approach, she observed in business meetings that supervisors of the case managers often discussed the scarcity of resources and the need to move to a medical model of home care, wherein only the sickest in the community would be provided care. This meant that individuals who needed only laundry services or housekeeping services would now be cut from the homecare program. Case managers raised concerns to management that these services help maintain individuals in the community and help them to avoid institutionalization. In this study's jurisdiction, neo-liberalist thinking was rampant and the government's health care plan stated, "health and wellness is a personal responsibility" (Ceci, 2006). The decrease in homecare hours was framed as a move to promote the independence of care recipients when in reality it was, these researchers found, a consequence of the narrowing focus on medical services (Ceci, 2006).

In a study about the experiences of people with disabilities who received homecare support, Marie Campbell (2008) looked at how the drive for cost-effective measurements changed the outcome of how care was provided. The increased

attention to administrative tasks such as needs assessments and worker assignments resulted in clients being seen as “objects” of care and labeled as “assignments” for staff. Home care workers were encouraged to stick to their assigned tasks. Any mention of relationships or rapport between staff and clients disappeared in the texts of the organization. Care had been constructed as an abstract concept, void of any specific relationship to the patients, and this had a “personal” cost for people with disabilities. Homecare workers were also impacted because they derived less satisfaction in their work, as the focus was on the task and not the person.

Purkis, Ceci and Bjornsdottier (2008) conducted a comparative ethnographic analysis of homecare in both Canada and Iceland that looked at the influence of neo-liberalist economic discourse on the delivery of services. The health care systems in both these countries are very similar, yet Iceland has not had the same neo-liberalist economic discourse as has Canada. In Iceland, the main tenet of homecare is flexibility. Nurses have the discretion to decide how much services to provide based on individual needs. They can put in help as much as 8 to 9 times a day. In Iceland, there is recognition that families differ in their ability to provide support and they need quality time with their loved one. Researchers found that in Canada, the opposite had occurred. Case managers have less flexibility as they are bound by eligibility requirements, administrative red tape and concerns about scarce resources. They also expect families to be the consistent, major part of the care plan. This means that family

caregivers are assumed to be responsible for most of the care-giving role, an assumption that unfortunately leads to burnout and exhaustion.

Taking 'Care' out of healthcare

Many scholars argue that discharge planning has become a managed activity that has more and more to do with the organization and less and less to do with quality patient care. This has consequences for care providers' experiences, knowledge and identities. For professionals, such as social workers and CCAC case managers, difficulties arise when they are expected to carry out policies and practices that do not necessarily align with their own disciplines' values and beliefs (Colley, 2012). Colley discovered that workers experience emotional suffering when expected to meet targets and expectations that are not aligned with their values (Colley, 2012). Concerns were raised about workers obtaining their identity from the organization, rather than from their professional background. Colley sees learning that centers only on developing skills for completing 'auditable' tasks as a way of 'not learning' because there is no opportunity to learn outside the measurable assignment or duty (Colley, 2012).

There are internal and external pressures to standardize all aspects of discharge planning to improve patient flow. In routinizing the process, there leaves little room for discharge planners to assert their professional judgment or to maintain their profession's values and standards. McAuley, Teaster and Safewright (1999), studied ten agencies over the course of two years that provided case management to over 2,300

seniors in the community. They looked at care coordination from both a ‘feminist ethics’ and ‘traditional regulatory system’ perspective. The feminist ethics perspective involves case managers using their intuition and emotion to foster relationships and to contextualize seniors’ needs based on their individual circumstances, whereas, a regulatory system perspective encompasses case management that is based on standardized procedures and assessments, lines of authority and the need to control resources (McAuley et al., 1999). In regulatory systems, decisions are usually made on the principle of the greatest good for most people, which can discount people who are marginalized and do not fit neatly into a care path, program or service. The authors conclude that case management should be based on individualized care needs, as well as following standardized processes (McAuley et al., 1999). Of added significance is the need for organizations to articulate the two perspectives and identify how each is shaping the way care is provided because the default setting is typically regulatory case management (McAuley et al., 1999).

Cutting costs and reducing time in hospital is part of the new normal in the Canadian health care system. Downloading of care to the community has put added pressure on patients, families and care providers. Both hospital social workers and CCAC case managers are part of a system that measures success by fast and efficient care. The reality is that more time is being spent on “working the organization” with less time being allocating to providing emotional support and guidance to patients. My research

focuses on how hospital social workers and CCAC case managers understand and negotiate their roles in the hospital and how each relates to one another in the discharge planning process.

Methodology

The theoretical framework for this research is symbolic interactionism because I am interested in gaining knowledge by examining how people give meaning to their interactions (Kreuger & Neuman, 2006). The fundamentals of symbolic interactionism originated in the early 1900's, from the work of social psychologist, George Herbert Mead, who claimed that people are active negotiators in the construction of their social world (Jeon, 2004). Building on this theory, sociologist Herbert Blumer named this process symbolic interactionism and was instrumental in moving it forward as a research methodology (Jeon, 2004). Symbolic interactionism suggests that there are multiple interpretations of how 'meaning' is understood in social interactions (Starks & Trinidad, 2007). Eakin (2010) defines this way of learning as a 'standpoint' perspective. She suggests that different viewpoints do not need to be oppositional, but rather, are necessary to have a better appreciation of the issues and make the invisible more visible (Eakin, 2010).

The research method I am using is 'constructivist grounded theory' created by Kathy Charmaz. It is an adaptation of the original 'grounded theory' created in 1967 by two sociologists, Barney Glaser and Anselm Strauss (Starks & Trinidad, 2007). Grounded

theory is different from much traditional social science research because it does not start with a hypothesis but rather, is an inductive way of thinking, whereby theory develops by describing and explaining the phenomenon as participants see it and in turn, how the researcher interprets it (Krueger & Neuman, 2006). Grounded theory is a systematic process that starts with the researcher continuously coding the data, writing memos about it and discovering emerging theories from this process (Starks & Trinidad, 2007).

Kathy Charmaz's constructivist grounded theory suggests that the researcher has a major role in shaping the data and determining theory development (Charmaz, 2006). In a continuum of methodologies, constructivist grounded theory would be considered in the middle with positivism at one end and post-modernism at the other (Thomas & James, 2006). This means that this research method is not in search of an absolute truth nor is it trying to deconstruct an experience. Instead, a constructivist grounded theory is rooted in symbolic interactionism because meaning is derived from the activity of participants, as well as the interactions between the participants and researcher (Jeon, 2004). It is a fluid, open-ended process that encourages looking deeper and deeper into the meaning of interactions, language and behavior (Charmaz, 2006).

Methods

In order to meet my study objectives, I conducted two focus groups: one with

hospital social workers and the other with hospital CCAC case managers. These two groups of workers were chosen because they have significant knowledge of discharge planning in the hospital. Focus groups were used to gather information because I wanted to discover the synergy and ‘group think’ of each set of workers in their own setting (Berg, 2007). My goal was to create an environment whereby participants felt comfortable to share information and did not feel restricted in what they had to say. The sharing of information in a group encouraged participants to respond and interact with one another (Berg, 2007). The information presented in these groups was not based solely on an individual perspective, but rather was information that was socially constructed in the group (Berg, 2007).

In trying to avoid any dual roles or potential conflicts of interest, this study was not conducted in the hospital in which I work. Instead I sought and secured the involvement of social workers at a nearby hospital. I then approached the CCAC in this area. My intent was to involve hospital social workers and CCAC case managers who worked in the same jurisdiction so that I could compare their experiences in discharge planning. I met personally with one of the CCAC senior leaders to discuss my research proposal and at her request provided a written description of my project for other members of the leadership team. After eight weeks and several email requests, this leader advised me that she did not feel that it was in my best interests or the social workers’ best interests to conduct the CCAC focus group in the same LHIN, due to

concerns about a negative impact on working relationships. She did however assist me by connecting me with CCAC staff in a different LHIN, who, after reviewing my research ethics application and the approval letter from McMaster's research ethics board agreed to support this study. Approval for my research was informal and individualized to each CCAC site. Throughout this process, it was difficult to understand the steps needed to conduct research with the CCAC because there was no formal Research Ethics Board application or ethics approval process identified on their web site or articulated by their staff. This lack of clarity and specified process represents a barrier to research focused on CCAC practices.

