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The Use of Senior Volunteers in the Care of Discharged Geriatric Patients

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This article reports on a project that utilized senior volunteers in the role of health advocates for geriatric patients discharged from a hospital. The project was evaluated to determine if healthy and active seniors could make a contribution to the health and social welfare of such discharged elderly persons. The study was conducted in Montreal, Canada and funded by a federal grant from Health Canada. The research collaborators came from a 414-bed secondary care university-affiliated community hospital, a community social service agency with a mandate to respond to the needs of its frail elderly constituents, and a university-based research centre

that works with health professionals in various settings to develop and evaluate service programs addressing the needs of disadvantaged families and individuals.

The increase in elderly populations in most countries in the world presents significant challenges, particularly with respect to community-based health care. Additionally, specific apprehensions arise when traditional sources of support for the elderly may be lacking. For example, family members may be deceased or may not live in close proximity; they may have insufficient skills; their own health condition may preclude them from care giving functions; or they may be in the paid workforce. Patients of advanced age who are discharged from a hospital to their own homes may, thus present special concerns for health and social service professionals. At the same time, as concern mounts, there is growing recognition of the potential contribution that healthy older individuals can make in meeting the needs of other elderly who are frail.

Background

Hospital discharge planning includes an assessment of patients' social and health care needs, the co-ordination of comprehensive services and supports, and the identification of patients who may be at risk of deterioration following discharge (Berkman, Millar, Holmes & Bonander, 1990). Comprehensive discharge planning may contribute to decreased readmissions and/or a reduction in subsequent lengths of stay (LOS), as the patient, family, and community support personnel acquire an accurate understanding of the patient's limitations or health care needs following hospitalization (Berkman et al., 1990). Hospital administrators, and their counterparts in public health care and private non-profit community-based service agencies, are increasingly expressing the need to ensure effective utilization of services and continuity of care for this at-risk group. Most have recognized the difficulties that have existed in ensuring systematic post-discharge follow up to this segment of the patient population.

Barriers to Continuity of Post-discharge Care

Even meticulous plans for hospital discharge do not always

ensure timely access to community-based health and social service resources (Wertheimer & Kleinman, 1990). Discrepancies between hospital recommended community-based care, services and supports—and the care and services a discharged individual actually receives—can contribute to problems which, in turn, lead to hospital readmission. Furthermore, lack of adequate home supports, services, or monitoring can result in an inappropriate move to a sheltered setting or to an institutional placement.

The stress of hospitalization possibly combined with grief over a recent loss or with fear of permanent, partial or complete loss of independence, may render ineffective a person's usual coping mechanisms and consequent home recovery (Johnson & Fethke, 1985). Discharged patients are sometimes unaware of the community services available to them due to a failure of hospital personnel to inform them about available community services (Jones, Densen & Brown, 1989). Rowe, Dulka, Pepler & Yaffe (1997) found, in a study of outcomes for 651 discharged hospital patients aged 55 and over, that at least 70% of patients reported that they failed to receive adequate information that might have made easier and quicker their home recovery.

Socioeconomic influences

Economic status is an important determinant of hospitalization outcomes. Limitations experienced by patients who are economically disadvantaged have been associated with unsuccessful discharges (Wimberly & Blazyk, 1989). Poorer and older patients have more frequent readmissions, and are at greater risk of not benefitting from services provided in the community, including home-delivered meals or collective or communal outings. Such former patients are also more prone to hardship as a result of their inability to pay for private services while on waiting lists for government subsidized services. Despite the known links between economic status and health outcomes, patients may not routinely be asked about their financial situation (Wimberly & Blazyk, 1989). In contrast, a recent study surprisingly found that 100% ($N=40$) of community-based primary care physicians who treat older patients included socioeconomic background as part of their assessment of patients' medical problems (Kaufman, 1995).

Adult children have traditionally provided parents with emotional and instrumental support in their old age, including acquir-

ing necessary information and arranging for the service delivery (Choi, 1994). Next to help received from a spouse, older persons rely on their children for assistance in both acute and chronic illness situations, and to help fend off the social isolation that may accompany old age. Childless elderly persons may successfully substitute relatives by seeking close friends or hiring formal care providers (Choi, 1994).

