Five types of cooperation tried successfully in various settings suggest paths by which hospital and nursing home relationships can be strengthened in the interest of better patient care and better community health planning.

Expansion of Cooperative Relationships Between Hospitals and Nursing Homes

ROBERT MORRIS, D.S.W.

DESPITE a limited basis for optimism, the prediction that cooperative relations between hospitals and nursing homes will expand is justified, for nursing homes have become a major component of comprehensive medical care. They now provide more than 450,000 beds, almost as many as general hospitals. The services they can offer represent one way of meeting needs brought to light by such modern conditions as the growing importance of chronic and long-term illness, emphasis on active treatment of all illness, the increasing demand for forms of nursing and physical care that cannot be provided in private homes, and the rising cost of hospital and medical care.

Most of the development in nursing home care has taken place outside the mainstream of medical care and health organization, and it has not been much influenced by the health professions, except in regard to safety, sanitation, and minimum nursing standards. Nevertheless, it is recognized that hospitals and nursing homes can serve each other's purposes. We need to go further and ask how these institutions, which are so different, can be brought together as partners in the same health-serving team. This partnership is essential if the words "continuity in medical care" or "comprehensive medical care" are to mean anything to patients, especially those with extended illnesses.

The difficulties of partnership are apparent if we consider the basic characteristics of these two organizations. The hospital is usually a nonprofit corporation, with a large number of beds, a rapid turnover of patients, a large professional staff of doctors, nurses, therapists and sometimes social workers, an administrative staff, a board of trustees, and wide support from the community through philanthropic gifts and government payments. The nursing home is usually a small institution administered by an individual for profit, with a nonprofessional staff supervised at best by a registered nurse and with occasional medical supervision. It cares for patients who stay for months and whose conditions change slowly, and it is dependent on current payments to keep going.

These real differences have been accentuated by unfortunate attitudes of doubt and suspicion. Hospitals have often complained about conditions of care in nursing homes: that simple physical and nursing care is poor, that patients are admitted who might be better cared for elsewhere, that they are kept bedridden unnecessarily. Nursing homes in turn have com-

Dr. Morris is associate professor of community organization, Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass. He presented this paper at the New England Hospital Assembly held in Boston, March 1960.

plained that hospitals are officious and authoritarian, that they refuse to share information about patients to be transferred or to plan in advance for their posthospital care, that they refuse to help the homes do those realistic things which can raise the level of care and still be within the reach of institutions with limited staffs or within patients' ability to pay.

Can two such different organizations really work together successfully? Experience in several communities suggests that they can, given a minimum of willingness to cooperate and to put aside suspicions of the past.

A willingness to work closely together implies sharing of purposes, agreement about common goals. In many respects these two institutions may have somewhat different goals. One is directed by the most advanced medical arts and sciences; the other, by the less complex aim of providing physical care. One is motivated by a desire to make sufficient return on investment; the other is concerned with keeping the deficit as low as possible. Despite these differences, both institutions care for sick people, and both can be interested in seeing that each patient receives the kind of care he requires, as measured by the best medical knowledge. Hospitals, as the community center for medical care, are, or should be, concerned with what happens to patients before and after their stay in the hospital; nursing homes are, or should be, concerned with the standards of good care.

Five general types of cooperation have been tried—tried successfully—but it must be confessed that they cannot yet be called typical, for there are still too few examples. The examples involve proprietary homes, nonprofit homes, hospitals, and public health or welfare departments, but the experiences of each may be useful for understanding the subject we are discussing. The five types of cooperation are: informal arrangements for transferring patients, training exchanges, joint planning for patient care, joint appointment of specialized staff, and administrative integration.

Informal Arrangements

An informal arrangement for transferring patients from hospitals to nursing homes is the most common form of cooperation. The need to plan discharge of many hard-to-place patients is often so pressing that a member of the hospital staff, usually the social worker, must be on friendly talking terms with nursing home operators in order to locate the right home for a specific patient at the required time. Some hospital staff members, almost accidentally, know a number of homes well. They can advise families and physicians which ones are best able to give the kind of service required, and can locate vacant beds in an emergency.

This approach has been carried further in a few communities. For example, the St. Francis Hospital in Peoria, Ill., sometimes invites the nurse director of the Washington Nursing Home in Washington, Ill., to predischarge conferences so that the home can share in the discharge planning and can make adequate preparations for the patients. The arrangement has worked so well that similar conferences are often held when nursing home patients have to be readmitted to the hospital for recurring active treatment periods.

The conferences have proved to be a wonderfully simple way to bring nursing home staff into the medical care team and to give them the feeling that they are an accepted part of medical care. The staffs of the two institutions can learn something about each other's way of working and thinking; a certain amount of teaching can take place, and a cooperative spirit begins to develop.

Such conferences, of course, are not necessary for every patient. They are especially useful when physicians prescribe treatment which is to continue after the hospital stay and which requires controlled care in a nursing home or periodic return to the hospital.

