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AUTHOR Lusky, Richard A.; And Others
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ABSTRACT

This learning module is one of three training modules that were developed for members of the Texas Gerontological Consortium for Continuing Education to use in preparing case managers working in human service professions coordinating community-based programs for frail elderly Texans. Module I deals with the following topics: foundations of case management (origins of case management; definition of case management; educational profile of case managers; components of case management; income and health programs; Older Americans Act Title III programs; families and the informal network; legal and ethical issues; profile of typical case management consumer; case manager's position in the community; agency outreach; key players in case management; case load, case mix, and time utilization; case managers in various settings) and basic intake interview techniques (basic interviewing skills, screening for eligibility, and Texas Department of Human Services eligibility requirements). Included in the module are the following components: estimate of time required to complete the module; lists of suggested videos and speakers from public/private agencies; topic outlines containing topic objectives, the information to be learned for accomplishment of each topic objectives; 42 references; and transparency masters. (MN)

A STANDARDIZED CERTIFICATION PROGRAM FOR CASE MANAGERS SERVING FRAIL ELDERLY TEXANS

MODULE I

This project was supported by award number 55110004 from the Texas Higher Education Coordinating Board, Austin, Texas. This Carl Perkins award was designed to develop three training modules to prepare case managers working in human service professions that coordinate community-based programs for the elderly. The training material was developed for use by members of the Texas Gerontological Consortium for Continuing Education.

Richard A. Lusky, Ph.D., Project Director
Donald R. Louis, Ph.D., Project Coordinator
David S. Boyd, M.A., Project Consultant

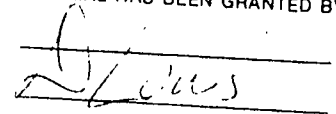
Center for Studies in Aging

University of North Texas

Denton, Texas

1995

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MODULE 1
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FOUNDATIONS OF CASE MANAGEMENT AND INTAKE INTERVIEW MODULE I

Time Requirements of 20 Hours

Suggested Videos for this module:

- No Place Like Home
 - After the Hospital, What's Next?
 - Growing Old in a New Age (vol.10 Illness and Disability)
-

Suggested speakers from public/private agencies:

- Social Security Administration
 - Texas Department of Human Services
 - Area Agency on Aging
 - Benefits Counselor (from AAA/contractor)
 - Hospital Discharge Planner
-

TOPIC

A. FOUNDATIONS OF CASE MANAGEMENT

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. Demonstrate a knowledge of the origins of case management and how it has become a major component of long term care.
2. Verbalize and comprehend a working definition of case management.(include outcome based and empowerment)
3. Demonstrate a knowledge of the educational profile of current case managers.
4. Identify the major components of case management.

5. Demonstrate an understanding of Social Security, Medicare, Medicaid community-based programs, and the Medicaid waiver programs.
6. Gain an understanding of the Older Americans Act Title III programs supported by the Texas Department on Aging.
7. Demonstrate basic knowledge of the family system as the informal provider network.
8. Understand the basic legal and ethical considerations experienced by case managers.
9. Demonstrate a basic knowledge of the profile of the typical client eligible for case management services. Profile mandates advocacy for consumers.
10. Understand the desired position of the case manager in the community and provider network.
11. Understand the basic components of agency outreach.
12. Demonstrate knowledge of the key players involved with the typical client.
13. Understand a basic knowledge of case load, case mix and utilization of time.
14. Demonstrate basic knowledge of the case manager's role in the hospital discharge process. Comprehend the desired position of the case manager as an elderly services provider in the community and the provider network.
15. Have insight as to how case management differs as a function of organizational structure.

Origins of Case Management

Providing care to older individuals in their own homes is not a new idea as provisions for in-home care were included in the first formal social welfare legislation in England in 1601 (Applebaum & Austin, 1990). Community-based services have received renewed attention in recent years from policymakers, advocates for seniors and persons with disabilities of all ages, and as a result of the desires of seniors being heard by policymakers.

The emergence of case management as an important mechanism for coordinated service delivery can be traced to

the Allied Services Act. The Allied Service Act was proposed by then Department of Health, Education and Welfare (HEW) secretary Elliot Richardson in 1971, in recognition of the need to improve coordination among HEW's own programs at both state and local levels. To this end, HEW initiated a series of demonstration projects, the Services Integration Targets for Opportunity (SITO) grants, designed to test a variety of services integration mechanisms, primarily at the level of local service delivery. Services integration techniques included newly developed information and referral systems, client tracking systems, comprehensive service centers and case management procedures. In 1974 HEW initiated the Partnership Grants program which represented an expansion of the SITO concept to include capacity building for services integration at state and local levels for the comprehensive planning and management capability components seen as necessary to support improvements in coordination of services at the delivery level. Forty-one sites were involved in the Partnership Grants program by June, 1975.

This federal initiative was an ambitious effort on two fronts. First, it involved administrative reform at the state level including the development of Comprehensive Human Resource Agencies (CHRA's) and, second, services integration by focusing attention on the client, what the client wanted from the service or outcome based, and/or the family that frequently requested assistance from more than one categorical program. Results of services integration efforts were to be seen at the level of service delivery. The intent of these efforts was to break down barriers between providers and to create a delivery system that was more responsive to consumers' total needs.

The most common element in the SITO projects was the case manager. Case managers in the SITO experience acted to assist clients in effective and efficient negotiation of the delivery system and served as the single point of accountability for client outcomes. The SITO case managers were human service generalists responsible for organizing resources for clients and for reliable transit of clients through the client pathway. The SITO projects taught a lesson on the nature of the complex relationships that exist between state and local administrative structure and the capacity to provide coordinated services to clients; that is the relationship between service delivery to clients and system structure. It was discovered that a primary barrier in the delivery of community-based services was the structure of funding, and

that the primary cause of fragmented services is fragmented funding.

The SITO projects highlighted the complexity of the case coordination function and gave birth to the role of the professional case manager. By the end of the 1970s it was recognized across many human service agencies that special training was needed for the professional who was to coordinate community-based services for special populations with varying levels of need. The evolution of case managers has been driven by differing motivational forces in the various disciplines.

Case management for the coordination of services to this nation's elderly went through a developmental testing period as the Department of Health and Human Services launched a series of National Long-Term Care Demonstration projects. Case management was tested in a series of over 15 federally sponsored demonstrations between 1973 and 1985. These projects were known as the *National Channeling Demonstration Projects*. Channeling refers to the specific intervention used in the demonstration to arrange and coordinate services needed to help impaired elderly persons remain in the community. The channeling projects were the first effort to place special emphasis on all activities at the client level including the client assisting with the development of the plan of care. The channeling demonstrations were based on the idea that is necessary to direct clients to a set of services that meet their assessed needs more appropriately. The demonstration projects seemed to make two very valid points necessary for the proliferation of any of an array of community-based long-term care services:

overhead - results from initial demonstration projects---

1. Community based services must be directed toward those persons who would otherwise use institutional care, so as to actually reduce the use of publicly reimbursed nursing home expenses.
2. Community based services must not be accepted as a substitution for care that was previously provided by family or friends. If substitution occurs to a significant degree, then public programs that subsidize community-based care are likely to be politically

unacceptable and viewed as a waste of tax dollars (Stephens & Christianson, 1986).

Broadening the definition of *long-term care*

During the period immediately following the enactment of Medicare and Medicaid in 1965, *long-term care* was generally considered synonymous with institutional care. This was due primarily to the fact that Medicaid funded nursing home care for those who qualified and afforded no options or alternatives. This nation witnessed the building of nursing homes at a very rapid pace, and they all filled. We failed to realize that we were not providing any options for those needing assistance with community living.

A growing concern over the rising cost of nursing home care, especially in light of the larger number of seniors with similar conditions occurred in the 1980s. This concern, coupled with acknowledgement by policymakers that the vast majority of older persons desired to remain in the community rather than being placed in nursing homes, has fueled the expansion of community-based long-term care programs. In recent years, the term *long-term care* has evolved from an emphasis on purely institutional care to a broad range of community-based services. Case management has evolved to assist seniors with the coordination of services tailored to their needs which will help them maintain their independence for as long as possible and in the least restrictive environment feasible. These newly emerging community services appear to help delay institutionalization and to minimize the stress of community living for the elderly and their families. It is estimated that for every nursing home resident, three or more seniors with similar frail conditions are living in the community (Applebaum & Austin, 1990).

The proliferation of community-based programs directed by case managers has caused nursing home numbers to remain relatively constant (Brody, 1987). This is remarkable when considering the fact that the fastest growing segment of the elderly is the old-old or those age 85+. While community-based services managed by case managers appear cost effective, they have not reduced the number of persons in nursing homes. Rather, they have helped bring services to those with multiple disabilities living in the community. The extent to which the community-based and institutional populations are alike remains a point of some contention. What is not in dispute is that institutional care

is fundamentally different from community-based long-term care services in at least one area. A nursing home is a single provider with an easily accessible resident population, while the community long-term care delivery system consists of a multiplicity of providers, most of whom deliver care in the consumer's home.

overhead - current factors driving case management movement

Beginning in the mid-1980s community-based programs for care of the elderly began receiving increased funding. These increases were the result of expansion of the existing federal funding sources, such as: Medicare, Medicaid, Title III of the Older Americans Act, Social Services Block grants and volunteer programs under Action. These increases have either occurred through an expansion of benefits, e.g., Medicare and Medicaid, or a reordered set of service priorities.