Access to information alone does not guarantee utilization of services by the elderly, as those with higher levels of education and income, and correspondingly better (theoretical) access to facts on resources, do not necessarily use these services (Choi, 1994). A tendency to be self-sufficient and unreliant on others may also be a barrier to seeking needed health and social services.

Health and Functional Status

Differing findings emerge from studies on discharge planning. Jackson (1990) found that patients at greatest risk for readmission were those who received the most community-based homecare services (i.e. nursing care, assistance with personal hygiene, housework, meal preparation), lived alone, had the greatest number of medical and nursing diagnoses, and were the frailest—though not necessarily the oldest—patients. By contrast, Victor and Vetter (1985) found that readmissions were not related to patients' social or demographic characteristics, but rather were a result of relapses and breakdowns in the patients' original medical conditions.

Findings of gaps in continuity of community-based care following hospital discharge suggest a need for follow-up. Even patients whose health care needs, at first glance, appear to have been met may have unresolved issues that are physical, social, or environmental in nature, and place them at risk for decline in health and consequent hospital readmission (Blumenfield & Rosenberg, 1988; Wertheimer & Kleinman, 1990). Studies of different models of discharge planning have pointed to screening procedures which fail to accurately examine or record patient post-hospital needs (Iglehart, 1990).

The Senior Volunteer as Peer-Advocate

The use of community volunteers is frequently cited as one

solution to the needs of frail elderly discharged geriatric patients (Blumenfield & Rocklin, 1980; Cnaan & Cwikel, 1992; Cusack, 1994; Ehrlich, 1983; Turner, 1992). However, as growing numbers of men and women are employed on a full-time basis outside the home in order to meet personal desires or economic realities, their availability for volunteering in the community is limited. As well, the reality exists that caring for an ill elderly individual may not be as attractive an area as in other areas of voluntarism.

The basic principle underlying peer-advocacy (that is, assistance by an elderly volunteer given to a dependent elderly person) is that the skills learned by the advocate can be transmitted to those in need in order to promote their more independent and effective functioning (Bolton & Dignum-Scott, 1979). As one example, by virtue of their everyday experience, elderly volunteers can communicate about and advocate for elderly individuals through role modelling.

In a health care context, peer advocacy occurs when a private citizen enters into a relationship with, and represents the interests of, an elderly person who may need assistance to improve his or her quality of life and obtain full rights and access to needed resources (Cohen, 1994). Discharge planning, however, confronts two possibly conflicting ethical constructs facing the peer-advocate (Clemens, 1995). The first is the principle of self-determination which maintains that individuals have the right to make decisions that are voluntary and free from undue influence. The other is the principle of beneficence which promotes the rights and the good of clients.

Voluntarism for the Elderly

The Third Age, or retirement stage of life, has the potential to be a period of personal enrichment, self-actualization and fulfilment by virtue of active engagement in challenging and worthwhile activities, such as voluntarism (Cusack & Thompson, 1992). It can be argued that volunteer activities should be available for all those 65 and over because they provide for a greater sense of usefulness, engagement, and purpose (Cnaan & Cwikel, 1992). So, too, can voluntarism permit persons to maintain a structure to their lives, and to do so using familiar, successful behavioural strategies. Thus, voluntarism provides opportuni-

ties for older persons to maintain, develop, or increase levels of activity in accordance with their personal preferences and lifestyles.

Voluntarism has also been found to be associated with higher life satisfaction among members of older population groups, as an extension of the activities and values that preceded retirement. Further, it has been associated with volunteer activities and community work which took place in the life of older persons (Cnaan & Cwikel, 1992). Not surprisingly, those people who rate their health as good or excellent are more than twice as likely to volunteer than those who perceive their health as poor to fair (30% vs. 13%) (Cnaan & Cwikel, 1992).

