Case study: Transition from institutional setting to community.

Edna R. is 76 years old, widowed, with two grown children who live nearby. She broke her hip and was hospitalized for a hip replacement. Following her surgery she entered rehabilitation but still has limited mobility. Her discharge team has recommended long term care in a local nursing home. She has been adamant that she wants to go back home. She wants her cats back from his son, to work in her flower garden and take her daily walk around the neighborhood at home, using a walker, instead of her walks through the halls. She lives in an older neighborhood with walks that are uneven.

Edna owns a home at 604 W. 13th Street, which is paid for. There are four steps front and back, with no railing. Her bathroom door is too narrow for her walker, the toilet is very low with no grab bars. She is not able to step over the tub to gain access to bathing. Her flower gardens are ground level, so her desire to maintain those may be difficult.

Before she broke her hip, Edna's family was concerned that she wasn't eating right. She says she is tired of cooking, and tends to fix a bowl of cereal (if her milk is still good) for most meals. If she doesn't have milk she eats a piece of toast. Her daughter has been picking up groceries for her about once a month.

Edna struggles with remembering to take her meds (for high cholesterol and high blood pressure) at the right time and in the right dosage, so her daughter checks them and refills her medication box every week or two.

She has been referred to your Center to complete a discharge plan to move back into the community. What do you need to know to determine if she is eligible for services from your Center?

What questions do you need to ask Edna to complete an Independent Living Plan (and discharge plan) with her?

What are the options for supports and services from your CIL to make the move back home possible?

How will you track the probable multiple services your CIL will provide to support a goal of transition?

Case study: Assisting an individual who is at risk of institutional care to remain in the community.

Debbie is a 46-year old woman who has been diagnosed with Multiple Sclerosis. She lives in a three-story home with her husband and two teen children. She has recently experienced more severe symptoms, and her home is not functional for her. She used to use just a cane, but now has many days when she needs a walker, even around the house, and a wheelchair out in the community. There are steps up to the main floors. Her laundry room is in the basement. Her two teens live upstairs from the main floor. The office and computers are also upstairs – convenient for the kids to work and print homework, but not functional for Debbie to keep the household books. The family doesn't have a lot of money to update their technology. There is no air conditioning in the home, and heat exacerbates the MS symptoms.

Debbie has days, although not every day, when she is unable to dress or bathe alone. Her husband works full time and his job demands a lot of overtime and shifts that rotate through the year, so he is not available to assist at the same time of day, as he works one shift midnight to 8:00, then after two weeks moves to 8:00 to 5:00 and then two weeks later 5:00 to midnight. She doesn't want to depend on family members for personal care.

Her doctor says she is at risk of falls, and wants to place her on some strong medication that needs careful monitoring. She often doesn't have the dexterity to handle her pills, and is sometimes foggy, mentally, and has trouble remembering to take them. The doctor believes, and Debbie fears, that her condition will continue to require more and more supports. The doctor is recommending that the family consider nursing home care to meet these increasing needs.

Debbie argues that she doesn't want to miss the day-to-day lives of her kids. Being there to see them off to school, being there when they get home to hear about their day before they go on to their sports and homework. She is no longer driving (her son recently got his license), but on days when she needs her wheelchair their vehicle doesn't accommodate it well, so she has trouble getting to the kids' activities. They have been using a chair that family members push, because she usually doesn't have the energy to push it herself.

How do you determine if Debbie is eligible for services?

What questions do you need to ask Debbie to assist her with a plan to remain at home?

What are some of the supports and services that Debbie needs to maintain her independence and family life in the community?

How will you track the probable multiple services your CIL will provide to support a goal of diversion?