Several factors have converged propitiously to elevate case management to the focal point for the coordination of community-based services targeting frail seniors:

- advent of case managers as a qualified professional to coordinate an appropriate package of community-based programs.
- desire of seniors who are frail to remain in their homes.
- additional funding for community-based services

**Toward a
 Definition of
 Case
 Management**

Long-term care case management is an intervention using a human service professional to arrange and monitor an optimum package of long-term care services (Applebaum & Austin, 1990). It is a service designed to coordinate multiple services provided to an individual client. The definition of case management set forth by the Texas Department on Aging is "a service provided by a qualified caseworker, on an ongoing basis, which includes individual assessment, individual service plan development, arranging of necessary care and services, follow-up, ongoing monitoring of client's status and the services delivered, and periodic revision of the overall service plan" (TDoA, 1991). The concept of case management has its roots in social casework. Case management is designed to fit within an ongoing service delivery network.

Case management, in its brief history has evolved as a service delivery strategy applied across multiple disciplines that provides community-based services for persons needing in-home supports. With the appropriate mix of services, frail, older, and/or disabled persons, who would otherwise face institutionalization, can remain in their own homes. Case management has emerged as a useful strategy with which to respond to a fragmented and complicated service delivery system. Based on the recognition that a client facing a complex and bewildering delivery system may need assistance with obtaining the services he/she desires, the case management role is a response to the fragmentation that pervades service delivery. The case manager coordinates and packages a set of appropriate services for the client. The importance of this integrating role is widely recognized and accepted. It is consistent with professional ideologies that call for treating the "whole" person and protecting the consumer from being fragmented by a fragmented delivery system.

Case managers serving the frail elderly are employed in a variety of settings that include, the aging network (AAAs), senior centers, city programs designed for the elderly, home health agencies, private organizations such as insurance companies and individuals. The goals of case management may be defined at both the client and the system level (Austin, 1988). The principle goal of case management at the client level is to arrange and monitor a package of health and social services appropriate to the needs of the client (Applebaum & Austin, 1990). To achieve this goal, the case manager involves the older client in a series of problem-solving steps, including assessing a client's needs, developing an individualized plan of care, monitoring the services that were delivered, and reassessing the client's situation as the need arises (Kane, 1990). At the system level, the principle goals of case management may include, enhancing the coordination of long-term care service delivery, preventing inappropriate use of services and containing costs by controlling client access to services (Applebaum & Austin, 1990).

Case management functions then, to obtain essential resources on behalf of clients, in collaboration with formal and informal sources. Case managers take responsibility for making the system work in the client's best interest, and they serve as the hub for assessing elders' needs and coordinating services to meet those needs. Other essential activities

include outreach to potential clients, screening and intake, assessment of the client's unique needs, developing a care plan, plan implementation, monitoring and reassessment of the care plan (Applebaum & Wilson, 1988).

From its inception, the Older Americans Act has discouraged Area Agencies on Aging from the direct provision of services. The intent of this policy was to prevent conflicts of interest between the AAAs and existing service providers in the public and private sectors. The Act does, however, allow state units on aging to determine that specific services are directly related to the administrative functions of AAAs and to delegate responsibility for direct provision of such to the AAAs. In 1993, TDoA, in a major policy shift, concluded that *CASE MANAGEMENT*, along with *information and assistance* (senior hotlines), *outreach and advocacy*, and *benefits counseling* are directly related to the administrative functioning of area agencies; and that these services can and should be provided directly by the AAAs.

The rapid growth in the number of very old Texans, with their greater likelihood of serious illness and functional dependence, has been responsible for the increasing number of persons either receiving or in need of case management services. Between 1980 and 1990, the population of Texans aged 75 and older grew by 38.7 percent, from 517,954 to 718,337. During that same period, the 85+ cohort grew by 53.2 percent, from 108,763 to 166,605 (Bureau of the Census, 1990). Currently, the number of persons receiving case management services in Texas is estimated to be 11,600. Professionals employed in the aging network believe that twice that number need the service, but they have not been identified due to a shortage of case managers. Furthermore, this figure is projected to double by the year 2000 (Turner, 1993).

The various community-based programs focusing on the frail, at-risk elderly comprise a fragmented patchwork of services which non-sophisticated elderly find difficult to access. In this complex organizational environment, the need to develop efficient cost-effective patterns of care and coordination of effort has become a paramount concern (Karuza, Calkins, Duffey, & Feather, 1988). Over the last decade, case management has emerged as the primary strategy for coping with fragmented and complicated service delivery systems and an essential element of long-term care for older persons (Seltzer, Ivry, & Litchfield, 1987).

Case management appears headed for widespread acceptance for a number of reasons. First, long-term care

health and social service delivery systems are complex and fragmented. In order to utilize needed health and social services, some functionally disabled older adults require assistance arranging services. Second, functionally disabled seniors often have multiple-care needs and require service from several providers. Finally, case management may be inserted into a fragmented system of community services without restructuring the relationship between providers and the system (Applebaum & Austin, 1990).

Case managers take responsibility for making the system work in the client's best interest, relieving some of the burden from the individual elderly client and his or her family. Case management is both an administrative service designed to arrange needed social and health services within the long-term care system and an advocacy service which protects the rights and wishes of clients during their interaction with formal and informal care providers. Case managers may also serve as gatekeepers by being responsible for cost containment through controlling client access to high-cost services.

Summary

 overhead - essential criteria for successful case management

There is no one common definition of case management, nor is there any one best model for a case-management program. During the life cycle of an agency, the structures, practices and staffing patterns undergo changes, as does the agency's definition of case management. The use of case management should be reserved for programs with the following essential characteristics (Steinberg & Carter, 1988):

- The defined goals and target groups are appropriate for the level of skill of the service staff and the capacity of the organization.
- Orderly procedures exist for identification and screening of consumers.
- The program is recognized for its expertise in mobilizing services and other resource options needed by its clients.
- The program incorporates a balanced perspective on the client's physical and mental health as

well as the client's social, environmental and economic condition.

- Comprehensive assessment procedures are well defined.
- Care plans derived from the assessment process reflect the unique needs, conditions and participation of the aged client.
- Care planning reflects planning, action steps and services procured.
- Provisions exist for follow-through, a supportive relationship and reevaluation of the client and the client's situation.
- Attention is paid to interorganizational linkages with participating service providers.
- The program's administrators and case managers are committed to service system improvement goals as well as to individual client goals.

Steinberg and Carter (1988) suggest that for case management to be a strong key component in a long-term care system, two important requirements must be met:

overhead - features necessary for case management----

- Case managers and the resources they control must meet high standards and
- The continuum of different levels of care must span not only the home-based and community-based options, but also residential facilities for long-term care. The more that a system succeeds in diverting some people from inappropriate institutionalization, the more attention must be paid to the linkages with and programs within those facilities that care for people whose impairments are greatest.

Thus, there are many individuals who claim to provide some type of case management in the existing system of

elderly service providers. Applebaum and Austin (1990) believe that there is an important distinction to be made between the type of case management that is provided in connection with direct services and comprehensive long-term care case management. These characteristics distinguish long-term care case management from other types of case management such as that provided by hospital discharge planners, home health agencies and other agencies such as insurance companies. They suggest that the following three key features distinguish comprehensive long-term care case management:

 overhead - key features of comprehensive-----

- intensity
- breadth of services encompassed
- duration of case management

Intensity refers to the amount of time case managers spend with their consumers. Indicators of intensity include the amount of time case managers have for providing information and support to consumers and their caregivers. Caseload size is a key indicator of intensity. A case manager with a case load of 50 to 75 for example, can provide more intense monitoring of client's conditions and service provisions than a case manager with a case load of 300. Practitioners providing comprehensive long-term care case management have caseload sizes that permit intense involvement with clients.

Breadth of services refers to how broadly case managers view the problem of clients. The breadth of services case managers can provide is a function of program financing, structured and comprehensive assessment, the care planning process and supervisory review. Generally, comprehensive long-term care case management involves a broad span of services to meet consumer needs and originating with multiple providers.

Duration refers to how long case managers remain involved with clients. Where funding for case management is tied to a specific service such as certified home health, case management may be withdrawn when the service is no longer reimbursable despite the consumer's needs. Indicators of longer term involvement between the case manager and client include formalized, scheduled reassessments and regular,

systematic monitoring of a client's condition and care plan. Frail seniors often require case management for extended periods. Duration of case managers' involvement is partly a function of the client's functional capacity.