In hindsight, it became clearer to me how beneficial it would have been to conduct focus groups with workers who work in the same area because there are so many variations in practice within each LHIN, as well as between LHINs, and the patient populations are often quite distinct. I discovered that it is difficult to make comparisons at the level of practice or approach to practice because depending on the hospital and CCAC there are different professionals responsible for discharge planning. In the setting in which the hospital social workers worked, they were considered the main discipline to facilitate discharge, whereas, the CCAC case managers, although they worked for a different organization, were the primary discharge planners for the hospital, instead of social workers. I reflect further on the significance of recruiting participants from settings with very different patient populations and discharge planning arrangements, as

well as the reluctance of the CCAC leadership to permit the focus groups of social workers and CCAC case managers to occur in the same LHIN in the discussion.

The social work participants were recruited from a large academic teaching hospital in southern Ontario. The CCAC case managers were recruited from two different community hospitals in southern Ontario. A recruitment letter and consent form was sent to both hospital social workers and CCAC case managers by using a staff email directory for each corresponding site. An intermediary person was used in each organization so that participants would not feel pressure to participate (Appendix A). The recruitment letter and consent form outlined my interest in understanding the front-line experiences of hospital social workers and CCAC case managers who were involved in discharge planning. I explained that this research was part of the Masters Program at McMaster University School of Social Work under the supervision of Dr. Christina Sinding. I invited each group of workers to attend an hour-long focus group at a place and time that was convenient for them. I invited them to directly contact me if they had any further questions or concerns about this research study.

Maintaining participants' privacy was done consistently throughout this study. Written informed consent was secured from each participant (Appendix B). This included obtaining permission to have follow-up interviews with participants and to send them a summary of themes. Participants were asked to complete a short demographic questionnaire addressing years in practice and years working at their

respective organization or healthcare field (Appendix C). This research study received approval from the Research Ethics Board.

The key questions were circulated to the participants prior to the focus group so that they could reflect on the role of discharge planning. A semi-structured interview guide was used; however, questions were open-ended and based on the information provided in the group (Appendix D). Participants were asked how they would describe their current role in the hospital. They were asked about what they look for in discharge planning and how they define a successful discharge. Further questions explored the challenges and barriers to discharge planning and how choice is understood in this process. Both hospital social workers and CCAC case managers were asked how their roles intersect with one another.

Pseudonyms were used to replace any reference to patients/clients, family members, health care providers, organizations etc. in the transcripts in order to address confidentiality. Participants were instructed to keep information shared in the group confidential. They were also cautioned that this was not a guarantee and that they needed to keep this in mind when sharing information. Participants were informed that the focus group would be digitally recorded. They were given the option to stop their involvement at any time and to refrain from answering any questions that they did not feel comfortable answering. Participants were advised that this study had received approval from the Research Ethics Board.

The focus group with social workers consisted of eight social workers, with an average of fourteen years experience. Six of the participants had graduate level education and two held an undergraduate degree. The focus group with CCAC case managers consisted of three participants, with an average of ten years experience. Two participants were registered nurses and one was an occupational therapist, with two having graduate level of education and one with an undergraduate degree. Two of the CCAC case managers were from a smaller community hospital specializing in post-acute programs and the other participant was from a smaller acute care hospital. Sampling for this study is not representative of hospital social workers or CCAC case managers; however, it is relevant for theory construction (Charmaz, 2006).

The data from the focus groups was coded into key points and sorted into further segments that were based on similar content (Charmaz, 2006). Special attention was paid to 'in vivo' terms, which is the language or sayings used by workers that are unique to their environment (Charmaz, 2006). Coding was the essential link to explain what was happening in the data and to make the linkages between conditions, actions and consequences (Corbin & Strauss, 1990).

Findings

Several themes emerged from my engagement with the interview transcripts. In this first section I draw from the focus group with social workers. Themes from this focus

group include pressures in discharge planning and the implications of these pressures for patients and families as well as for social workers. In the second section, I discuss the following themes from my focus group with CCAC case managers: pressures in discharge planning, experience of working in an organization that is not your employer and implications for CCAC case managers. In the final section, I explore the theme of inter-professional relations in discharge planning by looking at collaboration between social workers and CCAC case managers and how professional identity is understood.

The Heat: Pressures in discharge planning

Social workers identified two dominant sources of pressure on their discharge planning roles: the urgent focus on reducing wait times and organizational performance markers related to patients' length of stay (and tied to funding).

One of the foremost pressures on discharge planning is the provinces and LHINs' focus on reducing Emergency and Surgical wait times. Hospital emergency wait times are measured by the amount of time it takes individuals arriving at the emergency department to be seen by a physician and the time it takes to be admitted to a hospital bed. The province has set specified wait time targets and financial rewards are associated with meeting these time frames. Surgical wait time refers to the time it takes for a patient to have a surgical procedure done. If a patient requires a hospital bed after

surgery and there are not any available, surgeries are cancelled. The outcome is a loss of revenue for the hospital and physician.

One of the social workers, Sharon, described the pressures of wait time targets and bed availability [process of bed flow] by using an analogy of a front door and back door; meaning access to care is the front door and discharge planning is the back door. She explains that the priority is usually the 'front door'; however, we must pay attention to both processes. Jerry liked this analogy and expanded on it by stating that:

. . . there's so much focus on the front door and so much focus on getting that person into the system, getting them access to the bed, access to the physician group, diagnostics, the care at the front end of that but there's this gaping hole at the back door and people fall out the back door.

In both these quotes, social workers have conceptualized the need to pay attention to patients needing access to service, as well as those patients who need assistance in making a successful transition from the hospital to the community. From their perspective, the value attached to getting patients successfully 'in' for care is not matched at the 'back door' - there is not the same value attached to a successful, effective transition out of the hospital. Social workers also identified that some patients, due to complex physical, mental and social care needs, do not fit into any category and thus, there is no 'door' or adequate service for them. Responding to the 'gaping hole' aligns with social worker's social justice lens that attention needs to be paid to patients at the back end, whose needs are not easily or well met in the community.

With the financial pressures to reduce the time patients spend in hospital and to ensure hospital beds are available for new admissions, a subsequent repercussion on discharge planning is the internal organizational tension between two key markers of organizational performance: Length of Stay in acute care (or LOS) and the percentage of patients in hospital with ALC designations. Sharon (social worker) explained that practice guidelines specify an expected number of days in hospital for a particular health condition, and that hospital funding is linked to meeting these benchmarks. As soon as a patient is designated ALC, acute care LOS days no longer accrue. One set of pressures, then, aims to designate patients ALC as quickly as possible. Yet a contrary set of pressures requires that ALC rates be kept low, not exceeding a specified target.¹ Sharon has spoken directly with her supervisor about the tension on her ward between LOS and ALC:

I was very frank with my director and said ‘I appreciate you want your length of stay number for an acute ischemic stroke 5 days, hemorrhagic stroke 7 days, you know you want them down to those numbers but that’s going to mean that the ALC piece you know (will increase)’.

The social worker is describing the irony in trying to compartmentalize a patient’s stay into acute care and non-acute needs, as well as the reality that not all patients are

¹The provincial target is that patients who no longer need acute care should occupy no more than 10% of acute care beds in the hospital.

homogeneous and follow a predictable care path. Her comments also show how deeply social workers' daily work is linked with imperatives at the management level, imperatives that create conflicting 'motivations' for social workers. Similarly, Jerry describes how acute care physicians designate patients ALC as early as they deem possible because of the pressure for them to meet the acute care length of stay. This has a significant effect on staff, especially social workers that facilitate discharge planning, as some patients are designated ALC when they are not actually ready to leave the hospital. For example, a patient may be medically stable but awaiting a consult for a speciality service such as a Geriatrician to gain a better understanding of their cognitive status. A diagnosis is needed because the care plan can be very different for a patient with a reversible confusion due to a delirium and for a patient with a non-reversible confusion such as a dementia. In these cases the ALC designation should not be applied until after the assessment, as the patient needs this assessment to determine his or her care needs. Some acute care physicians would argue that this assessment could be done as an outpatient and thus, the patient is ready to leave the hospital. Social workers are left trying to explain this dilemma to patients and family members, who are already overwhelmed with the hospitalization. As Jerry says:

Your motivation is to make them ALC as quickly as you bloody well can because that makes [the acute care physician] look good . . . and my team are like, 'don't do that because it's going to mess up our ability to do this [discharge plan]'.

