ABSTRACT

This article examines the use of volunteers within hospital-based long-term care case management programs. As hospitals diversify into long-term care, the roles played by volunteers are also diversifying. A brief description of the involvement of volunteers with the frail elderly is followed by a comparison of the roles and relationships of volunteers within existing hospital auxiliaries and long-term care case management programs. Three models for structuring hospital-based volunteer programs that address the needs of the frail elderly within diverse communities are presented. Implications surrounding the involvement of volunteers beyond hospital walls are discussed.

Volunteers in Hospital-Based Case Management Programs

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Hospital diversification into long-term care is dramatically influencing the nature of health care in this country. In a 1986 survey of 3,500 hospitals conducted by the Hospital Research and Educational Trust of the American Hospital Association, sixty-six percent of the hospitals reported "that long-range plans . . . included development or expansion of services for the aging and chronically ill" (Handy, 1987).

As hospitals diversify into long-term care arenas, the roles played by volunteers are also diversifying. This article examines the involvement of volunteers within hospital-based long-term care programs designed to meet the needs of the frail elderly. Specifically, the authors' experiences with six hospital-based case management programs illustrate the importance of designing volunteer roles and relationships to address individual community needs.

The literature on volunteerism and aging has increased in the last decade, emphasizing the expanding importance of the volunteer role (Netting & Hinds, 1984; Netting & Thibault, 1986; Perry, 1983; Salmon, 1985; Zischka & Jones, 1982). Not only have volunteer programs been designed to serve the elderly, but many coordinators have targeted the elderly as a source of experienced, mature volunteers.

Well managed hospital-based volunteer programs are traditionally structured to meet the needs of patients and staff within the acute care setting. Volunteer roles and protocols have been clarified in order to develop a system that conforms to the requirements of a fast-paced medical operation. The community hospital is a center for volunteerism where gift shops are operated, mail and flowers are delivered, phones are answered, and a multitude of other tasks are performed which help to maintain a smoothly running organization. Mechanisms for report-generating are usually in place to capture numbers of volunteers and their characteristics. Cadres of volunteers who work together on specific tasks may wear smocks which designate their roles. Socialization from working with other volunteers on joint projects that benefit the facility adds to the visibility of the volunteer program in the community. In short, acute care hospital volunteers often perform within a highly structured, well documented, carefully coordinated, and highly visible system. In busy facilities where staff must often focus

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on the medical needs of patients, the volunteer can communicate caring and concern and provide a human touch as families await life or death decisions.

More recently, hospitals have begun to develop other kinds of innovative volunteer services that benefit their patients, such as advocacy and entitlement information (Bach, 1988; Ruiz-Salomon, Tuzman & Wolbrom, 1987). Volunteers also help by assisting with fundraising activities and by contributing financial resources for special building and/or equipment funds. Hospitals in large retirement communities may even attract so many older persons that volunteer waiting lists develop!

One of the major areas in long-term care in which hospitals are beginning to diversify is case management. Case management is a service provided most commonly to persons who are living in their own homes, but who are at risk of hospitalization or nursing home placement. Case managers are trained in screening, assessment of need, care and resource planning, and periodic reassessment of individual functioning. As many of the clients appropriate for this service are going from acute care to their own homes, case management appears to be a logical area for hospital diversification.

THE FLINN CASE MANAGEMENT PROGRAM

In late 1985, the Flinn Foundation of Arizona began funding hospitals to develop case management programs for the frail elderly. By Spring 1987, six not-for-profit hospitals in Arizona and New Mexico each had received three-year grants designed to facilitate the development of a long-term care case management program in their communities.

The hospitals' involvement in long-term care varied, and communities varied in terms of the resources available for addressing care planning. It soon became clear, however, that volunteer networks were being developed and expanded in varying ways to provide the informal supports so often missing in the more formalized service delivery system.

The hospital-based programs funded by the Flinn Foundation primarily use volunteers as adjuncts to professionally trained case managers. Aside from this, however, the programs are unique, ranging from the minimal use of volunteers to using multiple volunteers in numerous roles. Essentially, three structural models of volunteer program development have evolved from the experiences of the six sites.

Model 1: Autonomous Volunteer Program

The autonomous volunteer program characterizes three of the six hospitals. These case management programs have their own volunteer coordinators.

Hospital A is located in a rural county, and volunteerism has been an integral part of the case management program since its inception. An all-volunteer advisory council was formed prior to the program's being funded and has been extremely active in program development. Currently there are 19 volunteers with multiple roles and accompanying job descriptions, including case management assistance, ombudsperson advocacy, and clerical assistance. There are also plans to recruit volunteers to work with a therapeutic diet service being developed by case management staff.

Following nine hours of initial training, case management volunteers make weekly visits to assigned clients where they assist with small needs, run errands, and provide friendly visiting. Monthly meetings provide opportunities for case presentations, problem solving, and informal sharing and support. There are plans to carefully screen and select exceptional case management volunteers who will actually assist professional staff in conducting reassessment interviews with stabilized clients. Recognition has consisted of an annual awards dinner and special holiday gifts for each volunteer.