Educational Profile of Current Case Managers

The function of credentials and licenses is to differentiate those who have knowledge and experience in a field of endeavor from those who do not. The need for credentials and licensure stems from the fact that, in our anonymous urban society, individuals and organizations can readily present themselves as being qualified when they are not; often with catastrophic results. Many workers in the delivery of age-related services lack technical training in the precise areas of knowledge needed by case managers, whose duties require unique skills and abilities beyond the scope of any single discipline. In areas involving technical knowledge, or knowledge specific to a locality (such as a state and its array of human service programs), standardized training with accompanying professional certification can elevate the quality of services delivered. In this light, the certification of case managers should both improve and assure the quality of this service for too frail, at-risk, older Texans.

The Texas Department on Aging suggests that all case managers hold a bachelor's degree in any of an array of disciplines included in the helping professions. A similar position is advanced by Peterson and Wendt (1990), who believe that three categories of persons are potential candidates for case management education and training: an undergraduate degree student in a general liberal arts program; the general practitioner in an existing profession such as social work, nursing, or occupational therapy; and the professional gerontologist who has a bachelor's degree in gerontology and is working in the field of aging.

The results of a recent study (Joshi & Pedlar, 1992), found that 96 percent of practicing case managers view training in key skills to be essential for their effectiveness. The major barrier to needed training identified by the study was the unavailability of needed curricula. A second important barrier was inappropriateness of the training that was available. Respondents viewed existing training as failing to address the necessary topical areas. A third

barrier, cited from the same study, was that when agencies attempted to provide their own training, the trainers tended to lack the knowledge necessary for case managers, or that not enough time was devoted to necessary subjects. A vast majority of respondents indicated that the subject area in which they most needed training and additional knowledge was client assessment. Kane (1990) and Austin (1981) have reached similar conclusions.

Applebaum and Wilson (1988) reviewed the training needs of case managers representing the 10 channeling agencies comprising *The National Long-Term Care Channeling Demonstration Project*. They found three categories of training needs beyond the basic requirements of a bachelor's degree in a human service field. The first category involved the need to understand the client and included knowledge of health and disability limitations, health conditions, morbidity and mortality patterns and mental health needs. The second category involved understanding the service environment, including awareness of service providers, eligibility criteria, service unit costs, methods of negotiating with and monitoring providers, working with physicians and other medical professionals and support mechanisms for informal care givers. The third category encompassed the techniques of case management including functions of assessment, care planning, ongoing monitoring (including reassessment), performing multiple roles and time management.

Gerontological instruction provided by institutions of higher education generally cluster in the three following orientations:

 overhead - types of gerontological instruction

- Liberal arts
- Scientific
- Professional

There is no implied hierarchy in these three approaches. Each serves a useful and legitimate purpose.

Liberal arts education has as its purpose the acquisition of a philosophical understanding and appreciation of the processes of aging. The liberal arts are aimed at liberating the individual from the bonds of ignorance,

prejudice and cultural isolation. A liberal arts orientation emphasizes breadth of knowledge and the integration of that knowledge into a whole.

Scientific gerontology has as its purpose the description, prediction and ultimate control of aging. It emphasizes the generation and replication of knowledge, the importance of previous findings, research methodology using approved techniques and procedures to collect and analyze data and verification through replication and open review. Scientific gerontology emphasizes content depth rather than the breadth that is common to the liberal education approach.

Professional gerontology is rooted in a concern for the welfare of older persons, social justice and a raised awareness of their vulnerability. The focus of professional instruction is to develop skills and apply knowledge in a way that will improve the quality of life for older persons. Professional gerontology focuses on the training needs of professionals close to the point of service delivery through emphasis on relevance, assistance and intervention.

Frequently, case managers enter the field with backgrounds in other health/social services. It is generally accepted that case managers require unique skills and abilities beyond the scope on any single professional discipline. Practicing professionals with a discipline-based background may lack knowledge specific to aging or case management skills. Nursing training, for example, does not emphasize knowledge of community resources, and social workers are not trained to do preliminary health assessments. The breadth and scope of multidimensional client assessment crosses several professional boundaries. The task of coordinating health and social services requires a unique set of skills, including identifying client needs and negotiating and accessing community resources and services, among others.

According to one source (Steinberg & Carter, 1988), sixty percent of case managers have a bachelors degree in any of an array of the helping professions. The same source reports that some 25 percent of practicing case managers are working with less than a bachelor's degree. Approximately 20 percent of case managers have a nursing background, and another 20 percent come from backgrounds in social work. These figures seem to be congruent with the desire of the Texas Department on Aging. It is their desire that case managers have a bachelor's degree, however they recognize that appropriate related experience can substitute for up to one-half of the traditional four-year degree.

Components of Case Management

The components of case management are categorized as a function of a particular author and environment. Most authors, using an ideological approach, place the consumer of case management services as the most important component. From this perspective, the logical sequence is to begin with the client pathway (the route a client follows in the intake process).

There seems to be general agreement among practicing case managers to cluster the entire array of components around five phases that are common to all sources. This section will be presented around those five phases of case management which are:

overhead - major components of case management

- Intake
 - case finding
 - outreach
 - prescreening
- Assessment
 - physical
 - mental
 - physical environment
 - economic status
 - nutritional status
 - self-care capacity
 - services presently received
- Care Plan Development
- Implementation of Care Plan
- Monitoring, Reassessment and Closure

Phase 1: Intake

The intake process begins with **outreach** activities. Case finding and locating the target population are other terms for outreach. Case finding is a process through which a program identifies and establishes contact with individuals who need the services provided by the program. Older persons experiencing a disabling condition may have the most difficulty gaining access to services. As a result, outreach efforts help to locate these persons and connect them with appropriate services. Outreach mechanisms can include:

- services listed without information and assistance agencies,
- formal agreements with other provider agencies to make appropriate referrals,
- public information campaigns and
- being part of a nursing home preadmission screening process.

Case finding is intended to ensure that a high proportion of those for whom the service is the most appropriate mode of care actually receive community care - subject to their right to refuse it if they so wish. This is also known as *horizontal efficiency* (Challis & Davies, 1986). The same authors refer to *vertical efficiency* as the attempt to ensure that a high proportion of users have the appropriate characteristics for a particular service.

Case management should be undertaken at the request of and with the informed consent of the consumer or the consumer's decision-maker when the consumer is legally unable to make decisions. Consumers have the right to have their values and preferences considered and respected. Case managers endeavor to determine and strive to honor these values and preferences in all phases of case management practice.

The **intake interview** is the first major component involving the proposed client. Frequently this is done via the telephone. It is crucial at this interview that rapport be established that will establish the nature of a healthy professional relationship for the endurance of the client/case manager relationship. One approach is to guide the interview by means of a standardized list of questions from an intake form. This not only assures that all relevant topics are covered, but also organizes the answers so that they may be more readily accessed later by other personnel. The intake process is a **screening** process. Important information to be gleaned from this interview is a determination of:

overhead - information necessary from intake interview

- basic eligibility both functional, including an examination of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and financial,

- services currently being provided by the family,
- where the gaps in service exist,
- what are the client's/client's family's expectations (engage the client in the process),
- referral to proper agencies when client does not qualify for case management, e.g. meals-on-wheels.

Phase 2: Assessment

The second major phase involves an understanding of the client as a whole person, which includes acquiring knowledge of the client's strengths and needs in functional activities. Joshi & Pedlar (1992) define assessment as a "method of collecting in-depth information about a person's social situation and physical, mental, and psychological functioning which allows identification of the person's problems and thus the development of the care needs by addressing major functional areas." Assessment requires a basic knowledge of the aging process as well as being sensitive to the needs of clients and a basic knowledge of **medical terminology**, and skills needed for **working with difficult clients**.

The areas normally evaluated in a comprehensive assessment include physical health, mental functioning, ability to perform activities of daily living, social supports, home environment and financial resources. An emerging component in the assessment phase is the utilization of a benefits counselor to bring expertise to the case to determine the maximum benefits that can be brought to bear on the said case.

Case managers should draw on their experience, observations, judgement and expertise to analyze and synthesize the information obtained in the assessment in order to determine the consumer's needs for services, supports and resources. It is crucial not to disturb the services provided by the informal family network, but to determine the gaps in that service and work to fill those gaps. A functional approach recognizes that certain tasks must be done daily, however, the client might not necessarily be capable of accomplishing said tasks if family members are reliable providers of the task under consideration (e.g., meal preparation). It is important that the assessment be done in the environment in which the proposed consumer lives.

Phase 3: Care Plan Development

The purpose of the care plan is to clarify expectations and agree upon an individualized plan of services and other problem-solving activities based on the findings of the assessment process. Care planning is the process by which the information gathered during assessment is developed into a package of services for the elderly client. The care plan should reflect the consumer's values and preferences; include a written list of problem-oriented goals; and, describe the services from paid sources (formal services) and unpaid help provided by friends and family (informal services) that will be used to achieve the goals. Goal development is one of the most difficult aspects of case management because consumers prefer to state problems to be solved rather than goals to be achieved. The document should include a timetable for the activities and services to be provided, indicate the role and responsibilities of the case manager and include estimates of the cost of the care plan and who will pay for services. It is important to remember that "programs for the poor become poor programs." The development of the care plan requires that the case manager have knowledge of what resources are available in the community. Further, if the case manager is utilizing Older Americans Act Title III programs, he/she should be aware or have access to how many units of a needed service are available. The care plan identifies services that are going to be used by a client and will no longer be available in the community delivery system if, in fact, they are used by that consumer.