Taking the Heat: Implications for patients and families

The focus group with social workers identified several consequences for patients and families of the current conditions and pressures surrounding discharge planning. They are as follows: tension between government rhetoric and inadequacies in community resources for ‘aging at home’, constrained choices and coerced caregiving.

Social workers raised concerns about the tension between government rhetoric about aging at home and avoiding institutionalization and the availability or existence of adequate resources to support people in their homes. Jerry points out that in reality, the government’s focus has been on getting people out of the hospital, instead of building long-term solutions to allow individuals to stay or age at home as long as possible.

. . . with the government a few years ago having the whole aging at home philosophy thing unfortunately that really feels like lip service because what we’ve seen is we’ve seen a reduction in services not an increase in services. When they’ve done an increase in services related to the Home First model that’s not to keep people at home that’s to get people out of hospital.

Jerry went on to note that the ‘Aging at Home’ initiative promised funding to sustain people in their home in a way that created a genuine alternative to nursing home care, with more personal support workers and community programs. However, as he notes here, ‘home first’ funding does not actually provide more services in the community. Rather, it is targeted at getting people out of the hospital. Other social workers gave examples of how access and availability of services has changed for patients, making it more difficult to ‘age at home’ safely or well. They discussed situations where family

members have asked for housekeeping and meal preparation. This type of service was available in the past to help maintain people in their homes but now, home care services have been restricted to direct personal care, such as washing and dressing.

The fact that families are expected to take on more, with limited choice in services or sites of care are common in the discharge planning process. Social workers shared that their administration does not want them telling patients and families that they have choice in going to one program, in relation to another. Sharon describes her managers' philosophy about choice, with respect to post acute care programs.

I remember one time my manager . . . said 'you know what, this is not a buffet you know - there really isn't a lot of choice' . . . this was a matter of choosing one rehab program over another rehab program and the family preferred to go to one that was closer but the one that was further away came up first, she said, 'no, this is not a buffet, you go to the first available bed [program].'

In other situations social workers felt that the "home first" philosophy is propaganda because they are having to 'sell' the concept of home as the best choice for all patients and families, even when they are concerned about the patient's capacity to manage at home or about the adequacy of services to support the person at home. Not offering genuine choice causes angst for social workers because they are not presenting patients and families with all the options that are available to them.

There are also situations where patients and families, for whatever reasons do not feel that they have energy, right or power to challenge existing practices. Jerry pointed out that these families are "taken advantage of" because people will succumb

to pressure to accept inadequate discharge plans” and that “is successful from the system’s perspective.” Joe notes similar concerns about how the concept of choice is misrepresented when talking to patients and families. She felt that hospital staff is “spewing propaganda” by pressuring families to look after their loved ones or to pay for private care. Shona also agrees by stating, “There really are not that many choices” for patients or families. These viewpoints show that social workers struggle with having to sell plans as a ‘choice’ when in reality, patients and families have limited choice, especially if they do not have adequate finances or family support.

For hospital social workers, risk was intertwined with forced choices and the pressure to move patients out quickly before assessment of risk can take place. Jerry described a situation in which managers attended a family meeting with him because they wanted to encourage a family member to take a patient home to await a nursing home placement, despite Jerry's reservation or concerns that this was not reasonable. He expresses the concern:

That families are going to be expected to do - to not do, that's not the right word to agree to situations that ... we would find unreasonable but the expectation is that's the way or the new way.

For families, the pressure to discharge patients quickly has resulted in ‘care’ being downloaded on to them. Allison commented, “I don’t think we’ve ever asked families to do what we’re asking families to do now”. Joe also felt that family members are being blamed and judged if they are not willing to take family members home or be the

“back up plan” (meaning provide personal care) if CCAC services do not show up or cannot be arranged for that day. Joe explains that in reality the “patient’s daughter has a life and her daughter has a job” and she may not be in a position physically, emotionally or financially to take on this role. Jerry provides a critical look at the downloading of care onto the family by stating the following:

. . . the system can’t acknowledge that [it is reliant on families] because if the system acknowledges that then the system falls apart and the system’s built on the families going to pick up the slack. Slack to be undefined.

Taking the heat: Implications for social workers

Social workers identified several themes that impact the work that they do in the hospital: tensions with increased ALC patients, feelings of being deskilled or not believed by management, not able to do the work that is important, and having to work against the organization that employs them.

When ALC numbers are high, the competence and commitment of the institution - and by implication the social workers - is called into question. In some cases the ‘culture’ of the hospital is being blamed for the higher ALC numbers, instead of the pressures on the hospital to meet targets that are not realistic for the setting. In one specific incident, a manager made a disparaging comment about the ‘culture’ of the hospital and this in turn was interpreted by the social workers as a ‘lack of respect’ for

their work. They also recognized that questions or doubts about the quality and effectiveness of social workers' work was leading management to institute additional layers of oversight:

. . . because well if we don't really watch them they're probably not doing what they should be doing or they're doing things that we don't want them to do so we need to really keep an eyeball on them.

The social worker is describing the increased surveillance that is being done to staff because they are not meeting the expectations of administration. Again this message is intended to be negative and does not validate the difficult and emotional work that the social workers do on a daily basis.

More specifically, management sees the increase in patients designated ALC as a sign that social workers and teams are not doing proactive discharge planning - essentially, not doing their jobs. The social workers I interviewed described being held accountable for the higher number of ALC patients, despite it being a result of their environment.

. . . what drives me nuts is that to me . . . on paper to the LHIN and to all these people who are all about these ALC numbers - that [the 'high' rate of ALC patients] makes my team look bad. So I have gone to them multiple times to say this patient is not ALC and do you know the implications of them sitting as ALC right now? Because that means ... they're sitting here without a plan and the LHIN will come back and say well you know you have a high ALC rate what are you guys doing wrong, right? (Joe).

Gilda offers a different position than her fellow social workers. She feels that the attention to ALC numbers is beneficial because it tells a story of the patients who are not

able to leave the hospital. She states that she wants management to be aware of the patients behind these numbers. For most of the social workers in the focus group, however, the involvement of administration in their daily work due to increased monitoring of ALC numbers was seen as a negative. They felt direct pressure to come up with a discharge plan quickly, despite some patients being made ALC prematurely, having complex care needs and the reality that there are long wait lists and lack of community resources to transition patients from the hospital.

In defining what is a successful discharge Sharon stated that she immediately thought of length of stay, because hospital administration focuses on this benchmark. She further explained that she did not think of this from a social work perspective, but rather from the perspective of the organization. On her unit, there are standardized care paths for patients, based on diagnosis, that outline plan of care and length of stay. She describes how hospital administration views a successful discharge:

. . . a patient comes through, receives their care in a timely way, makes the benchmarks for length of stay without going over them or even perhaps being an overachiever and getting out of here before the length of stays are hit. The family not having to do much adjustment. The family not having to have much intervention or interaction with us. And that the patient then goes back primarily to their previous level of function there doesn't need to be all this extra intervention to support that patient.

She explains that this is not the reality of her work. In fact, she states that the reason they are so busy is most discharges do not follow this 'preferred' administrative course.

Joe sums it up best by stating that a successful discharge should not be measured by length of stay; she suggests that the “benchmark” should actually be “best care.”

Social workers identified that they spend a lot of wasted time and energy doing activities that do not add any value to patients care and in reality, prohibits them from spending time with patients. Social workers are caught in a complex system because they are expected to come up with discharge plans for patients who are much sicker in a time-compressed length of stay. The expectations on them, often made them feel deskilled because they are not meeting the needs of their organization or the needs of patients and families. Jerry states:

So instead of everybody trying to use what time and energy we have to figure out what’s best for the patient I have to go to all these meetings and talk about all this stuff which doesn’t make anything better for the patient. All the time that is spent thinking about and talking about and strategizing about all these things doesn’t give me more time at the bedside. Doesn’t give me more of an opportunity to try to connect people with resources or just listen to them tell me why they’re freaked out or help them problem solve through whatever situation they find themselves in.

With so much pressure to move patients out of the hospital, social workers stated that they try very hard to humanize patients so that they are not just considered a ‘number’ or a ‘disease’. Joe commented that administration does not see the struggles of the family and the ‘40 phone calls’ that social workers make in trying to move a discharge plan forward. Instead, when a discharge does not happen, administration “is freaking out” and is unable to see the toll on the patient and family.