Unique elements of senior leadership in voluntarism include (a) the richness and diversity of life experience, (b) genuine concern and empathy for others, (c) the need to be involved, recognized, have fun, conserve energy, make time count, (d) the matter of choice (e.g., the time and the freedom to choose what to do and when to do it), and (e) the issue of power and control (e.g., respect for, and recognition of, seniors' strengths and rights (Cusack & Thompson, 1992). A suitable framework upon which to develop a senior volunteer program includes the notion of shared participatory cooperation (Cusack & Thompson, 1992).

Perry's (1983) study of the willingness of the elderly to volunteer concluded that the respondents more often wanted meaningful assignments that involved interpersonal communication rather than activities with mechanical or physical tasks. Similarly, Ozawa and Morrow-Howell (1988) found that elderly volunteers overwhelmingly preferred to provide services that were social in nature and that provided needy elderly with reassurance.

Senior volunteers seek rewards that, in fact, may be less evident when their efforts involve interactions with difficult patients or clients who are depressed, unresponsive, hostile, or feel hopeless (Blumenfield & Rocklin, 1980). Encouragement and support to volunteers is particularly necessary in these situations. Volunteers may also benefit from learning techniques that lead to effective outreach with those for whom interaction is particularly difficult. Valuable opportunities may allow volunteers to bring out into the open and diffuse feelings of anxiety, over-identification, and frustration. For example, regular

group meetings may provide opportunities to promote solidarity for disseminating new information and for discussing helpful principles.

There are potential particular drawbacks, however, to seniors acting as volunteers to other seniors (Blumenfield & Rocklin, 1980). The older volunteers may over-identify with clients or patients, causing the volunteers increased anxiety. They may also feel compelled to do something and, hence, take over, re-enforcing dependency rather than finding new ways of restoring autonomy (Cohen, 1994).

Project Rationale and Development

The present project results from the findings from other studies which have concluded that systematic follow-up, especially for at-risk older individuals, contribute to better patient care and post-hospitalization management, thus reducing the likelihood of readmissions. The project also arose from the desire to determine if there is a potentially beneficial role that seniors can play in the lives of geriatric patients discharged from hospitals (Edwards, Reiley, Moris, & Doody, 1991; Hauser, Robinson, Powers & Laubacher, 1991; Thliveris, 1990).

The research team was comprised of a family physician, a social worker, and a coordinator of senior volunteers (the latter was based in a social service agency). The project had an advisory committee comprised of "stakeholders" interested in care of the elderly, including representatives from the participating secondary care community hospital from which the patients were recruited, two local health and social service centres (CLSCs), and a community agency addressing the needs of frail elderly. The advisory committee took part in the review of the study protocol, in the project evaluation, and in the dissemination of findings. The study protocol received approval of the appropriate research ethics committees and was conducted between October 1996 and April 1997.

Objectives

The goal of the project was to determine whether it would be possible to recruit and train a cohort of senior citizens who could function in a time-limited capacity as volunteers. To be evaluated

was whether elderly persons discharged from a hospital could be assisted by elderly volunteers in order for them to receive the community services designated in a discharge plan, and also to advocate for their more recent service needs (as necessary). Beyond the potential benefit of positive outcomes for patients, the study also aimed to determine whether there were potential benefits for the senior volunteers themselves, and for the community at-large.

Recruitment of Patients

To be eligible to participate in the study, patients had to be aged 70 years of age or older, reside in the Metropolitan Montreal area, speak and read either English or French, be accessible at home by telephone, and have a primary hospital nurse indicate that the nature of their medical/social problems required a written discharge plan for community services. A research assistant liaised with these nurses from October, 1996 to February, 1997 to identify individuals who met participant patient criteria.

During hospitalization, a research assistant approached qualifying patients with a verbal and written description of the study. Explained to them was the extent of their involvement in the project and assurance that they could change their mind about participation without negative consequence to their health care. An informed consent document was subsequently signed if they agreed to participate. Discharge summaries, which included names of recruited patients and their age, address and phone number and recommended services, were supplied by a hospital-based research assistant to a coordinator of senior advocates who would then link patients with volunteer advocates.