For many clients, the point of entry is at discharge from an acute care facility. The case manager needs information as to the involvement of either/both programs funded by Medicare and/or Medicaid. If the consumer has Medicare benefits for home health, the case manager needs to have knowledge of how long those benefits will last, what gaps in service exist during the benefit period and what gaps will exist at the close of the Medicare benefits. Should the consumer qualify for Medicaid benefits, the case manager needs to explore what gaps remain when the waiver programs are implemented.

Phase 4: Implementation of Care Plan

Case management requires the timely and cost-effective implementation of each consumer's care plan through the

arrangement and coordination of informal and formal services. In the course of implementation, the case manager assumes many roles and performs a variety of tasks, including negotiating with providers, advocating on behalf of the client, short-term counseling and referral.

The implementation phase requires the use of effective communication with the client, family members, providers and physicians. The most frequently overlooked aspect is the failure to communicate with family members and physicians. The case manager will be called upon to share client information which calls for legal knowledge regarding client confidentiality.

Implementation mandates a knowledge of community resources. Effective arranging of services requires extensive knowledge of the long-term care system, including types of services available, accessibility and eligibility criteria for program entry. Current practicing case managers voice the notion that, all too often, it is necessary to create a new service and/or locate new resources. Other aspects include mediating conflicts between clients and providers, monitoring for service gaps and developing client participation and self-reporting.

Phase 5: Monitoring, Reassessment, and Closure

Monitoring

Case management requires monitoring sufficient to determine that case management is being provided at a level appropriate to meet the consumer's needs, that services are provided in accordance with the care plan, that services continue to meet the consumer's needs and are of high quality and that problems are resolved promptly. Monitoring serves as an opportunity to assess the consumer's satisfaction with case management and provider services, review the consumer's status and situation, evaluate the impact of provider services on identified consumer needs and review the costs of the care plan.

Monitoring is a critical case management task that enables the case manager to respond quickly to changes in the client's status and to increase, decrease, terminate or maintain services as indicated. Responsiveness to changes in a client's needs can have a dramatic impact on service costs. The frequency of monitoring varies depending on the intensity of client needs and the type of services being delivered. For instance, a consumer who has just been discharged from the

hospital after an acute illness and is temporarily receiving home health care, may need substantial monitoring. When a client is stable and receiving a minimum of services the requisite frequency of monitoring will be less.

overhead - roles played by case managers

Steinberg and Carter (1988) list the following five roles played by case managers in the monitoring phase:

- Validating that the provider agency is delivering the quantity and quality of service that it has promised. This may include the examination of written reports from the provider agency as well as documentation obtained through observation at the service site.
- Provide moral support and technical support to the provider in solving specific problems. This activity could require consultation conferences and additional staff meetings with providers. This role is made easier when a relationship exists between agencies prior to a specific case.
- A third monitoring role is addressed to the client. Through personal contacts with the client, either by telephone or visits in the home, verification is made that the client is using the service as it was intended. If problems exist that have to do with the client's attitude or behavior rather than those of the service provider, then the monitor seeks to assist the client through counseling, obtains counseling from another source or works with the client to revise the care plan to better suit the client's preference.
- The fourth role is teaching the clients to monitor their own care givers. Case managers, when possible, should meet with clients and family members at which time the recipients are invited to let the case manager know if the service delivery is satisfactory.

- The fifth role is evaluating the effectiveness of service delivery. In this instance the case manager is seeking information to verify that a service is producing an appropriate effort or possibly producing unintended, undesirable side effects. An important example of this role is an evaluation as to whether the client is becoming more dependent as a function of receiving a service. Another example is monitoring for the condition of the informal providers--e.g., could they be experiencing burnout.

Reassessment

Reassessment is the scheduled or event-precipitated examination of the consumer's situation and functioning to identify changes which have occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the care plan. Reassessment is an attempt to identify changes in consumer needs, strengths, abilities, resources, functional and cognitive capacity and limitations and to determine the consumer's continued need for case management and other direct services. Reassessment may involve the use of all or part of any instrument used in the original assessment, however, in most instances reassessment tends to be a partial reevaluation of the most significant consumer problems. Frequently, reassessment dates are written into the care plan based upon the case manager's judgement of an appropriate time frame.

overhead - reasons for reassessment

The purpose of reassessment is to determine whether services need to be changed in any way. Changes may include replacement of one service by another, modification of intensity of service or termination of services. These considerations apply not only to the services obtained through case management, but also to the service of case management. The following are causes which may precipitate reassessment:

- standardized intervals prescribed by agency policy, such as six weeks, three months, or six months;
- on a schedule written into the care plan based upon the case manager's expectations;

- when a new case manager is assigned to the case;
 - the presenting problem has been resolved, alleviated or redefined, i.e., abrupt change in physical or mental status;
 - when a planned service is discontinued by the service provider or the client;
 - when there is planned withdrawal of a service and a need to help the client to see the change in a positive light;
-
- when a new unanticipated crisis or impairment befalls the client or family or there is an unanticipated improvement in the client's situation, e.g., death of a client's spouse or member of the informal caregiver network;
 - when there is agency pressure to terminate improved or stable cases to make way for new, waiting clients;
 - when there is a change in the living arrangements e.g., consumer is placed in a hospital or nursing home.

While assessment will be addressed in Module II of this series, the case manager is advised to inform the client that the thrust of the reassessment effort is to determine unmet needs and not a guarantee of service. Case management seeks to arrange for services not currently being provided by the informal network. This same mind-set needs to accompany the case manager during follow-up assessments. A prime consideration for scheduled reassessments is not to create dependency by providing more services than are needed. The case manager should remember that it is easier to increase services than to decrease them.

It is important to keep in mind that service plans are not set in stone and often change as the consumer's needs change. The reassessment should identify when or if needs have been met, how services should be altered to meet them or establish new goals and strategies to address needs. Whenever it is determined that a plan is to be one of a short term duration, such as when a client has a fractured limb, when the caregiver will be away temporarily or when the consumer has demonstrated prior independence before and does not want services long-term, the case manager should note this in the narrative and the service authorization should be written accordingly. It is important that the client

or family members understand any short-term authorization period.

Reassessment visits may be done at a minimum of every six months although it is recommended that most consumers be visited quarterly or more often, if needed. To prepare for a reassessment visit, the case manager should review the report of the most recent visit and case progress notes. This visit is a good time to follow-up on any problems mentioned by other providers.

Closure

The majority of clients enter case management services following the onset of an acute condition. Recovery or adaption for seniors generally has prolonged time requirements. Therefore, the majority of cases are regarded as long-term cases. However, case management requires that services be terminated when the consumer no longer needs case management or the services coordinated by case management. Many practicing case managers express a reluctance to terminate cases when there are improvements in the situation because it is then very cumbersome (with new paperwork) to reopen the case if changes occur later. At the same time, practitioners believe that in selected cases termination not only helps to reduce excessive case loads, but also makes it possible to elevate a consumer to a renewed level of independence.

The more successful a program is in targeting to the most vulnerable elderly, the greater percentage of the caseload is carried for the long term. There are a number of occasions, however, when cases are closed.

overhead - common reasons for case closure

The following list represents the most common reasons for terminating clients (Steinberg & Carter, 1988).

- The client himself terminates,
- The principal service provider recommends termination.
- A single service provider accepts comprehensive responsibility for the care.

- The consumer enters another living arrangement,
- The consumer insists on services that the case manager thinks will be counterproductive or refuses recommended services.
- The presenting problem has been alleviated and the case manager thinks that the client or caretaker can carry responsibility for service procurement and task coordination.
- Demands for services and scarce resources make it necessary to set priorities among clients and withdraw services from those who can still benefit but whose needs are less hazardous than others.

A client's case may close for many reasons, however, in the incidence of the client's death, placement in a nursing home or relocation to another area, the Case Manager should consider the following:

- Confirm with the family/friends of the client that the information is correct.
- Notify all service providers and community resource providers who were involved with the client.
- Document why the case is closing and other pertinent details in the progress notes.
- Process necessary paperwork to close the case.

If the client is no longer "need" eligible for services based on his/her ability to complete activities of daily living such as bathing or meal preparation, the case manager will explain this determination of ineligibility to the consumer in person and give a two week notice of the termination of services. The client may sign the voluntary assent form agreeing to the termination of services, or the case manager may need to send a notice of action which allows the client to appeal the case manager's decision to terminate services to the agency's Internal Review Committee. The case manager may consider contacting the Volunteer Coordinator at any of the provider agencies to arrange for volunteer assistance if the client desires. Another alternative is to provide the client with a list of private pay resources or to refer the person to a private pay case management program. Then the case is closed.

Income and Health Programs

If the client is placed in a nursing home, the case manager will keep the case open for two weeks to one month to ensure the placement is indeed long-term. At the end of this period, the case manager will contact the family or nursing home personnel to confirm the living arrangement. If confirmed, the case will be closed.