Challenges occur because patients are a heterogeneous group; care plans should be based on individual needs, and not the needs of the organization. Social workers point out that management is so far removed from the delivery of care; they do not see or know about the impact on the front-line. Sharon discusses the layers of bureaucracy in discharge planning that is “not patient friendly”, “family centred” or “social work centred.” In fact, she describes an additional “complexity” or “heaviness” of work because she is expected to dialogue with middle and upper management about discharge planning, which in itself wastes time and causes a delay in the process.

Overall, situations like these caused emotional angst for social workers because there is a constant tension between their professional integrity and the bed pressures of the hospital. Jerry eloquently explains the personal tension of working in a system that ‘pushes’ patients out the back door, while he is frantically trying to find appropriate community services or supports. He indicated that at times, in order to do the ‘right’ thing, he has to work against the system that employs him, for the benefit of the patient.

So yea I could push them, I could be part of a system that pushes them out the back door into that that sort of hole, that chasm where there aren't a lot of things for them to grasp onto that's going to help them not hit the bottom of that. My job is to try my darnedest to connect them and sometimes the best work I do is [say], 'I can't find the door or the door doesn't open' and that's the constant conflict that I think a lot of us feel which is the stressful piece that I'm employed by a system that I have to work against, at times, because it's the right thing for me to do . . . so then you're in an active, tangibly active against relationship, you're in an anti-relationship with your own employer, your own

system because you know that's what you need to do and you know that you have to do it because it's the right thing.

The experiences of CCAC Case Managers

As indicated previously, I shifted the focus of this study from the relationship between CCAC case managers and hospital social workers to the common and distinct ways they experience their discharge planning roles and responsibilities. In the focus group with CCAC case managers, they expressed concerns about the pressures to discharge patients quickly; however, they had different perspectives and experiences than hospital social workers regarding government initiatives and how ALC is operationalized in their hospital. They described the uniqueness of working in an organization when they are not employees of it and how this affects their discharge planning roles. Also, CCAC case managers expressed the same desire to spend more time with patients and families so that they can arrange the most appropriate services and care plans.

CCAC case managers, as the discharge planners in their respective hospitals, shared their concerns about the pressure to discharge patients quickly when there are bed pressures in the health care system. CCAC case managers described how they receive information daily about patients who are designated ALC and how this directs the work that they do. One of the case managers, Sheila, who was the only coordinator from an acute care hospital, stated that although the imperative to discharge patients as

soon as possible is present, the culture in her hospital is extremely supportive. Sheila describes how she receives a daily “big printout” of all the ALC patients in the hospital and attends weekly rounds with the whole team, including the Vice President of the hospital. She identifies a process where all team members come together to discuss ALC patients and the barriers to discharge. The intent here is to problem solve and to not blame one individual or discipline for a delay in a patient’s discharge. CCAC case managers did not experience tension between ALC and LOS. In fact, Sheila explains that there are times patients are made ALC prematurely, however, hospital staff and physicians were receptive when this is pointed out to them.

With respect to the ‘Aging at Home’ initiatives, all three of the case managers felt that the government programs were working in their community because patients were being discharged home with more services and were staying home longer. Kate stated she has seen a change in the number of people requiring long term care and that there are “now able to be better managed in the community.” Although their case management role did not extend outside the hospital, Sheila felt that she would become aware of patients who were not coping in the community because they would appear in the Emergency Department as “frequent flyers.” She also felt that there were more options for patients in their community because the private sector had “stepped up” and built supportive housing complexes. When I mentioned that these homes were not

subsidized, it appeared that most of the patients with whom Sheila worked had private resources.

Although CCAC case managers are the discharge planners in the hospital, their role was unique in that they did not have to enforce discharge planning policies such as 'home first' or in their hospitals, the 'short wait list' policies² because they are not employees of the hospital. The case managers explained that they are expected to support and refer to these policies, but in their hospitals, social workers are responsible for delivering any messages about hospital discharge planning policies. CCAC case managers further pointed out that any complex patient and family situations, including housing and finances were referred to social work for assistance. Sheila explains that in rounds if a situation is a "mess" the team refers to social work.

CCAC case manager's experience of working in an organization that was not their employer varied with different case managers. Sheila felt "very supported and very much part of the team". She explains:

We communicate, all of us, on a weekly basis . . . and the VP is right here . . . and . . . she says, 'if you need support, if you need support I'm more than happy to meet . . . [with you] and with the family'.

² If a patient needs to stay in the hospital to wait for a long term care home, they must choose one long term care home from a short list, meaning one that has a wait list less than three months - typically the less desirable homes.

Kate offers a different perspective about what it is like to be a case manager in the hospital. She feels that it is “challenging” especially when the hospital is putting pressure on you to “move that bed or get that patient out.” She indicated that this affects her ability to prioritize her work especially when the message from the hospital is, “we want you to enforce our policies but they’re not our policies.” The fact that CCAC case managers work for a separate organization can in some cases work to their advantage because they can defer to hospital staff to reinforce policies and yet, in other ways, it can be a disadvantage because hospital staff expect CCAC case managers to ‘work’ for them and expedite discharge plans for patients as soon as possible. Kate acknowledges that this is not an easy situation for her, so she obtains support from her fellow CCAC case managers and the management of her organization.

Social worker- CCAC case manager relations at the front-lines of discharge planning

In this final section, I discuss the inter-professional relations at the front lines of discharge planning by looking at the collaboration between hospital social workers and CCAC case managers and how professional identity is understood.

In their focus group, hospital social workers offered mixed viewpoints about their relationship with CCAC case managers. Some social workers felt that CCAC case managers experienced the same pressures that they do and work collaboratively in developing discharge plans. Others lamented about the past when CCAC case managers

were actually embedded in the teams. This meant more continuity and the ability to build relationships. Allison elaborates on this former model in their hospital:

. . . there was not a tribal struggle. . . it was very much looking at the patient together. It was very collaborative and very consistent.

Another social worker described the tension that can occur when working with CCAC case managers regarding availability of home care services in the community. The CCAC case manager advised her to not talk to patients and families about homecare hours because it was a CCAC role to do so and could lead to misunderstandings. The social worker stated that she was advising the family of the maximum number of hours and was not guaranteeing any service. She states:

I literally had a case manager say to me not long ago... ‘Why would you ever tell families that they can get 3 hours?’ . . . And I said ‘well that’s very interesting because it's kind of common knowledge, I know that everybody says that and you can’t tell me I can’t say that because I know that that’s your {maximum} number of hours.’ She’s like, ‘well I really don’t feel again that you should be saying that.’ I [said], ‘well then we agree to disagree about that.’

Jerry feels that the relationship between hospital social workers and CCAC case managers has been purposely set up by management to be less collaborative. He feels that the front-line case managers are being “counseled to not work” in a collaborative manner with social workers because CCAC is supposed to be a “stand-alone” organization. He explains:

Their structural upper management whatever you want to call it is actively promoting a distancing, a division between frontline social work staff and

frontline CCAC staff. They don't want us to be developing those collegial relationships that we had in the past where we were teams, where we would have a case manager embedded in the team and we would function as a team and they would be a member of the team.

Jerry states that the model now is to have CCAC case managers float and rotate on units on a weekly and monthly basis, with little opportunity to form long term working relationships with the team members. Joe pointed out that as a new social worker, she was taught by her fellow social workers to seek out and build a relationship with her CCAC counterparts because they are crucial for discharge planning. Both these workers have identified the desire and need to have CCAC case managers embedded in their care teams. As an experienced social worker, that has a history with homecare, Jerry offers a critical view on CCAC management because he has seen the changes over the years. He referred to CCAC's involvement with teams as "more narrowed" than in the past, with a focus on standardized needs assessments. Jerry has identified that CCAC case management is based on regulatory functions, instead of the preferred feminist ethics perspective, which values fostering relationships, be it with patients and families, or team members.

Professional identity at the front lines of discharge planning emerged as a very relevant and challenging theme for social workers. CCAC case managers easily described themselves as discharge planners whereas, hospital social workers identified themselves based on the pressures that they were experiencing. Initial responses from the social

workers to a question about their role in the hospital focused on how they are responsible for managing bed pressures. Their comments included: “I tell people I do crowd control” or “It's a lot of putting out fires. It's crisis management.” Upon deeper reflection, social workers discussed how they help patients and families move through a very complicated health care system. Allison offered this explanation of the role of a social worker in the hospital:

. . . social workers really do bring the second and third dimension to the patient in the bed by dealing with . . . and advocating for that patient as a person with family, with consequences . . . and what the family situation is . . .