Recruitment of Volunteer Senior Citizen Advocates

Outreach to potential seniors volunteers was made through the posting of notices in local community agencies that addressed the needs of frail elderly or that provided volunteer services in the community. Recruitment announcements were also placed in the newspapers most widely read by those in the Montreal area. The publicized responsibilities for the volunteers included the following activities: (1) Telephone contact with an elderly patient post discharge to arrange a home follow-up visit; (2) An

evaluation, according to a discharge plan and using standardized questionnaire, to determine if services identified in a hospital discharge plan were in place; and (3) The identification of other services that might be valuable, but not identified in the discharge plan; and (4) Taking initial first steps to try to get the assistance required.

The recruitment criteria for the volunteers were that they be aged 60 and over, have an interest in voluntarism and advocacy, agree to participate in an interview to assess their general ability to interact with their peers, and be available to participate in training sessions. Candidates completed an application form that included information about their age, gender, past volunteer experience, time availability for the project, and relevant past or present work experience. In consideration of their own needs, volunteers were asked whether they had any allergies to pets or cigarette smoke, since they would be making visits to patients' homes.

The coordinator of volunteers conducted personal interviews with interested volunteer advocates. In the interviews, the potential volunteers had to demonstrate reasonable interpersonal communication and interviewing skills, an ability to verbally administer a short questionnaire and to accurately record responses, give evidence of being able to be objective, non-judgmental, and flexible, and have an interest and ability to initiate—at minimum—a single follow-up to an identified problem in a persistent, but diplomatic, fashion.

Volunteer Training

Two different three-hour sessions were held with volunteers to review the project goals, volunteer roles, the nature of the patients needs as well as their own, basic interviewing skills (including active listening and empathy), observation strategies, and guidelines for dealing with unexpected eventualities during home visits. Volunteers were also sensitized to the types of elderly patients that they might encounter during the course of the project: living alone or lacking social supports; chronically ill or in pain; with hearing, vision, or mobility limitations; in palliative care; with limited financial resources; or with some

form of temporary mild cognitive impairment. Role playing of potential situations that might arise supplemented discussions.

The senior advocates were sensitized to matters related to health and social services as they affect the elderly and they received specific training to identify gaps in post-discharge continuity of care. This was facilitated through the use of a questionnaire developed for the project which focused on an inventory of items generally associated with community based services (medical, nursing, home assistance). The questionnaire also provided an opportunity to compare existing services to those identified in the discharge plan and to make a preliminary assessment of what additional assistance might be required (e.g., with activities of daily living such as help with housekeeping, meal preparation, or medication supervision). Dates of onset of services, or perceived reasons for absence of these services, were to be recorded.

Manuals supporting training sessions were given to each volunteer to consult on such topics as communication skills, observation of the patient's living environment, nature and range of normal homemaker services, tips regarding home safety, medication use/abuse by the elderly, and dietary suggestions.¹ At the end of the training session, volunteers and all those associated with the research project were required to sign an oath of confidentiality beyond the confines of the project.

Post-Discharge Patient Contact

The project required that the volunteers make contact minimally during the third post discharge week and maximally at the fourth week. This allowed for a reasonable time interval to elapse between the time of discharge and the potential onset of the utilization of home services. The volunteers observed what was actually taking place by using the previously-described short questionnaire. Discrepancies between the hospital discharge plan and what was actually observed by the volunteers initiated a process whereby the patient with identified needs was linked to appropriate community-based care providers. The questionnaire was initially administered during face-to-face interviews in the patients' homes; however, toward the end of the data collection period, some interviews were conducted over the telephone. This

permitted a determination of patients' understanding of their discharge plans, their perceived post-hospitalization needs, and a summary of the presence or absence of recommended and/or needed services and supports.

Project Results

The study took place during a Canadian winter when the negative impact of snow and ice is difficult to predict in advance. A particularly inclement weather pattern during the project period made home visits by the senior volunteers difficult to accomplish. Consequently, later in the project the study protocol was modified to permit, when weather necessitated, for volunteers to make contact with some patients not in their homes but by telephone.