Hospital B has a paid half-time volunteer coordinator responsible for all aspects of volunteer program development. Currently she has 31 active volunteers and has completed three full 25-hour training sessions. A training manual, multiple forms and orientation materials have been developed. The coordinator provides numerous personalized touches to the program, including frequent individual evaluations on each volunteer, as well as opportunities for each volunteer to evalu-

ate the case management program. She also keeps in touch by telephone and facilitates monthly meetings which include speakers and opportunities to socialize. These meetings are important because the work of the volunteers can be isolating and emotionally draining.

Typical activities performed by these volunteers include transporting clients to doctors, running errands with the client, socialization for the client, information and referral, light housekeeping, light meal preparation, taking clients to church, and providing respite for family members. One volunteer went to the library and got talking books for a blind client to enjoy while the volunteer was on vacation.

Hospital A has a volunteer who coordinates, whereas Hospital B employs a part-time paid staff person who coordinates volunteers. Both programs do their own recruiting and are independent from their hospitals' larger volunteer programs. Case management coordinators indicate that this is because traditional hospital volunteers are not comfortable with leaving the hospital setting and going into the client's home.

Hospital C, although its volunteer program is in the initial stage, appears to be moving toward an autonomous volunteer program separate from the hospital auxiliary. This hospital has recently been accepted as a project of the local Junior League which will assist in setting up an ongoing committee on aging, and assist in the development of a volunteer program by recruiting and providing volunteer recognition. Once volunteers are trained, they will be assigned to a case manager who will provide on-the-job training and match them with appropriate clients. This program currently has two volunteers, both of whom assist with clerical work within the office. One of these has also been providing limited Medicare counseling for clients.

Interestingly, this autonomous model is consistent with these three case management programs' structural and organizational relationships within the larger hospital system. In each case, the case management program is located in a building which is separate from its respective hospital and tends to function fairly autonomously from other hospital departments.

Model 2: The Interface Model

The interface model is characterized by a desire to involve community volunteer resources without hiring a volunteer coordinator or working directly with volunteers. Hospital D is the best example of this scenario.

Hospital D's case management staff has considered the use of volunteers, but has not been able to integrate them into their program for a number of reasons including a lack of coordination with the hospital's existing volunteer program and uncertainty over the program's future. Case managers do refer to volunteer-based programs within their local community for informal service provision. This has worked fairly well because there is a church-related volunteer program that provides light housekeeping, friendly visiting, companionship, and shopping services. Located in a community that has volunteer programs in place, case managers are familiar with resources that can link volunteers with clients. Given the structure of this case management program within the hospital, and the lack of coordination that has occurred between the hospital's auxiliary and the case management component, a dependence on the community for volunteer resources has been necessary. In a community that has resources available, this has resulted in care planning that at least partially meets client needs without the problems of directly coordinating volunteers.

Hospital E would probably lean toward this model, but unfortunately the neighborhood in which this hospital is located does not have the volunteer resources available to Hospital D. Hospital E is located in a high crime-rate area of a large city, making volunteer recruitment difficult. Volunteers are fearful of visiting frail older persons in this low socio-economic part of the city. Recruitment problems plague the larger hospital volunteer program as well as the case management volunteer program. A potential source of volunteers is a nearby apartment building for the elderly, but these older residents feel particularly vulnerable in their environment and many

also lack transportation. Therefore, Hospital E has not found a viable manner in which to provide volunteer linkages through a formalized volunteer program. Case managers in this hospital often rely upon the most informal of volunteer resources, linking clients with neighbors and churches on a one-to-one basis whenever there is an opportunity.

Model 3: Hospital Integration Model

Hospital F exemplifies Model 3 which integrates the hospital's auxiliary program with the case management program. Case management staff actively work with the hospital volunteer coordinator in recruiting and placing volunteers. Although some volunteers come directly from the community, there is a sense of volunteers being a part of the hospital system. This is obvious to anyone entering the office since volunteers wear the traditional hospital smock identifying them as part of the hospital volunteer program.

Structurally, this model may be a logical outgrowth of a case management program that is integrated into the hospital system. Therefore, the hospital integration model may be more a reflection of the way in which the entire case management program has been developed rather than just how the volunteer component has been established.

Hospital F's case management program draws from a variety of volunteer sources, including university student interns. Students serve as case aides, a retired nurse volunteer from the community conducts home visits as needed, and another volunteer serves as a respite worker. Volunteer coordination for ongoing case aides will be one of the responsibilities of a new clinical supervisor. Recognition activities are coordinated through the hospital's volunteer service and include such benefits as meal and prescription discounts, special parking, and insurance coverage.

IMPLICATIONS

These three models illustrate how diverse hospital-based case management programs can be in terms of one component: volunteer involvement and coordination. Volunteer programs reflect the uniqueness of each case management program, reminding staff to consider the entire program before designing volunteer roles and relationships.

As these hospitals have moved into long-term care arenas, there are special considerations that have accompanied the diversification of volunteer roles. First, volunteers are often asked to perform their tasks in the homes of older persons. This raises issues surrounding personal liability when a volunteer works beyond the hospital walls. Volunteer coordinators must investigate insurance coverage so that appropriate cautions are taken to protect the volunteers and the program.