The social workers pointed out that, despite their own broader views of their roles, hospital administration sees discharge planning as social workers' main responsibility. Shona said “I would say that discharge planning is in in bold letters” implying that her organization places importance on this activity and this is where she spends the majority of her time. This sense of discharge planning being an imposed and problematic role for social workers, contrasts with the perspective of CCAC case managers.

Social workers spoke critically about discharge planning work that they do in the context of the health care system. They adopted a social justice lens that looked at how they can assert themselves and their professional identity into a system that is flawed. Jerry defined himself as a “trailblazer” and stated that to be able to speak up to administration, it has to be part of your personality. He explains that there are certain social workers and CCAC case managers “who are not afraid to draw fire” and are

prepared to “stand up to the system.” Shona (social worker) agrees with Jerry’s viewpoint and states:

. . . isn’t it sad that ultimately if you’re looking at what’s best for the patient... and ultimate patient care, you have to be willing to put yourself (in that position).

Jerry explains that if this is “not part of your character” or that you are not prepared to go “against the system or your manager” than you will do the “minimum” for your patients because you are doing what you are told to do. From a social justice perspective, both Shona and Jerry are suggesting that social workers need to continue to advocate for patients and stand up to a health care system, that in their experiences, is not organized around best patient care. Other social workers agreed, in particular, Joe, who was a more recent graduate from university. She indicated that she struggled with incorporating what she learned in her social work program about anti-oppressive practice and the realities of discharge planning in the hospital. There was a sense that this group of social workers needed to get together, needed to discuss issues impacting them at the front-lines, and that they needed to talk about their role as hospital social workers and consider collective or mutually supportive actions.

Discussion

Summary of Key Findings

This research study began with an interest in understanding how hospital social

workers and CCAC case managers make sense of their roles and how each relates to the imperative of moving patients quickly through the healthcare system. In the focus group of social workers, themes emerged that illustrated the 'heat' in discharge planning and the implications this pressure had on patients and families, and the role of social work. Two dominant sources of pressure on discharge planning were the provincial focus on reducing wait times and organizational performance markers related to patients' length of stay. Social workers voiced their concerns about government rhetoric and the inadequacies in community resources for 'aging at home', constrained choices and coerced caregiving that had implications for patients and families. With ALC patients, social workers also identified feeling deskilled because they were not meeting the needs of their organization or the needs of patients and families. They also felt mistrusted by management because they had to attend extra meetings about their ALC patients and comments had been made by managers to suggest that social workers are not doing proactive discharge planning. They also shared concerns about having to spend time on administrative activities that did not add any value to patient care.

In the focus group with CCAC case managers, themes emerged regarding their role as discharge planners in the hospital. CCAC case managers identified that there are significant pressures to discharge patients promptly, especially with the increased attention to ALC patients. They discussed how in their community, government initiatives such as 'Aging at Home' was working because patients were being discharged

home with more services and were staying home longer. CCAC case managers described the unique experience of working in an organization that is not their employer and having to facilitate 'their' discharge planning policies. Although they did not have to communicate or enforce these policies - social workers and hospital administration did this - they felt the pressure to be supportive of the process. Ultimately, CCAC case managers wanted more time to spend with patients and families so that they could arrange the most appropriate services and care plans.

Other themes that emerged from this study were the inter-professional relations between social workers and CCAC case managers and how professional identity impacts the role of discharge planning. Experienced social workers talked about times past when CCAC case managers were embedded in their teams and the positive relationships that developed because they worked closely together. They were concerned about the contemporary "tribal struggles" between social workers and case managers regarding role responsibilities and turf. In this situation, social workers were referring to the expansion of CCAC's role within the hospital and how case managers are now doing work, such as capacity assessments for admission to long-term care and choice lists that had previously been social workers' responsibility. The concerns about 'tribal struggles' led to further speculation by social workers that upper management did not support a close, collaborative relationship between the social workers and CCAC case managers because it was better to keep their roles distinct and to not blur any responsibilities, to

minimize workplace grievances. The final theme was on professional identity and “character” which social workers felt was needed to stand up against a system that is not always working in the best interests of patients and families.

‘Standpoint’ Perspective and Limitations

Information provided in these focus groups showed that social workers and CCAC case managers’ interpretation of their roles was dependent upon their professional identity, employer and the environment in which they work. The pressure to reduce time in hospital and discharge patients quickly is prominent in all hospitals; however, there were subtle differences in how this mandate was executed. In the smaller community hospitals in which CCAC case managers worked, they were embedded in teams and felt less responsible for the lack of resources or barriers that impede discharge planning. In contrast, social workers in the larger academic hospital felt that they were being held responsible for social issues and lack of resources that influenced planning for patients. The different viewpoint or ‘standpoint’ of hospital social workers and CCAC case managers allowed me to see discharge planning from both of their perspectives and to appreciate the uniqueness and similarities of their situations (Eakin, 2010).

At the same time, the fact that the focus groups occurred with workers in two LHINs and different kinds of hospitals represents a limitation of this study. As the patient populations and discharge planning policies were distinct in each LHIN and

because social workers were from a large academic hospital with regional programs and the CCAC case managers were from small community based hospital, it was difficult to compare their experiences. As mentioned previously, social workers worked with many patients who most often lived in poverty and did not have access to affordable housing or subsidized supportive living. CCAC case managers did not identify this concern in their community; however, they did specify that the social workers in their hospital became involved with patients who had financial issues. As well, although I appreciated the interest, time and information the focus group of CCAC case managers contributed to this study, I would have liked to have seen the number of participants higher, so that I could have a broader perspective of their experiences, especially because there is no research on their work in the hospital.

Connecting the Themes to the Literature

Even with these limitations, the themes that arose from the focus groups were rich and informative and illustrate the pressures hospital social workers and CCAC case managers experience at the front- lines of discharge planning. This study complements the research by Phillips & Waterson (2002) and Lechman and Duder (2009) that explored the increased pressure on social workers to do administrative tasks, with less time to spend on patients' psychosocial needs. In my study, hospital social workers talked about the wasted time and energy being spent on increased administrative duties, such as attending meetings with management regarding their ALC patients, when their time and

skills could be much better spent at the 'bedside' talking to and assisting patients and families with transitioning from the hospital to home or to another place of care. Much like the study done by Philips and Waterson (2002), social workers were not being permitted the time to do the 'social' that is needed to help patients.

As a result, social workers talked about feeling demoralized by increased surveillance and management concerns about a 'culture' that is not doing proactive discharge planning. Literature on discharge planning espouses the benefits of earlier intervention to avoid delays in leaving the hospital (Wells et al., 1999; Lechman & Duder, 2009; Dainty & Elizabeth, 2009) but, are narrowly focused and do not encompass a social justice perspective for patients. The fact that Dainty and Elizabeth (2009), discussed the need for a 'discharge planning checklist' for physicians, to improve communication and understanding of discharge planning, and failed to mention the barriers or social conditions that impede discharge planning, is revealing. Failure to look at this, speaks to the work of Heimer and Steven (1997) that suggested that social workers pick up the 'messes' or psychosocial issues that no other profession wants to talk about, let alone help in managing. My study shows that social workers not only 'picked it up', they take the heat for discharge planning issues that were beyond their control.

Dainty and Elizabeth (2009) also raised concerns that discharge planning is a neglected skill that is not taught in undergraduate and graduate programs. Once again

their view is narrowly focused, looking at discharge planning as a set of competencies, instead of a complex psychosocial activity. Colley (2012) would label this standardization of discharge planning as ‘not-learning’ because the competencies do not involve critically thinking or looking deeper at the current conditions impacting discharge planning. Learning should include having the opportunity to talk about ethical issues in teams or group settings, to get a better understanding of discharge planning concerns in a community. Opportunities for learning would help staff, especially social workers and newer graduates from the program, see the connection between theory and practice, which is often lacking in the workplace. With more social workers being program managed and not supervised by someone of the same profession, the threat is that others will define our role and ‘squeeze out’ the ‘social’ in our profession.