Project Volunteers

A total of 13 senior citizens (ten of whom were women) volunteered and met the inclusion criteria to conduct the follow-up home visits. The volunteers ranged in age from 60 to mid-80s; four were between 60 and 65; five were between 66 and 75; and four over 75 years. Of the 13 volunteers, 11 were retired, one was a full-time geriatric nurse, and one was unemployed. Of those volunteers who had worked outside the home prior to their retirement, two were in social work, two in teaching, one in office work, and three in the field of commerce or business. Eight spoke both English and French and seven of the group spoke a third language.

Project Patients

A total of 121 patients were initially recruited and, as expected, some withdrew over the course of the study. Among those reasons for withdrawal from the project were the following: Refusal to participate in a post-discharge visit; could not be reached by phone; remained in the hospital; had been transferred to chronic care or rehabilitation institution; died; volunteer was unable to visit; patient was on vacation; and patient information was lost following discharge. While the program design called for the follow-up of 80 patients aged 70 and over during a three month period, 75 patients ultimately received volunteer follow-up.

The ages of patients ranged from 72 to 95 years, with an average of 83 years. Under 60% were living alone; the majority of this group were women. The range of hospital stay days was between one day and 113 days, with mean LOS of 10.6 days.

Patient-Volunteer Interaction

The number of patients contacted per volunteer ranged from one to 20, with an average of 5.8 contacts. Successful volunteer contact which took place during the specified three to four weeks post-discharge period represented 49.4% of the total. An additional 25.3% of the contacts took place one to ten days earlier than planned, and the remaining 25.3% of the contacts took place one to 21 days later than intended. Of all contacts, 41% of the interviews occurred, as intended, in the patients' homes; 57% took place, unintended, by telephone; and one person preferred a meeting outside the home in a neutral location.

Through the follow-up surveys, the volunteers were able to document which services were received following discharge. These services included meals-on-wheels, household assistance, physiotherapy, education, friendly hello calls, assisted transportation, bathing, and new follow-up medical assessments. In addition, volunteers were to make and record the distinction between new and resumed (and previously-used) services.

It was found that 14 patients (18.6%) needed—on average—1.4 services (e.g. assisted transportation, household chores, meals, mobility help, accompaniment, bathing) which had not been identified for them in the discharge plan. In all, the senior volunteers identified 13 patients in need of what amounted to an average of 2.4 new services; seven of these services were unavailable. The volunteers assessed needs independent of the patients' reports and through their own assessment of patients' situations. From a survey of 12 recently-hospitalized seniors, it was learned that they believed that needed services had not been recommended for them, with transportation assistance the most often reported missing service.

Focus Group Findings

Based on the recommendations from a study by Blumenfield and Rocklin (1980), a focus group was held to provide a forum

for the volunteers to discuss their involvement in the project. The senior volunteers were highly satisfied with their roles and involvement in the project to the degree that it was their desire and hope to motivate other seniors to participate in similar advocacy endeavours. They indicated an interest to learn how frail elderly persons are managing their post-hospitalization needs, so to offer them information and advocacy, as needed.

The senior volunteers participated as well-motivated contributors toward the development and meeting of project objectives. This project also provided the volunteers with unique insights into a vulnerable group of people: recently discharged geriatric patients who required continuity of community care. It also afforded them opportunities to deal with illness and to analyse their own reactions to the experience of others. They helped at-risk seniors find their way through the medical system and the advocate volunteers developed a greater understanding of the system, illness, and the impact illness has on individuals and their families. Other knowledge that senior volunteers obtained was a sense of reassurance that, at least within the context of the limits of the study, community services were generally available. Senior volunteers spoke of the need to better understand the role of advocacy and rules for how to get things done, and a desire to develop "maps" to use the health care system, to ensure personal consumer rights, and to make other seniors aware of the valuable role that they can play as potential volunteers in similar projects.