Hospital A, for example, has developed a written policy regarding liability. The health care corporation carries a general and professional liability insurance coverage for acts volunteers do under the direction of any of their programs. These acts have to be within the training and educational qualifications of the volunteers. The volunteer's professional health and auto policy provides main coverage first, and then the corporation's plan is used as a secondary or supplemental coverage. In other words, the corporation's plan is designed to underwrite anything not covered by a volunteer's existing insurance.

Second, volunteers who primarily work with individual clients in their homes will not have the opportunity to work with other volunteers. Assuming that many persons may be motivated to volunteer because they desire the chance to socialize with peers, these persons may not be likely candidates for roles that take them into the home environment. This requires the volunteer coordinator to develop innovative ways in which volunteers who wish it have the opportunity for peer support, ongoing training, and group interaction. Two of the hospital programs discussed above are very deliberate in designing training that provides an opportunity to share experiences and to problem-solve with other volunteers as well as with case managers.

Third, orienting volunteers to work in acute care hospitals is very different from orienting them to perform in long-term care settings. Not only do the volunteers have to understand the full continuum of care, from hospital to community-based

in-home services, but they have to know how to function with less direct supervision. Case managers may assign and introduce volunteers to specific clients, and careful instructions may be given, but often volunteers are alone with clients for extended periods of time and must depend on their own judgment if a problem arises. This differs significantly from a hospital setting where there is someone in the next room to call in the event of an emergency.

In addition, adequate orientation requires that volunteers understand the concept of case management. One reason given for Hospital C's reluctance to jump into a volunteer program has been the director's insistence that one has to struggle with program identity before bringing in a corps of volunteers to work with staff. This kind of self-awareness takes time. However, a well-conceptualized program can excite and attract volunteers just as a poorly conceptualized program can turn people away.

Fourth, ongoing (both on-the-job and inservice) training is essential. This requires a large commitment from staff in that case managers must be willing to spend time with volunteers. Coordinators may monitor and follow-up with volunteers, but it is the case manager who must be certain that the care plan is adequately addressed by the volunteer. One volunteer coordinator indicated that it had taken approximately six months to reduce resistance from case managers regarding the involvement of volunteers. This initial resistance can easily occur when professional staff are not used to working with volunteers, have had unpleasant experiences, or are threatened. If staff resistance can be overcome, the involvement of case managers in ongoing training is very helpful. Volunteers need a chance to debrief with professionals who know the older persons the volunteers are serving.

Fifth, retention of volunteers is difficult in many programs that deal with very disabled persons. These hospitals target the frailest of the frail. Often staff experience burnout and case manager turnover is high. It would be unrealistic to believe that volunteers would not burn out as well. Appropriate mechanisms need to be in place to nurture volunteers (*i.e.*, support groups, ready access to the volunteer coordinator, opportunities to change assignments, *etc.*) so that they are not lost, and it will also be necessary to provide ongoing recruitment and training of new volunteers.

Sixth, the volunteer management model chosen by a specific hospital-based case management program will vary, often based on the structure of the program itself. Designing volunteer programs that address the needs of older clients may vary by hospital, by program staff, and by the community in which the hospital is located. If the community has volunteer resources in place, case managers may find that this serves their care planning purposes well. On the other hand, if resources are limited, coordination with an in-house volunteer program already in place may work to the program's advantage. Even if an autonomous model is developed, it would be wise to work closely with the hospital program so that recognition opportunities can be shared. Possibly, recognition events can be jointly sponsored. Volunteer programs in which in-house volunteers actually follow older persons back into the community can be designed. The sense of continuity provided by volunteers who work with older persons as they leave the hospital could be invaluable to case managers who never have enough time to do all they want to do for clients.

On the other hand, care must be taken not to conflict with other volunteer programs in the hospital. As hospitals diversify, recruiting case manager volunteers may be difficult as home health, guardian, and hospice programs compete for qualified persons. Conceivably, as hospitals diversify, volunteer coordinators in numerous programs could be recruiting volunteers. Cooperation is necessary so that volunteers are not confused by multiple and overlapping roles. If designed appropriately, referrals of volunteers interested in different aspects of acute and long-term care could result in a pool of volunteers targeted to the program of their choice.

Volunteer programs take time, energy and resources. The potential for hospital diversification and the resulting continuum

of care can be very positive. However, the uncertainty within the health care environment and the changing system makes it hard to predict how long programs will survive. The programs discussed are foundation-funded for three years each. As they strategize regarding how to become more self-sufficient in a changing environment, the use of volunteers has the potential to assist in the development of community interest and support for the program.

Of particular importance to the effective involvement of hospitals in aging and long-term care services is a strong knowledge and understanding of those community-based services that comprise the "aging network." One method of helping hospitals better understand community agencies is to involve community-based volunteers in planning, developing and implementing long-term care services. Community involvement has always been evident in hospitals through voluntary boards of trustees, active hospital auxiliaries, and patient relations programs. The involvement of volunteers as an integral part of hospital-based long-term care programs can be viewed as one method of integrating acute and long-term care services within a local community.

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