Economic status in old age is vitally important because the presence or absence of financial resources has a considerable impact on an individual's capacity to adjust to aging. Income determines whether a retiree's values and preferences can be realized. Adequate financial reserves grant the elderly a greater degree of control over their lives, including such decisions as housing options, leisure pursuits and dietary habits that correlate highly with preventive medical care.

Aging affects income needs in several ways. Retirement reduces the amount of money needed for employment-related expenses such as transportation, special clothing and meals away from home. By this time, the elderly person's children are well into adulthood, leaving the household free from costs allocated to young dependents, including educational expenses. Offsetting this is the fact that decreased physical competency increases the need to buy services that formerly could have been provided by oneself or one's spouse. For example, persons over 80 years old are unlikely to engage in painting their home or doing their own yard work. Most sources agree that the elderly can maintain themselves on slightly less money than those under 65 in comparable lifestyles.

Older Americans receive direct funds from a variety of sources. Some have earnings including salaries or wages or self-employment income; most have a retirement pension, including Social Security. Compared strictly on the basis of money income, persons 65 and older on an average receive substantially less than those under 65. In 1986, the median income for families age 65 or older was \$19,932 or about 65% of the median income of families under 65, which received \$32,368 (AARP, 1988).

Furthermore, the distribution of money income is substantially less equal among the elderly than it is among the non-elderly. In 1986, 34% of elderly families had incomes below \$15,000, compared with 18% of non-elderly families. There is, however, a greater concentration of non-elderly families than elderly families at the very lowest income level,

suggesting that basic federal income protection programs available for the elderly are accomplishing their intended objectives.

Although the elderly as a whole have a higher incidence rate of poverty than the balance of the population, some subgroups of this population have even higher percentage rates. The three subgroups of the elderly with the greatest degree of poverty are women, minorities, and those who live alone. These subgroups represent seven out of every ten noninstitutionalized older persons and nine out of ten elderly poor persons. The oldest of the old experience a higher percentage of poverty than younger elderly.

The lower incomes of older women are largely associated with a pattern of economic dependency on men. In 1986, the median income of elderly women was \$6,425, or 56% of that of elderly men (AARP, 1988; Kart, 1990). While older women in every age group are more likely to be poorer than men of the same age, the oldest women were the poorest, with one in five falling in the poverty category. Older married women have the lowest income due largely to continuing dependence on the spouse's income; they also benefit from the income of a spouse because married men have the highest income (\$12,265 vs. \$5,253) (AARP, 1988).

Black and Hispanic elderly have lower incomes than white elderly. Black males in 1986 received 56% of the income of white males, and Hispanic males fared only slightly better with 61% of white male income (AARP, 1988). The same source reports the income levels of black and Hispanic women at 67% and 68%, respectively, of their white counterparts. The percentage rates of elderly blacks in poverty was nearly triple that of whites, with the Hispanics' rate more than double.

Aging changes the available sources of income to which older people have access, as both direct income sources and financially valuable indirect income sources are reduced. Direct income sources include earnings, pensions, income from assets and public assistance. Indirect income sources include Medicare, Medicaid, the food stamp program and other programs, such as transportation services. The income of older people with additional sources is nearly double that of those relying mainly on pensions. Retirement pensions come in two basic varieties--Social Security benefits and job-related pensions. The elderly depend more heavily on Social Security for their income than any other source; in 1992, 38% of all income received by retired persons came from that single source.

Social Security

Guest speaker from Social Security Administration. Ask for office manager and request speaker to address overview of programs for retired persons, including SSI and Medicare. Sometimes office will have specialist just on SSI. Each office has one who does presentations.

Compulsory old-age insurance has approximately a century of history. One hundred years ago, Chancellor Otto von Bismarck established the first social security system in Germany, setting the retirement age at 65 because only a small minority of people reached that age. When President Franklin D. Roosevelt created the U.S. Social Security System in 1935, the median life expectancy was 63.7 years; therefore, it was not expected that the number of people claiming pensions would be large. More than 130 countries now have some type of old-age/disability/survivor's program, and those programs constitute the single most important source of income for older persons in industrialized societies.

Initiated on August 14, 1935, the Social Security Act represents the closest approximation the United States has achieved to modern "welfare states" with systems of public protection for citizens against the hazards of old age, unemployment, ill health, disability and poverty. The programs signed into law on that one crucial day had some distinct patterns that have largely survived and shaped the provisions of public benefits in the United States over one-half of a century later.

Health insurance was purposely omitted from the original act out of fear that it would cause the entire act to fail in Congress. Physicians acting through the American Medical Association and insurance companies had the political clout to frighten reformers away from public health insurance. The three original major parts of the legislation that passed Congress were: unemployment insurance, public assistance and old-age insurance. The centerpiece of Social Security is the one program originally established on an entirely national basis--old-age insurance. Although Social Security is referred to as an insurance program, it is actually a transfer payment from a fund in which current contributions are placed. Because of actual and artificial inflation and related increases in benefits, both the wage base and the rate of contributions have increased substantially.

The intent of the original act was to create jobs for younger workers and for contributions to exceed payments, allowing a substantial reserve fund to accumulate. The reserve fund did accumulate during the initial years, and payments began considerably earlier than originally thought possible, with benefits beginning in 1940. As Congress expanded benefits during the next 40 years, the program became insolvent in November of 1982. President Ronald Reagan created a bipartisan committee to reform the system. The Congressional action taken restored the system's financial soundness, and today it reflects one-fourth of the federal budget.

Social Security eligibility is related to work rather than to need, and the benefits are available to those who have reached age 62 and have worked in covered jobs for a specified minimum period of time (usually 10 years). Social Security retirement benefits also carry a 50% spousal benefit, which means that a retired couple receives 150% of the pension entitlement amount of the covered worker.

The standard retirement age under Social Security is 65. Those who retire early receive a benefit that is reduced by an amount that compensates for the greater amount of time over which benefits will be drawn. Those who retire after age 65 receive an increased benefit that only partially compensates for the shorter time that benefits must be paid.

The Social Security Administration utilizes a "retirement test" to determine whether a person otherwise eligible for retirement benefits is considered retired. According to the 1983 amendment of the Social Security system, unless a person can be considered substantially retired, benefits are not payable. The retirement test acts to reduce benefits paid persons under age 70 who earn more than a certain amount annually (\$8,440 in 1988). Benefits are reduced \$1 for every \$3 earned above that amount. The full benefit retirement age, which is currently age 65, will be gradually increased to age 66 in the year 2009 and to 67 in the year 2027.

The elderly rely heavily on Social Security benefits, with nine out of every ten elderly persons receiving some income from Social Security. Thirty-one percent of the elderly depend on Social Security for 80% or more of their income, and the elderly with the lowest incomes are the most dependent. Social Security benefits, on the average, replace 55% of the earnings of the last year of employment for retired couples and only 37% for single persons. Although the pur-

chasing power of Social Security has increased 650% since 1965, the basic intention remains that of providing a minimal income floor below which no recipient would fall, not providing a lavish pension (Atchley, 1988).

The principles on which Social Security or OASDHI (old-age, survivors, disability and health insurance) are based are as follows:

overhead - principles of social security

1. Participation is compulsory for covered groups; hence, it is an earned right.
2. Benefits are related to covered earnings.
3. It is intended as one of several potential sources of income maintenance, offering a floor of protection.
4. Funds come from payroll taxes.
5. Benefits are weighted to provide higher relative returns for low-income workers, and wages above a cutoff point are not subject to tax.
6. A person must be retired in order to draw benefits. The proceeds from the total of the two halves of the payroll tax (approximately 15%) is divided into three funds: 70% goes to the Old-Age and Survivors Insurance Fund, 20% into Medicare benefits, and 10% into a fund for disabled workers of any age.

Income maintenance programs represent a major investment of federal dollars. The two largest federally funded income maintenance programs are the Supplemental Security Income program (SSI) and the Social Security Disability Insurance program (SSDI).

Supplemental Security Income (SSI)

In 1974, SSI replaced the previous state and federal categorical public assistance programs of old-age assistance, the program being financed from general revenue derived from income taxes and administered through Social Security offices. For those who are not eligible for SSDI benefits, who receive a small disability benefit or who are without other

minimum assets or income, SSI provides monthly income assistance authorized by Title XVI of the Social Security Act. The SSI program has a uniform set of eligibility requirements and a minimum payment level for all states. SSI payments are based on financial need and involve a "means test," with limitations on both income and assets. The basic federal SSI payment in 1989 guaranteed \$368 per month for an individual and \$553 a month for a couple. These benefits are a supplement for those whose Social Security benefits are below this level and act as a guarantee that nearly everyone will have the minimum coverage. The person's resource eligibility limit is \$2,000. SSI recipients are also entitled to other benefits such as Medicaid, food stamps, home care programs and rehabilitation.

Social Security Disability Insurance (SSDI)

SSDI was enacted in 1956. The 21-year delay in benefit payments following the 1935 Social Security Act resulted from fear that they would discourage rehabilitation and work force re-entry. It was further thought that the determination of disability as a cause for unemployment would be subjective and difficult to administer.