Training Exchanges

In some communities selected nursing homes are used by professional nursing schools or by schools for practical nurses to help train students. The homes are not affiliated formally with the schools, but are used as field resources. In some programs the students merely observe nursing home care; in others, they actually work in a home for a few weeks and carry out nursing or nurse aide duties under supervision.

Examples of nursing homes in which training programs operate include the Mahoney Nursing Home, Peoria, Ill., McKinney Nursing Home, Yonkers, N.Y., Manor Rest, Montrose, N.Y., and the Capitol District Home for Jewish Aged, Troy, N.Y.

These opportunities for observation or work in a nursing home enrich the student's experience and give her some knowledge of care in long-term institutions, where the tempo and objectives are so different from those of a general hospital. At the same time, they stimulate the nursing homes, which are necessarily on display, to do a better job. Careful advance planning between the nursing home director (usually a registered nurse) and the nurses' training supervisor is required so that new professional skill can be brought into the home. The result is that key staff get to know and trust each other, as well as to learn from each other.

Much in the experience of the nursing homes can be put to good use by hospital nursing staffs and the nursing profession, especially in regard to care of long-term patients. To cite one example, a recent series of field studies conducted in nonprofit nursing home programs for the aged revealed the fact that bedsores were no problem even for patients who had been bedridden for long periods. Yet when some of these same patients were transferred to a hospital for treatment of 10 days or 2 weeks, they returned with new bedsores. The explanation probably is found not in "bad" nursing as measured by general hospital nursing standards, but in the difference in nursing technique for short-term and long-term patients, a difference about which nurses in general hospitals may have something to learn.

Another kind of teaching exchange arrangement has been tried in several communities between public health or public welfare departments and nursing homes. In one form the public agency employs nursing educators, occupational and physical therapists, and social workers to help interested nursing homes train their own staffs in modern concepts of rehabilitation and patient care. Examples are found in the State program of the Illinois Public Aid Commission and the local program of the Erie County Health Department, Buffalo, N.Y. The specialists, available at the request of the nursing home, are prepared to instruct either the nursing supervisors, nurse aides, or attendant staffs in new techniques. Even though home staffs change rapidly, it is hoped that a core of workers will be trained over a period of years.

The advantages of this arrangement can be very great. Nursing homes are usually too small to provide the kind of continuous on-the-job training which medical and nursing care seem to require. A public agency, or for that matter a hospital, can use some of its training staff to raise the standards of nursing home care. This educational approach can be especially important in helping nursing homes apply new knowledge about rehabilitation through which disabled persons are helped to maintain the level of self-care they have reached after active treatment under medical control.

A variation of this approach is based on the belief that small nursing homes cannot ever provide the services of specialists which proper nursing home care requires, except at exorbitant cost to the patient. Such care, based on the most advanced principles of comprehensive medicine and rehabilitation, requires a variety of skills and equipment for a variety of special patient conditions. To meet this situation, some health departments employ nutritionists, physical therapists, occupational therapists, and social workers to give direct service to patients in nursing homes, following physicians' prescriptions. With this help the cooperating homes can expand and upgrade their services as well as increase the skill of their own staffs. These programs have sometimes been started with a minimum of organizational superstructure. One health department employs a team of specialists to work a few hours a week in nursing homes. However, even the most informal plan has required someone to arouse interest among nursing home operators and to overcome their suspicions.

Providing specialists' services is still experimental, and it remains to be seen whether, in time, the nursing homes can support these services on their own. There are several possibilities along this line. Groups of nursing homes may want to pool their own funds to employ specialist staff for their joint use, or public health and welfare agencies may want to

continue to provide such staff as a community service. These programs are, after all, a natural extension of the licensing function now carried on by these public departments. They mean that the department not only sets standards, but goes ahead realistically to help nursing homes achieve those standards in daily practice.

Alternatively, general hospitals may want to enter into similar arrangements with one or a group of homes which their patients use. It might seem that this undertaking would overburden hospital staffs and increase the already high cost of hospital care, but actually it may prove less costly than inadequate care which results in hospital readmissions or unnecessarily prolonged disability.

There are many other ways in which hospitals can share information and help raise nursing home standards. A number of nonprofit nursing home programs for the aged have obtained expert help from hospitals in rebuilding their facilities, in planning kitchen layout and organization of food service, and even in recruiting nurses or nurse aides. There is little reason why similar arrangements cannot be extended to the proprietary field.

Joint Planning for Patient Care

Joint planning between a hospital and a nursing home may seem like an effort to pair off a dwarf with a giant but it has worked. A recent study of 10 cooperative programs between general hospitals and nonprofit homes for the aged indicates several ways in which joint planning can benefit both types of institutions. This study was part of a large-scale inquiry into coordination of health services for patients with long-term illness conducted by the Council of Jewish Federations and Welfare Funds. The institutions were located in St. Louis, Chicago, Cincinnati, Philadelphia, Baltimore, Troy, N.Y., New York City, and Toronto, Ont.