Discussion

This article illustrates the potential use of senior citizens as volunteer advocates for elderly discharged from the hospital back to the home setting. While there were a large number of patients who were enrolled but did not get follow-up (for the reasons cited), the study was not intended to test how many patients could be recruited and ultimately followed-up. Rather, the goal was to see what kind of outcome there might be in the interaction between elderly patient and senior volunteer where such contact occurred.

The volunteers were a relatively well-educated group, given prior or current occupations. Their involvement suggests that

under a well-structured recruitment process, it is possible to find older people interested in being volunteers for the sick elderly. Participants indicated that beyond the potential benefit for the ill person, there were other factors which contributed to their motivation and their satisfaction. Specifically, volunteers believed that what was learned in the orientation sessions, and dealing with even only one ill elderly person, provided a rewarding experience. They acknowledged, at a personal level, a desire to start thinking about how they themselves could better prepare for the eventuality of their own illness or for family members. Furthermore, they spoke of the desire to share their knowledge and experience with family and friends, and that they would encourage others to volunteer in similar programs. The volunteers further referred to a need to develop a better personal "mental set" of how health and social services work, and of the importance of advocacy and consumer rights in health care.

The volunteers were able to successfully identify patients who required services that had been proposed at discharge, but not initiated. As well, they were able to take the next step to contact a community resource to get advice on behalf of the patient. In some cases, they were able to do most of this on their own. Given that 36% of the home visits took place in the presence of another member of the patient's family, the senior volunteer was also able to impart important information to a relative regarding the accessing of health and social service systems.

The logistics underlying a successful volunteer program using seniors require certain special considerations. Just over 50% of the patients followed were contacted either earlier or later than indicated by the protocol. Beyond the challenge of finding a mutually-convenient time during which to meet, volunteers were most influenced by climatic conditions. The majority of follow-ups took place in unpredictable winter weather, prompting appointments to be scheduled earlier or later than intended. Heavy snow falls, uncleared streets, and slippery sidewalks caused a number of deferred home visits. The fact that a little over half of the interviews actually took place over the telephone instead of in the home was an adaptive measure taken by the senior advocates to minimize potential risks to themselves due to weather hazards. Knowledge of these particular issues suggests the need to have

a selection process for volunteers that recognizes the importance of scheduling visits according to physical abilities and personal limitations or concerns. One might imagine similar concerns in other geographical regions subject to such constraints as extreme heat, torrential rains, tornados, or other climatic extremes.

Conclusion

This paper describes an antecedent effort to follow-up a group of discharged geriatric patients who returned home following hospitalization and the use of older volunteers who helped to reduce situations or eliminate factors which place seniors at-risk. Findings contribute to a better understanding of barriers to health and social services for such at-risk elderly. Furthermore, the project promotes, and defines, inter-agency and inter-professional collaboration which will benefit seniors at-risk, while demonstrating the value of senior advocates. The project design, implementation and results may benefit organizations striving to improve the quality of life for at-risk elderly as well as those promoting the contributions that seniors can make in bringing about positive change for an at-risk group. Volunteer advocates, regardless of age, can work for the benefit of older, recently-hospitalized individuals by providing emotional and instrumental support through friendship, advocacy, and by making opportunities available for them to learn new skills necessary to obtain needed services.

The demonstration project addresses needs common to many older Canadians, both those recovering at home following a hospitalization who may be isolated and frail and those who are healthy, active, and wish to participate and contribute to their communities through voluntarism. The project demonstrated a way by which seniors, themselves, can advocate on behalf of their frail and disadvantaged age-peer counterparts to increase well-being and reduce and eliminate factors which place older seniors at-risk, and lead to rehospitalization or institutionalization.

This unique one-to-one relationship seems to be of mutual benefit to both patient and volunteer, and the senior volunteers bring dynamism, enthusiasm, and interest in both helping the patients and their own personal investment in further strengthening the health and social service network. The program is simple

enough that it can be adopted in communities in various countries in the world. It is a model which benefits older patients and older volunteers, alike, while ensuring a more effective formal health and social service system.

Note

1. Copy of the training program may be obtained from Jewish Support Services for the Elderly (JSSE) in Montreal.

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