Initial eligibility for SSDI was narrowly defined, with benefits paid to severely disabled workers of 50 years of age or older. The SSDI program has been expanded through several amendments. Currently to be considered under SSDI, an individual must have physical or mental impairments that prevent gainful activity and are expected to last for at least 12 months. SSDI is summarily described as an early retirement program for the disabled.

Medicare

Medicare is a federal health insurance program that was legislated in 1965 as Title XVIII of the Social Security Act. The basic goal of Medicare has been to provide America's older adults with financial protection against the burgeoning costs associated with hospital, nursing home and physician care. There are two parts to the Medicare program: Part A, which covers basic hospitalization and certain post-hospitalization costs and Part B, which covers physician services and out-patient therapy under specified conditions. Part A coverage is automatic for any person qualified for Social Security or a railroad pension either as an insured worker or as an eligible survivor or dependent of an insured

worker. Part B of Medicare is optional and requires payment of a monthly fee that is adjusted periodically. Current rates for Part B may be obtained from any local Social Security office.

Part A of Medicare is financed by a portion of the Social Security payroll tax that finances old-age and disability retirement programs. Over 90% of all persons age 65 and over are covered by Medicare health insurance. The Medicare program provides only partial payment for covered services, and the services covered are restricted; the focus being on curative and rehabilitative care and centered around acute care services. Medicare was established as a categorical program because the Senate Finance Committee came to believe that adequate coverage should be available to all rather than to assist the aged only after they have become needy.

With the explosion in numbers of Americans in the over-75 age category and particularly the "old-old," above 85 years of age, forces have been exerted to redirect Medicare so as to more closely meet the needs of the frail elderly with chronic conditions. Rehabilitation services for the elderly are addressed primarily from a medical perspective, with disability being defined as a medical problem whose resolution lies in medical treatment.

Medicaid

 Guest speaker from TDHS on Medicaid and Community Care for the Aged and Disabled (ACDD). Address all community based programs including waiver programs of 1929B (PASPE) and Nursing Facility Waiver.

Whereas Medicare is an entitlement program, Medicaid is need-based. The medical assistance program is provided under Title XIX of the Social Security Act and is a federal-state matching program in which Medicaid benefits and eligibility criteria differ from state to state. The federal share of funding is determined by a formula that provides a higher ratio of federal to state funds for poorer states. The federal share ranges from 50% to 83%. Eligibility is linked to income standards for identifying the categorically needy or for determining medical need. Medicaid can pay for prescription drugs, eyeglasses, supportive services and long-term nursing home care.

**Older
Americans Act
Title III
Programs**

The Older Americans Act (OAA) originated in 1965 as the main focal point for needs of all the nation's elderly and represented a shift in the federal focus from income maintenance to coordination and funding of a comprehensive service system for the elderly. Although the OAA has used age 60 rather than income as the main criterion for service eligibility, it encourages a targeting of services for the poor and minorities while realizing that all of the aging population is at risk for obtaining services.

Just as other disciplines with federal connections have responded to changing target populations through legislative measures, so has the field of aging. The various amendments to the Older Americans Act, and particularly the 1987 updates, reflect a recognition on the national scene that there is a growing need for services for the frail homebound elderly. It is important that the case manager for the elderly understand the basics of the act, its administration and the services for which it provides.

overhead - three tier structure provided by Older Americans Act

The Older Americans Act established the U.S. Administration on Aging (AoA) and initiated what has become a three-tiered administrative structure of federal/state/local aging service delivery networks. Each state has a unit on aging, usually a department, commission or division. Title III authorized grants to state agencies on aging for the development of a comprehensive and coordinated delivery system of supportive social services and home-delivered nutritional services. To qualify for funds, the state agency was required to divide the state into separate geographical areas with a minimum of 100,000 population and establish area agencies on aging (AAAs) charged with coordinating existing services and fostering the expansion and development of community services for the elderly.

AoA is one of the programs under the auspices of the U.S. Department of Health and Human Services and operates through ten regional offices. Approximately 670 AAAs, located throughout the 50 states, are responsible for funding and monitoring various service programs such as senior centers, congregate nutrition programs and numerous possible support services such as home-delivered meals, transportation, recreation and socialization, home chore assistance, health screening and educational programming.

overhead - policy objectives of Older Americans Act

The objectives of the Older Americans Act address the inherent dignity of the individual through ten policy objectives as set forth in Title I: (1) adequate retirement income; (2) physical and mental health services; (3) suitable housing; (4) restorative services; (5) employment services; (6) retirement with health, honor and dignity; (7) meaningful activity in civic, cultural and recreational opportunities; (8) efficient community services; (9) immediate benefit from research findings; and (10) freedom in planning and managing one's own life. The mental and physical health needs of the elderly are addressed by the OAA. Of the ten objectives of Title I listed above, three are directly related to mental health and wellness.

The Older Americans Act of 1965 (OAA) and its subsequent revisions state that the people of our nation are entitled to the full and free enjoyment of several objectives, among which are:

1. Full restorative services for those who require institutional care and a comprehensive array of community-based, long-term care services to appropriately sustain older people in their homes.
2. Efficient community services, including access to low-cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed, with emphasis on maintaining a continuum of care for the vulnerable elderly.
3. Freedom, independence and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit and protection against abuse, neglect and exploitation.

Title III of the OAA assists state and area agencies on aging to foster the development and implementation of comprehensive and coordinated service systems, in order to:

1. Secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive resources;
2. Remove individual and social barriers to economic and personal independence for older individuals; and
3. Provide a continuum of care for the vulnerable elderly.

Title III requires AAAs to allocate "an adequate share" of their funds to three categories: access services, in-home services and legal services. In addition, AAAs are allowed to contract for ombudsman services, counseling services, case management, health screening, employment services, crime prevention, victim assistance and volunteer service opportunity programs. Section 307(a)(10) actually forbids state units and AAAs from providing direct services unless there is a totally inadequate supply of said services. Thus, local AAAs are the frontline forces in implementing the OAA and for carrying on the theme of program coordination, need assessment and priority setting.

The case manager coordinating a plan for a senior citizen needs to understand Title III. There are seven parts to Title III (A through G), each with its own level of funding. Section 321 of part B lists 18 categories of supportive services the local AAA may fund. At least four relate directly to mental and physical health: (1) services designed to avoid premature or unnecessary entry into an institution and to assist individuals in long term care facilities who are able to return to their communities, (2) services designed to attain and maintain mental and physical functioning, (3) services for the prevention of abuse and (4) services to enable mentally and physically impaired older individuals to attain emotional well-being and independent living.

The OAA mandates that every AAA establish local information and assistance services in adequate numbers to ensure that all older individuals within the geographical service area covered by the plan will have reasonable access to services. These offices develop and maintain a comprehensive listing of agencies along with eligibility requirements, hours of operation and services provided. Additional programs provide services to older persons and are

generally referred to as the informal aging network. This includes church-sponsored facilities, private clubs and numerous national organizations.

 Guest speaker from Area Agency on Aging or one of its contractors that can/will speak on Title III programs sponsored by the Texas Department on Aging. Participants should be given a handout which provides an overview of those 38 programs.

The Texas Department on Aging lists and supports an array of 18 primary services and 20 secondary services of which a limited number are required by each AAA. The AAAs are charged with monitoring the quality of the required services. The required services in each AAA catchment area include the following three clusters:

overhead - clusters of required services-----

1. Access services - transportation, outreach, information and assistance and case management;
2. In-home services - homemaker and home health aides, visiting and telephone reassurance, chore maintenance and supportive services for families of older individuals who are victims of Alzheimer's disease; and
3. Legal assistance.

From its inception, the Older Americans Act has discouraged the AAA from the direct provision of services. The intent of this policy is to prevent conflicts of interest by the AAAs channeling clients to their programs rather than those of other potential service providers. However, the Older Americans Act recognizes that not all forms of aging service provision lend themselves to this kind of abuse. The Act allows the state unit on aging to determine that a given service is directly related to an AAA's administrative function and to delegate responsibility for directly providing that service to the AAA.

One of the key philosophical shifts occurring in 1993 at TDoA was a judgement that *information and assistance* (senior hotlines), *case management, outreach and advocacy* and *benefits counseling* are directly related to the

administrative functioning of area agencies and that these services can and should be provided directly by AAAs. The need for case management services is expected to double between 1995 and 2015.

An emerging area of interagency cooperation is evident with the *Pre-Admission Screening Presumptive Eligibility* (PASPE) program. While the Older Americans Act generally directs the AAAs to work through contractors [section 307 (a)(10)], the current emphasis as mentioned above, is a movement toward the direct provision of case management. PASPE is a program of the Texas Department of Human Services (TDHS) that cooperates with AAA case managers. While TDHS is the funding agency for this package of in-home services, AAA case managers have the authority to determine eligibility with services starting immediately. This program has positive implications for the targeted population of this study.