The fact that social workers were brought together in a focus group to discuss discharge planning issues gave them the opportunity to raise concerns about ALC that has not been mentioned in other studies. Social workers identified the organizational tension between acute length of stay and ALC days and shared their experiences about patients being designated ALC prematurely. Social workers indicated that there is pressure for physicians to shorten or meet targeted acute length of stays, which can result in patients being designated ALC prematurely, even when they are still acute (or still requiring services of consultants or allied health professionals) and not ready to leave the hospital. For example, patients who require a rehabilitation program, but are

designated ALC too early, will be found ineligible for this service because their care needs exceed what the program is able to provide. Social workers have to delay applying to these programs until patients' health status improves, resulting in an increase in ALC days, with patients not officially on a waiting list for any program. For patients who want to return home but still require the services of allied health, the designation of ALC means that they need to leave the hospital as soon as possible, because they have been deemed not to need the intensity of acute care. This situation also causes undue stress for families because care is often downloaded on them and there is an expectation by the hospital that they are going to 'pick up the slack' of the health care system. Social workers experienced the 'heat' when advocating for patients and families in these situations. Administration viewed any delay in discharge as social workers not doing proactive discharge planning, instead of understanding the difficulty in arranging a plan for patients when they are not physically or emotionally ready to leave the hospital.

In contrast, CCAC case managers did not experience the same type of tension between LOS and ALC and in fact, they felt well supported by hospital physicians when they questioned patients ALC status and their inability to discharge plan because patients were still acute. In addition to the differences in care settings discussed above, this draws attention to a bigger issue of the inconsistencies in how ALC designations are applied, despite a provincial definition. Even within the same organization, physicians

do not always agree about how to designate patients ALC. For example, one physician might say a patient with an infection, such as clostridium difficile, which causes severe diarrhea and abdominal pain is not suitable for an ALC designation because the patient's care needs are high, and in other cases a physician will determine that this same patient is reasonably deemed ALC because this infection does not require admission to an acute care bed. A further layer of complexity has to do with how certain kinds of health conditions come up against the admission criteria of community agencies. Even if there was agreement among hospital staff that a patient with clostridium difficile does not require an acute care bed, for example, it is also the case that no post-acute program, long term care or retirement home will accept a patient with this type of (contagious) infection. So to designate a patient with clostridium difficile 'ALC' creates a situation in which social workers must work on a discharge plan for a patient who essentially cannot be discharged. Some physicians take this into account; others do not.

Ideas for Future Research

More research is needed on how the definition of ALC is applied in order to gain a better understanding of the variances in practice across hospitals in Ontario, the ways patterns of funding affect ALC designations, and how premature ALC designations are affecting readmission rates, patient wellbeing and safety, and social work practice.

Although outside the scope of my research, further discussions need to happen about creating established targets for ALC patients that are 'weighted' according to the needs

of a community, such as higher poverty rates, lack of affordable housing and available community resources. At this point, social workers, especially those in large regional care centres as my participants are, are absorbing the ‘heat’ for irrational and inconsistent practices and lack of community resources that are a barrier to discharge planning.

My study also draws attention to the need to do more research on the impact of government initiatives such as ‘Home First’ on patients and families. I would like to see research that examines patients and families’ experience of the ‘Home First’ philosophy and what it is like to go home after a hospitalization and to wait for a long-term care bed. Were the services adequate, did a bed offer come quickly, were their choices restrained, did the patient have to come back to the hospital? Currently, none of this information is being collected by the hospital or the CCAC. For patient groups who follow a more predictable care path, such as hip and knee surgery, congestive heart failure and chronic obstructive pulmonary disease, there has been much interest in improving transitions of care, by providing a consistent coordinator who arranges home care services and follows the patient from hospital to home. It would be beneficial to see research that would invest in looking at how we can improve transitions for patients who do not neatly fit into a predictable care path such as patients with complex mental, social and cognitive needs. These patients too are in need of seamless support so that they can successfully transition from one environment to the next; however, as of yet,

they have not received the same attention as patients with the above-mentioned surgical interventions or medical diagnoses.

Implications for Practice

The literature that I have read for this study has helped me understand the context of discharge planning in relation to the bigger, systems issues. The book by Rankin and Campbell, “Managing to Nurse: Inside Canada’s Health Reform” (2006) gave me a framework to look at the work that hospital social workers do. Although I knew that social workers were spending much more time on administrative tasks, I did not have the language to explain that what we were truly doing was ‘social working the organization’. The fact that social workers do meet the needs of the organization by responding to its imperative to get patients out quickly and to track ALC patients, in addition to ‘working it’ by advocating for patients and families and finding services that will help meet their needs is validating to me as a social worker. Likewise, the study by Pope (1991), provided an interesting perspective on wait lists and helped me further understand that the tracking of ALC numbers, gives the illusion that the government is addressing the needs of these patients, when in reality they are not. Of particular interest to me is that despite ‘Aging at Home’ and ‘Home First’ initiatives, there is a growing number of patients who are deemed ‘ALC’ and need to wait in the hospital for long-term care because their needs cannot be managed in the community. Unfortunately, allowing patients to stay in the hospital for long-term care because there

are no other options is considered a 'failure' and must be reported to the LHIN on a weekly basis, as part of the ALC tracking and performance measures. Hospitals' ALC rates and the number of newly designated patients for long-term care are shared with other hospitals and comparisons are often made to see who has the lowest rates and has reduced the number of patients waiting for long-term care. Supporting patients and helping them successfully and safely transition from the hospital to long-term care home is not rewarded. For me personally, I try to be very cognizant of the language that I use with my colleagues and CCAC counterparts, to show that I do not see this as a personal failure on individual workers or patients and families, but rather, a reality of our current health care system.

I began this research by wanting to gain a better understanding of the roles of hospital social workers and CCAC case managers in relation to one another, as both hospitals and CCAC have been mandated to work together to improve discharge planning processes in the hospital. I knew that this study could be considered political because hospitals and CCAC staff seldom speak publicly about any difficulties that they have with each other, for fear that either one would not be seen as 'good' partners by the LHIN or province. My initial intent was to conduct the focus group of hospital social workers and CCAC staff in the same LHIN, with the same practices. Unfortunately, my contact at the local CCAC advised me that I should conduct my research outside the LHIN in which I work, so that I would not damage any relationships with my CCAC

counterparts. The fact that efforts towards transparency and system improvement are not more actively embraced is frustrating to me as a social worker. I struggle with why I was blocked and what was ‘not learned’ because I did not explore this relationship. However, in saying this, it was enlightening to looking at practices of hospital CCAC case managers in another LHIN, because it provided me with a different understanding of the relationship between social workers and CCAC case managers in the hospital.

In the current healthcare context, social workers need to find a balance in being a ‘good’ social worker and being a ‘good’ employee. Part of this balance is showcasing the skills that social workers have in building relationships, managing conflict and ‘massaging’ the system so that the needs of the organization and the needs of patients and families can be met. This is aligned with a feminist ethics perspective that encourages treating people as individuals based on context. In being a ‘good’ employee, social workers are also responsible for incorporating a regulatory approach that looks at managing and standardizing processes of care, that helps organize their work and allows them to work quickly to meet the organization’s expectation to improve access for other patients, who too are in need of hospital care (McAuley et al., 1999). Social workers see the connection between all the pieces of discharge planning - the front door and the back door and even when there are no doors. However, all of this work can be at a cost, this is very emotional work that is seldom recognized by administrators. Social workers need to feel empowered to arrange their own support, be it formal or informal, so that

they can discuss practice issues and what it means to be a social worker in an acute care setting.

As explored by other researchers Gregorian (2005) and Wilder Craig (2007), the question of what it takes to be a hospital social worker in today's current political, social and economic climate emerged as a relevant theme in my research. Social workers identified that there is a certain "character" needed to work in an acute care hospital and an ability to take the "heat", "draw fire" and "stand up" to a system that is flawed. Heat also conjures up visualizations of being out of control, extremely uncomfortable and burnt. Social workers who are constantly battling 'heat' or practices that do not align with their professional values are at risk of work place burnout. There does need to be a way to control the pressures and to be able to 'stop' processes that do not seem safe or appropriate for patients. Social workers do bring a different view to the discharge planning process that is not a 'how to' manual but rather, is looking at situations from the patients and families' perspectives and advocating for them when systems or processes are oppressing them. Recommending that a discharge should not happen or be delayed does take a lot of confidence on the social worker's part - clear reasons for the delay need to be communicated to physicians and hospital management. It is beneficial to have allies, other health care team members who have similar concerns about the discharge plan. Physicians, who are the only profession that can write discharge orders and are ultimately responsible for their patients, are less likely to do so

when confronted with social workers and team members with well-articulated safety concerns for the patients. For the most part, social workers are very creative and do try to find appropriate services and destinations for patients because they want to be seen as a valuable part of the healthcare team and do not want to be seen as obstructive by hospital management.