The key to the cooperative programs was development of mutual confidence and trust. In every instance, the institutions began with a massive distrust of each other and skepticism that anything could be done that would not serve one institution at the expense of the other. The hospitals were convinced the homes gave substandard care and did not want to improve. The homes were certain the hospitals only wanted to "dump" difficult patients and didn't care what happened to them, or feared the hospitals wanted to swallow up and dominate the administration of the homes.

Despite these obstacles, the 10 projects demonstrated several areas in which the work of these institutions could be planned jointly with beneficial results for the patient in the form of continuity in care and improvement in services in both institutions. This joint planning has been carried out with strict regard for the administrative and financial independence of the nursing homes, and all steps were taken by mutual agreement.

A major achievement was agreement about transfer of patients between hospital and nursing home. This means that the hospital must determine exactly what each patient needs in the nursing home and share the information with the nursing home staff in advance of discharge. Those who need much help to retain their physical functioning are sent only to homes able to give such care. Those who need to progress gradually from bed to ambulation are sent to homes with staff able to follow this cycle. Those with mental complications are sent to homes capable of coping with the extremes of human behavior. These arrangements also provide for emergency or planned return of patients to the hospital without delay. In effect, the nursing homes are assured of priority hospital admission for certain classes of patients.

The cooperation has gone further in several communities. Prescribed regimens of physical or occupational therapy, clinic treatment, and continuing diagnostic studies for nursing home patients are carried out by physicians who use the hospital resources just as freely as if the patient were still in the hospital. The hospital laboratory does diagnostic work on request; occupational therapists or physical therapists give treatment as prescribed. All the special facilities of the hospital are immediately available to the physicians who supervise the patients in the nursing home. There is no need to delay treatment because it is hard to get, because the home does not have the resources, or because no one wants to readmit the patient

to a hospital bed. Usually transportation back and forth must be arranged, although in some communities the hospital staff visits the nursing home regularly as if it were an extension of the hospital, especially for certain mobile laboratory and treatment procedures.

Initially, there was fear that these arrangements for sharing services would lead to abuses of the hospital's overbusy staff, but the fears have proved unjustified. Moreover, the arrangements have produced an unexpected side benefit. Previously, a significant number of patients were readmitted to a hospital because the nursing home could not provide proper care or because there was not enough medical backing to give the home confidence that it could safely care for these patients. In the joint programs, many such patients were satisfactorily cared for in the home, with the assurance of hospital backing as needed. The result was a decreased demand for hospital readmission and a less-than-predicted demand for outpatient services.

Joint Appointment of Key Personnel

Joint planning for patient care has sometimes led to another level of cooperation, joint appointment of key personnel. The crux of the 10 plans studied has been a growing unity in medical and nursing understanding. As this developed, administrators of the two kinds of institutions were able to agree about the physicians and nurses who could work together. Several nursing homes (for example, the Lucien Moss Home, Philadelphia, the Jewish Center for the Aged, St. Louis, and the Beth Abraham Home, New York) have consulted hospitals about selection of a physician to serve as medical supervisor or director of the home's medical program. In each instance the home chose its physician from the active hospital staff, and more important, chose him with the advice of either the hospital director or the chief of the hospital medical service. In at least two nursing homes (the Lucien Moss Home and the Jewish Center for the Aged) the nursing supervisors have been drawn from the hospital nurses' teaching staff, on the basis of consultation with the nursing director.

These steps must seem like a radical development, and I cannot emphasize too strongly that they were taken because both nursing home and hospital wanted them. Both agreed to them voluntarily without any loss of independence in control of their own policies. The hospitals needed a nursing resource in which they could have complete confidence, and the homes were able to improve their care at minimum cost by drawing on the resources of a hospital.

In a few instances cooperation has gone still further, to full integration wherein the hospital takes over the administrative and financial control of a nursing home and operates it as an arm of the hospital. This may prove to be a useful path for future development, but it cannot soon affect the thousands of independent nursing homes, both proprietary and nonprofit, which will continue to exist as independent organizations.

Conclusion

The five major types of cooperation—informal arrangements for patient transfer, training exchanges, joint program planning, joint appointment of key staff, and administrative integration—suggest several paths by which hospital and nursing home relationships can be strengthened in the interest of better patient care and better community health planning. They are practical means by which a vast new resource is added to the community health team. Nursing homes are already a significant factor. There remains the task of learning how to bring them into the medical care family, along with physicians, nurses, hospitals, health departments, social agencies, and others.

We have relied for a long time on licensing and control as a way to work with nursing homes. These examples point a new way, the way of cooperation and mutual help, to close the gap between these two sectors of our medical organization.

What we now require is some center or impetus in every community and in every State to encourage the widest spread of these tested methods for voluntary cooperation. Hospital associations, medical societies, public health and welfare departments, health councils, and associations of nursing homes are equally suitable leaders. Which will take advantage of the opportunity?