Area agencies on aging (AAA) exist in Texas, under administrative authorization of the Texas Department on Aging (TDoA), to function as area planning and coordination authorities. TDoA authorizes AAAs to plan for and coordinate a system of community-based services which is intended: 1) to secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; 2) to remove individual and social barriers to economic and personal independence for older individuals; and 3) to provide a continuum of care for the vulnerable elderly.

The TDoA has formally authorized its 28 AAAs to pursue the 38 generic services listed on the handout in developing a continuum of care. However, service prioritization occurs within the individual AAAs. Therefore, no single AAA offers all of the authorized generic services. Findings indicate that not one of the AAAs in Texas currently offers all of the services which are authorized by the Texas Department on Aging. Furthermore, some services that do exist are only offered by a few of the AAAs. Some of the generic services are offered by only a few of the AAAs.

 overhead - TDoA services (participants receive handout)

However, there is a core of services which the AAAs have a mandate to plan and coordinate under reauthorization of the Older Americans Act. While these services are

mandated, not all of the AAAs in Texas provide these mandated services. By mandate, each AAA should provide for the following core services in addition to legal assistance, nutrition services and senior centers:

- 1) Services associated with access to services:
 Transportation,
 Outreach, and
 Information and assistance.

- 2) In-home services:
 Homemaker,
 Home health aides,
 Visiting,
 Telephone reassurance,
 Chore maintenance,
 In-home respite for families and adult
 day care as respite for families
 Minor modifications of homes that is
 necessary to facilitate the ability of
 older individuals to remain at
 home and that is not available
 under other programs and
 Supportive services for families of elderly
 victims of Alzheimer's disease and
 related disorders.

Guest speaker - Benefits Counselor (or one qualified to speak on subject)

overhead - case managers seek to fill gaps in service

Families and the Informal Network

Families and the informal caregiving network play a vital role in the case management process. Family-provided help is the backbone of in-home care for frail seniors. Earlier we cautioned that case management, as well as all community-based services for frail seniors must not be viewed by the family as a substitution for care that they had previously provided. If substitution occurs to a significant degree, then public programs will be politically unacceptable.

The concept of family involvement and family issues in the case management process of older persons to some could seem peculiar; however, it represents the cornerstone of the case management process. According to Brody (1986),

families, not the "formal" system of government and agencies, provide 80 to 90 percent of medically related and home nursing personal care, household maintenance, transportation and shopping. They link the older person to existing formal services provided by the government and agencies. They respond in emergencies, provide intermittent acute care and receive the elderly when the latter are discharged from hospitals, rehabilitation facilities and nursing homes. They do the triage, participating in making decisions about calling the doctor and which doctor to call. The family also provides the expressive support--the concern, affection and sense of having someone on whom to rely--that is the form of family help most wanted by the elderly. (p. 89)

In addition, support and assistance provided by family members may help an older person to stay independent in the home for a longer period of time than otherwise would be possible.

Every society has its own social myths, those collective beliefs which everyone within a given society knows to be right and everyone accepts as true. In American society, a widely held belief is that the elderly are alienated from their families, particularly their children; to some extent, the elderly have internalized this belief. Brody's statement helps to dispel this myth. The reality of the situation is that, although extended families tend to live in separate households, there is considerable contact between the elderly and their families and much help-giving--a great deal of which involves the elderly helping their adult children (Brody, 1986).

The family has evolved in that it is no longer an economic unit, and it is in some respects reflective of a higher degree of mobility. However, some facts have remained constant. About four of every five noninstitutionalized persons over 65 in the U.S. have living children. This has not changed in 30 years (Corgiat, 1989). The family network of any one person is not static, for it changes as needs change. While the proportion of older persons with adult children living under the same roof has declined, the proportion of old people with children within ten minutes' distance has remained fairly constant.

Families are homeostatic; that is, they seek to maintain the status quo even when that state is problematic. Illness, especially chronic illness, places additional burdens on families. Brummel-Smith (1989) reports that 10 of the top 15 stressful life events are family-related. The onset of a disability affects the whole family system, as it is the basic unit of care. Illness, disability, or mental health conditions of an older family member may disrupt the family balance, leading the family into conflict about issues of dependency, role transitions and continuity. When the family system is strained by having a needy older member in conjunction with having its own unfulfilled needs or insufficient resources, it ceases to be a willing source of support (Corgiat, 1988). The potential for family conflict is further heightened as the balance of independence and dependence needs of the older person shifts. Feelings of guilt arising from inability to meet filial responsibilities can precipitate additional problems.

An older person in distress communicates this condition to caregivers. Family members are touched in varying degrees by the emotional distresses and bothersome symptoms experienced by the elderly family member. This stage for the family can be difficult because younger family members frequently do not know how to respond to the older person's emotional problems or how to determine what the older person really requires. Families also have their own issues which can prevent optimal intervention.

Another important outcome of family science has been the development of the systems approach. The systems approach represents an extension of a biologic system perspective to a human situation (Edinberg, 1985). The family is seen as one of the components of a hierarchically arranged system. Any change in one component of the system will affect all the others. While the family affects the chronic condition, the condition simultaneously changes the family. A basic premise is that each family is an interdependent system with patterned sequences of behavior that follow certain rules or principles which govern all systems. Edinberg (1985) gives the following tenets of a family system:

 overhead - basic tenets of a family system

- The total system is more than the sum of its parts.

- To understand the individual requires an understanding of the total system and its relationships.
- Relationships and behaviors are interactive; that is, all events are part of a sequence. A response is also a stimulus for another response from other family members. To think of any family member's behavior as simply a response is inaccurate.
- To change individual behavior, the system's patterns, styles or motivation must also be altered as systems work to maintain themselves at a current level of functioning.

The physical and environmental demands associated with caring for a disabled family member are often similar; differences in problem-solving strategies frequently distinguish families who cope from those who do not. Families differ widely in their approach to problems and in the quality of their solutions. According to Corgiat (1989), family variations in response to the same potentially stressful events can be attributed to differences between families in selectively attending to events. Stress is interpreted by the case manager as the result of the interaction between the family's resources and their perception of an event.

When confronted with problems, families do whatever they do best; each one applying its own version of problem-solving (Pinkston & Linsk, 1984). When this fails to work, they try harder with more of the same strategy. Thus, each family under stress has a natural tendency toward exaggeration of its own special character. These problem-solving strategies develop a semi-autonomous life of their own to which people in the system become habituated. Consequently, the repertoire of strategies becomes limited, and family members repetitively apply the same solution to different problems without regard to their effectiveness. Case managers should be aware that the continuation and exacerbation of problems often result from behaviors that were intended to resolve the initial problem.

There is an unfortunate tendency in many discussions of the aging family to talk as though the presence of an older family member creates a new situation for both the family and the case manager. Corgiat (1989) says that, while younger family members are anxious to define the older person as the problem, the case manager needs to determine what strategies the family has used because they reflect established themes of which some are prone to failure.

Corgiat (1989) believes that all families can be understood in terms of paradigms. Family paradigms are templates for patterns of behavior that, by their redundancy, become recognizable as characteristic of a family's way of dealing with life. He defines three basic family paradigms: closed, open and random. The closed family tends to be traditional, stressing maintenance of normal established family patterns. Since continuity and uniformity are given priority, the family unit tends to be more important than the individual. One of the major implications for case managers is that closed families have a strong commitment to control information; consequently, they have many secrets. When confronted with problems, the closed family will become more isolated, more rigid and increasingly more dysfunctional. The closed family system is more likely to deny learning new strategies. Closed families have one "identified pattern" which sustains the family process. Younger family members use the older relative's chronic and/or disabling condition(s) as a means of avoiding other issues.

The random family is a sharp contrast to the closed family. Whereas the closed family values stability and continuity, the random family values change. The random family promotes continued change by opting for novelty and variety. When confronted with stressful situations, the family can become locked in a highly competitive fight for survival with everyone looking out for themselves. As family members work with increasing independence to find solutions, the family process tends to become chaotic and uncoordinated. The needs of individual members are lost in the quest for independence. For the case manager, the random family will view intervention requiring family cooperation as a threat to individuality. The older person seeking case management services will find little emotional support because all family members are vying for limited resources.

The image of the open family is that of adaptability and participation. The needs of the individual and the group are equally important to the open family, and adaptability of

the interests of both is the family's goal. The open family believes in the sharing of feelings, thoughts and ideas, and it tends not to censure information or regulate communication. When confronted with problems, the open family will persistently try to work out solutions that reflect consensus. The case manager can assist this type of family with appropriate information because the tendency is for the family to inundate themselves with information which heightens a sense of ambiguity. The open family frequently lacks leadership, discipline and clear family rules. The older person seeking case management services will receive little support from the open family because of constantly shifting rules and endless negotiations. Open families have long histories of unsolved problems and incomplete projects; thus, the problem of an older family member can easily become another pending family project.

Herr and Weakland (1984) caution the case management professional that, although family units may remain intact, middle-aged children are notoriously unreliable in describing problems experienced by their parents. This fact is further exacerbated through the trait of middle-aged children sounding so remarkably convincing about the true nature of their parent's problem that often the parent agrees and label him/herself with a certain mental/physical health condition. When a disagreement or complaint occurs, the elder parent's credibility is then at stake because the opinion of the articulate middle-aged child is assumed to be more reliable.