Moving forward, this research has given me a different perspective on the work that social workers and CCAC case managers do and the need to do something different about the way I practice. Upon reflecting on the pressures on social workers, a social work colleague and I recently met with a group of social workers to discuss what they needed to support them in the work that they do. The group came up with a purpose - they wanted a clinical peer supervision group where they could obtain feedback about difficult patient situations, as well as the opportunity to discuss ethical issues that occur in their day-to-day practice. The group has decided to meet bi-weekly and individual social workers have taken responsibility to facilitate discussions. Although this is a small step, it provides social workers with a venue to share information with other social workers and to learn from one another. Much like the study of Wilder Craig (2007), social workers need a venue to share their stories and spread their 'collective wisdom' so that we can continue to be a resilient profession.

Concluding Remarks

The pressure to move patients out of the hospital as soon as they are deemed not to require acute care has had major implications for front-line staff. For social workers, many of the patients that they work with face challenges in leaving the hospital, due to care needs, finances and inadequate resources. From management's perspective, any delays in discharge are seen as social workers not doing proactive discharge planning. Social workers identified that they experience pressure in sustaining their values in light of organizational pressures that frequently challenge these values. Often times, they take the 'heat' for issues that are beyond their control. Now more than ever, social workers need to advocate for themselves and find venues or opportunities to be able to talk about the work that they do, to learn from each other and to educate other professionals and administration on the value of their skills in managing conflict, navigating systems and 'working' the organization. Social workers need to support one another in doing this work because there are times when social work is in conflict with other professionals and management, to do what is necessary for patient and family wellbeing, and to sustain a social justice commitment to ensure care for marginalized patients.

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APPENDIX A

Recruiting Email for Hospital Social Workers

Cover email:

Please see message below and attached information about a study being conducted by Lori Lawson towards her MSW thesis. I encourage those of you with roles in discharge planning to consider participating. For more information, or to express your interest in the study, please contact Lori Lawson directly.

Dear Social Workers:

I am conducting a research study on the front-line experiences of hospital social workers with respect to discharge planning. I want to explore how hospital social workers define their intentions and understand their roles in discharge planning. I also want to understand how your roles in patient care intersect with the roles of CCAC case managers. I am interested both in what works well in these care processes, and what is more difficult or could be improved.

This study is part of the requirements for my Masters in Social Work at McMaster University, under the supervision of Dr. Christina Sinding. It has received ethical clearance from the Research Ethics Board of Hamilton Health Sciences.

I am looking for volunteers who have a role in discharge planning from the hospital to the community to participate in a focus group of approximately one hour in length. I will pick a time and location that is convenient for you. I will send you information prior to the focus group so that you can reflect on your experiences. You will be asked to review a summary of themes from the focus group so that you can offer feedback on the findings.

Any names used in the focus groups (of yourself, your patient/clients or their family members, work colleagues, of hospitals or other organizations) will be replaced with pseudonyms. Any information about the participants will be presented in aggregate form so that no one individual will be identifiable. I will make every effort to preserve your confidentiality.

The detailed information sheet and consent form for this study is attached for your perusal.

If you are interested in learning more about this study and possibly participating, please email me at lawsonla@mcmaster.ca.

Thank you for considering this request! I hope to hear from you.

Lori Lawson BA, BSW

MSW candidate, School of Social Work

McMaster University

Recruitment Email for Hospital CCAC Case Managers

Cover email:

Please see message below and attached information about a study being conducted by Lori Lawson towards her MSW thesis. I encourage those of you with roles in discharge planning in the hospital to consider participating. For more information, or to express your interest in the study, please contact Lori Lawson directly.

Dear Case Managers:

I am conducting a research study on the front line experiences of CCAC case managers with respect to discharge planning in the hospital. I want to explore how CCAC case managers define their intentions and understand their roles in discharge planning. I want to understand how your roles in patient care intersect with the roles of hospital social workers. I am interested both in what works well in these care processes, and what is more difficult or could be improved.

This study is part of the requirements for my Masters in Social Work at McMaster University, under the supervision of Dr. Christina Sinding. It has received ethical clearance from the Research Ethics Board of Hamilton Health Sciences.

I am looking for volunteers who have a role in discharge planning from the hospital to the community to participate in a focus group of approximately one hour in length. I will pick a time and location that is convenient for you. I will send you information prior to the focus group so that you can reflect on your experiences. You will be asked to review a summary of themes from the focus group so that you can offer feedback on the findings.

Any names used in the focus groups (of yourself, your patient/clients or their family members, work colleagues, of hospitals or other organizations) will be replaced with pseudonyms. Any information about the participants will be presented in aggregate form so that no one individual will be identifiable. I will make every effort to preserve your confidentiality.

The detailed information sheet and consent form for this study is attached for your perusal.

If you are interested in learning more about this study and possibly participating, please email me at lawsonla@mcmaster.ca.

APPENDIX B

LETTER OF INFORMATION / CONSENT FOR SOCIAL WORKERS

From Hospital to Home: Front-line Experiences of Hospital Social Workers and Community Care Access Case Managers

Investigators:

Local Principal Investigator:

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Student Investigator:

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Purpose of the Study

You are invited to participate in a research study conducted by Lori Lawson on the experiences of hospital social workers and Community Care Access Centre (CCAC) Case Managers on the challenges in discharging patients from the hospital to the community. This is a student research project conducted under the supervision of Dr. Christina Sinding.

My name is Lori Lawson and I am a Masters in Social Work candidate presently enrolled at McMaster University. I am in the process of completing the thesis requirement of the program. The purpose of my study is to explore how hospital social workers define their intentions and understand their roles in discharge planning. I will also conduct a separate focus group with CCAC case managers on the same topic.

Procedures involved in the Research

I would like to invite you to attend an hour-long focus group with other social workers to share your experiences in discharge planning. I am interested in learning more about how you define a successful discharge, as well as some of the challenges you face in moving patients quickly through the health care system. I would like to have a better

understanding of how your role intersects with the role of CCAC case managers, with particular interest in appreciating how you approach the idea of choice for patients.

With your permission, the interview will be audio recorded and transcribed. I will be asking you basic demographic information such as your gender, years of experience in the field and education level. The focus group will take place at a time and location that is convenient for you.

I am also asking your permission to approach you for a short individual follow up interview (no more than half hour) to clarify and expand on themes from the focus group. As well, I am requesting your permission to send you a summary of themes from my study, for your comment. You are free to decline either or both of these requests and still participate in the focus group.

Potential Harms, Risks or Discomforts

The risks involved in participating in this study are minimal. You may feel uncomfortable with describing your experiences or you may find it stressful to remember an unpleasant event or experience. You might worry that your response reflects poorly on your work site or that specific statements you make may be traced back to you. You may worry that punitive actions may result from your participation in this study.

I will take every precaution to ensure the confidentiality of any and all information that you provide. I need to make you aware that because the study uses a focus group method I cannot provide you a guarantee in this matter, and you should keep this in mind in your comments. You do not need to answer any questions that make you uncomfortable or that you do not want to answer.

In terms of reporting the findings, every effort will be made to preserve your confidentiality. The information I collect about you (for instance, years of practice and the place you work) will be used only to describe the sample, and not linked to any quotes of yours that I may use.

You can withdraw from the study at any time without consequence.

Potential Benefits

It is my hope that through participation in this study you will be given the opportunity to share your concerns about discharge planning in our current economic and political

climate. I hope that the information you share helps to improve the transitioning of patients from the hospital to the community and to learn more about the complexities of interprofessional collaboration.

Confidentiality

I want to assure you of the importance of confidentiality. Every precaution will be taken in this endeavor. Anything that I find out about you that could identify you will not be published or told to anyone else, unless I obtain your permission. Information that you provide will be presented in a manner that is non-identifying and only relates to this study. I will ask other participants to respect your privacy, but cannot guarantee they will do so, and you should keep this in mind in your comments.

The information obtained by me will be kept on my person or in a locked file cabinet. It will only be available to my academic supervisor and me. The computer that I will be using is my personal computer which is password protected. Upon successful defense of my thesis the information you provide will be shredded, and audiotapes will be destroyed.

Participation and Withdrawal

Your participation in this study is voluntary. If you agree to participate, you can decide to stop at any time, even after signing the consent for or part way through the study. If you decide to stop participating, there will be no consequences to you. In cases of withdrawal, any data that you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results

I expect to have this study completed by September 2013. If you would like to receive a brief summary of the results sent to you personally, please contact me via my email address that has been provided.

Questions about the Study

If you have any questions or need more information about the study itself, please contact me at lawsonla@mcmaster.ca.

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013.

CONSENT

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study by Lori Lawson, of McMaster University. I understand that I will receive a signed copy of this form.

- 1. *I agree that the interview can be audio recorded.* Yes No
- 2. *I agree to be approached for a follow up individual interview, which I understand that I can decline.* Yes No
- 3. *I agree to be asked to review a summary of the study themes, which I understand I can decline.* Yes No
- 4. *I would like to receive a summary of the study's results.* Yes No

If yes, where would you like the results sent:

Email: _____

Mailing address _____

Name of Participant (Printed)	Signature	Date
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Consent form explained in person by:

Name and Role (Printed)	Signature	Date
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LETTER OF INFORMATION / CONSENT FOR CCAC CASE MANAGERS

From Hospital to Home: Front-line Experiences of Hospital Social Workers and Community Care Access Case Managers

Investigators:

Local Principal Investigator:

Dr. Christina Sinding
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 22740
E-mail: sinding@mcmaster.ca

Student Investigator:

Name: Lori Lawson
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 522-1155 ext. 34067
E-mail: lawsonl@mcmaster.ca

Purpose of the Study

You are invited to participate in a research study conducted by Lori Lawson on the experiences of front line staff involved in discharging patients from the hospital to the community. This is a student research project conducted under the supervision of Dr. Christina Sinding.

My name is Lori Lawson and I am a Masters in Social Work candidate presently enrolled at McMaster University. I am in the process of completing the thesis requirement of the program. The purpose of my study is to explore how CCAC case managers define their intentions and understand their roles in discharge planning. I will also conduct a separate focus group with hospital social workers on the same topic.

Procedures involved in the Research

I would like to invite you to attend an hour-long focus group with other case managers to share your experiences in discharge planning. I am interested in learning more about how you define a successful discharge, as well as some of the challenges you face in moving patients quickly through the health care system. I would like to have a better understanding of how your role intersects with the role of hospital social workers, with particular interest in appreciating how you approach the idea of choice for patients.

With your permission, the interview will be audio recorded and transcribed. I will be asking you basic demographic information such as your gender, years of experience in the field and education level. The focus group will take place at a time and location that is convenient for you.

I am also asking your permission to approach you for a short individual follow up interview (no more than half hour) to clarify and expand on themes from the focus group. As well, I am requesting your permission to send you a summary of themes from my study, for your comment. You are free to decline either or both of these requests and still participate in the focus group.

Potential Harms, Risks or Discomforts

The risks involved in participating in this study are minimal. You may feel uncomfortable with describing your experiences or you may find it stressful to remember an unpleasant event or experience. You might worry that your response reflects poorly on your work site or that specific statements you make may be traced back to you. You may worry that punitive actions may result from your participation in this study.

I will take every precaution to ensure the confidentiality of any and all information that you provide. I need to make you aware that because the study uses a focus group method I cannot provide you a guarantee in this matter, and you should keep this in mind in your comments. You do not need to answer any questions that make you uncomfortable or that you do not want to answer.

In terms of reporting the findings, every effort will be made to preserve your confidentiality. The information I collect about you (for instance, years of practice and the place you work) will be used only to describe the sample, and not linked to any quotes of yours that I may use.

You can withdraw from the study at any time without consequence.

Potential Benefits

It is my hope that through participation in this study you will be given the opportunity to share your concerns about discharge planning in our current economic and political climate. I hope that the information you share helps to improve the transitioning of patients from the hospital to the community and to learn more about the complexities of interprofessional collaboration.

Confidentiality

I want to assure you of the importance of confidentiality. Every precaution will be taken in this endeavor. Anything that I find out about you that could identify you will not be published or told to anyone else, unless I obtain your permission. Information that you provide will be presented in a manner that is non-identifying and only relates to this study. I will ask other participants to respect your privacy, but cannot guarantee they will do so, and you should keep this in mind in your comments.

The information obtained by me will be kept on my person or in a locked file cabinet. It will only be available to my academic supervisor and me. The computer that I will be using is my personal computer which is password protected. Upon successful defense of my thesis the information you provide will be shredded, and audiotapes will be destroyed.

Participation and Withdrawal

Your participation in this study is voluntary. If you agree to participate, you can decide to stop at any time, even after signing the consent for or part way through the study. If you decide to stop participating, there will be no consequences to you. In cases of withdrawal, any data that you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results

I expect to have this study completed by September 2013. If you would like to receive a brief summary of the results sent to you personally, please contact me via my email address that has been provided.

Questions about the Study

If you have any questions or need more information about the study itself, please contact me at lawsonla@mcmaster.ca.

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any

questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013.

CONSENT

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study by Lori Lawson, of McMaster University. I understand that I will receive a signed copy of this form.

1. *I agree that the interview can be audio recorded.* Yes No
2. *I agree to be approached for a follow up individual interview, which I understand that I can decline.* Yes No
3. *I agree to be asked to review a summary of the study themes, which I understand I can decline.* Yes No
4. *I would like to receive a summary of the study's results.* Yes No

If yes, where would you like the results sent:

Email: _____

Mailing address _____

Name of Participant (Printed)	Signature	Date
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Consent form explained in person by:

Name and Role (Printed)	Signature	Date
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APPENDIX C

Demographic Questionnaire:

1. Gender: _____
2. Which organization do you work for? <input type="checkbox"/> Hospital <input type="checkbox"/> Community Care Access Centre
3. How many years have you worked for this organization?
4. What is your professional background?
5. How many years have you worked in this profession?
6. Please indicated your educational level (check all that apply): <input type="checkbox"/> Graduate <input type="checkbox"/> Undergraduate <input type="checkbox"/> College/Diploma <input type="checkbox"/> Other (please indicate) _____

APPENDIX D

INTERVIEW GUIDE

Focus Group Script:

Thank you for agreeing to participate in this study. The purpose of this study is to seek a better understanding of how hospital social workers and CCAC case managers understand their roles and how each relates to the imperative of moving people quickly through the system.

Please do not use patient/client names or names of colleagues in our focus group. If you do, I will make sure to change the transcript by replacing the name with a pseudonym. You will have a chance to review a summary organized into themes from this session. Feel free to not answer any questions. You are also free to withdraw from the group at any point.

I will do all I can to keep everything you say confidential. Your name will not be shared by me with anyone from the hospital or CCAC. I am also asking each one of you to keep confidential everything that is said here. I cannot however; guarantee that each person will do this, and you should keep this in mind in what you decide to say.

I will be using a tape recorder and I will take notes. Before I turn on the tape recorder, do you have any questions?

Interview Questions:

Please describe your current role in the hospital?

When you are involved in discharge planning, what do you have in mind? What are you trying to achieve?

How would you describe a successful discharge plan? What worked? Why did it work?

What do you see as some of biggest challenges in discharge planning?

Probe For:

- Source of the challenges
- How they respond to challenges

I want to talk about how your roles intersect with the roles of CCAC case managers.

First I would like to talk about some of the challenges in working together.

Probe For:

- Understanding of the idea of “choice” and choosing to “live at risk” in the community? How is choice valued, and how could it be considered as problematic?
- Understanding of community resources (the nature of the services, how adequate they are, how they are provided, limitations)?

Now I would like to talk about times when things have worked well.

Probe For:

- What was in place (shared understandings, clear processes, etc.) that helped things work well?

If you had a wish list, what do you think would improve the transitioning of patients from the hospital to community?

Do you have any further comments or concerns that you would like to share?

Thank you for participating in the study.