Because a large proportion of community-based long-term care is provided by family members, case managers' interactions with the informal system are critical to good practice. The challenge is to support rather than supplant the informal system while providing care to disabled relatives and friends. Case managers have to be cognizant of the effects of new services on clients and their families. For example, arranging a home-delivered meal for the husband being cared for by his frail wife may seem like a good service. However, if preparing her husband's meal was one of the wife's major caregiving tasks, this could have a negative effect on the couple. Similarly, bringing in a formal service that had traditionally been completed by a visiting family member may reduce some important family interaction. Case managers must carefully observe how their intervention affects family roles and responsibilities.

For the case manager, the need is clear to see as many family members as possible. Family members of all ages should be assumed to be involved in the caregiving of older adults. Part of seeing the family is seeing them together, not individually--or, worse, not seeing the elder at all. The process of seeing and hearing for oneself is the same for families with younger members as for families with older members. With the latter, it is easy to be misled by sincere, but distorting, middle-aged children.

Knight (1986) advises the case manager working with older families to seek answers to:

 overhead - themes case managers need to observe-----

- Is the current problem a new one?
- Who is disturbed about the problem?
- Is the family talking about the problem?
- Is the family supplying accurate information?
- What is the family's historical pattern of offering assistance?

By answering these five questions, keen insight can be gained on the family system and problem-solving strategies. It is of critical importance that the family also grasp the distinction between illness and aging. Understanding that problems are due to an illness implies the possibility of learning about the illness and developing ways to cope with it. The case manager can link family members with others who have similar conditions, which helps reduce fears associated with a chronic condition.

Any discussion about the role of family must consider that many seniors have no immediate family to assist with personal care, and that they are the most prone to seek institutional care. Thus, it is reasonable to target case management to those who lack social support. There are two common hazards to using this criterion for entitlement (Steinberg & Carter, 1989).

First, living alone is not a sufficient indicator of isolation or risk. For many elders, living alone is related to liberation, economic well-being and successful coping. There is some evidence that many elders who live with relatives and need help from them suffer more depression than those in

their own home who obtain help from formal agencies and non-resident family, friends and/or neighbors.

Second, care from family members is not always a guarantee of being helpful, whether there is direct abuse or an excess of dependency-breeding, guilt-driven family care. When an older person is utilizing valuable help from an informal support network, the members of that network may need the help of a case manager to bring an objective assessment of the situation and to arrange for respite. In rare cases the client may be receiving conflicting or overabundant help from too many uncoordinated informal sources.

At the same time, case managers need to be sensitive to the demands placed on family members and that their efforts frequently can be extended with the availability of *respite* services. Caregiving can and does extract a heavy emotional and physical toll. Respite services are provided in a person's home to relieve other family members or primary care providers of their responsibilities for providing care on a temporary basis for short periods of time. The primary caregivers may or may not remain in the home during the delivery of respite service. Respite service may be provided during crises resulting from specific events or on a regularly scheduled basis. For example, respite service might be provided while a family member is recovering from an illness, on a Saturday to allow for shopping, to obtain rest or participate in events the respite participant enjoys or at a time when the respite participant indicates a need for a break in the usual routine. Family caregivers report that the availability and utilization of this service is one of Title III's most important programs in helping them to sustain their efforts.

Summary:

 overhead - information needed on each family

- What tasks are the family doing at present?
- Can they be counted on to continue performing those tasks?
- What gaps exist in meeting present needs?
- What are the expectations of the family?

Legal and Ethical Issues

- Will the provision of Respite Service extend the informal caregiving effort? If so, at what frequency?

Legal and ethical issues are included because case management frequently raises difficult questions about what type of care is appropriate. Ethical dilemmas may be particularly difficult because of pathological changes that are irreversible. Services usually must be long-term, and consumers must participate actively in services. This section addresses three issues: establishing a basic understanding of autonomy, beneficence, confidentiality and fidelity; addressing the legal nature of all written documents; and the need for consent.

Promoting human welfare is a primary ideal upheld by all human service practitioners. Professional organizations, such as the National Association of Private Geriatric Care Managers, American Psychological Association, the American Association for Counseling and Development, the National Association of Social Workers, the American Psychiatric Association, and the National Rehabilitation Counseling Association have developed codes for professional behavior. All of these various codes have been impacted by the Hippocratic Oath taken by physicians who are expected to serve their patients without thought of remuneration in a manner that is obligatory and non-reciprocal. Physicians and clients are not viewed as equals in a partnership because the power of knowledge is held by the physician to bestow upon the client in order to facilitate healing (Fitting, 1984). The physician's role is sustained because of the passive nature of the recipient in an acute care environment. All helping professions have inherited this legacy to some extent, and case managers working with older consumers may find themselves caught in the role of the benevolent authoritarian protecting persons who are older from harm. A major topical point results through assessment procedures and the information from assessment. This can range from the fact that many case managers do not come under the protection of the law for privileged information, to failing to recognize a treatable condition (Edinberg, 1985; Knight, 1986).

Ethical principles which guide all clinical practice--autonomy, confidentiality, beneficence, truth-letting and justice--should also direct decisions about case management with seniors. Ethical dilemmas arise over and over again. An ethical dilemma is a situation in which the two

alternatives are defined or limited by opposed ethical principles. Kermis (1986) credits the American value system as contributing to the dilemmas, such as social policy that produces the greatest good for the greatest number. It is important for the case manager to recognize the distinction between trying to resolve problems resulting from functional limitations and trying to resolve value dilemmas. After the distinction is made, consumers are better able to accept the services that will help sustain them in their homes. Only then can intervention be designed to reduce the stress associated with value issues. Problems may be either soluble or insoluble and occur in situations that include uncertainty or difficulty. Dilemmas are always insoluble and require the individual to select from two equally balanced alternatives. The individual facing a dilemma is confronted with choosing between the rejection of a desirable goal or the acceptance of an undesirable one. There are many ethical principles that can fall in opposition to each other resulting in dilemmas for case managers. Two opposing pairs are recognized as occurring frequently with elderly case management. The first is the conflict between beneficence, and the second is respect for autonomy (Howell, 1988).

The Principle of Beneficence

The principle of beneficence is an ancient underpinning of professionalism and also of the more simple, less pretentious and more primitive art of giving care to another person. As a concept, beneficence has its origin in the works of Hippocrates, who wrote that, with respect to disease, the practitioner should make a habit of two things--to help or at least do no harm.

Although the principle seems clear in the abstract, applying it in particular cases may be controversial because people may disagree over what is best for the consumer. Whether the case manager is working directly with an older consumer or with younger family members, as a friendly responsibility or as work done for pay, there is an underlying assumption that what is being done ought to promote the well-being of the consumer. For the case manager, multiple implications emerge. First and most basic is the principle that, if the consumer is not benefiting from the relationship, it should be terminated. Second is the implication that, if beneficence includes preventing harm, certain persons need protection. When we apply this concept to disabled elderly

persons, we are close to the legal concepts of guardianship and involuntary commitment.

The Principle of Autonomy

The second ethical, and frequently opposing principle, is that of autonomy. According to the principle of autonomy or respect for persons, individuals have a right to make decisions about their bodies and their minds. They may refuse professional help even if it jeopardizes their own well-being. Furthermore, clients may stop receiving professional assistance. Respecting consumers as persons requires case managers to obtain informed consent, preferably in writing. This allows the case manager to share concerns with other professionals in order to obtain their professional insights.

Autonomy enters the area of ethical considerations primarily because of the mental deficits that can surface in the latter years, such as with a dementia. Diminished competence generally means that one is dependent upon others or is incapable of rational deliberation. There is increasing acceptance of the notion of legal incompetencies or situation-specific assessments that serve to ensure that an individual loses as little of his or her rights to self-determination as is necessary for the circumscribed need to make delineated decisions. The implication for the case manager working with older clients is that marginal competence requires a judgment about decision-making capacity. Assessment procedures contribute to two errors--mistakenly preventing persons who ought to be considered competent from directing the course of their own treatment and failing to protect incapacitated persons from the harmful effects of their decisions (Fitting, 1984).

Autonomy issues are frequently encountered with older persons following the onset of a disability (Lo, 1989). Such persons who have not experienced case management probably cannot appreciate its benefits. Decisions about case management often must balance short-term changes against long-term benefits. Case managers then need to focus on the benefits and quality of life issues resulting from the implementation of the appropriate services.

A second common opposition between ethical principles is the conflict between the requirements that a case manager "protect the vulnerable" and make equitable distribution of scarce resources. In the ethical traditions of our government and society and of our dominant religious and philosophical

traditions, we take pride in our determination to care for those who are old, weak, poor or have special needs. The case manager, on the one hand, is admonished to be a resource person giving consumers direction to needed services and, on the other hand, is told that our national budget requires abandonment of the notion that everyone deserves every possible benefit.

The Principle of Confidentiality

The principle of confidentiality of information evokes respect for the privacy of consumers and protects them from adverse consequences that might occur if information were disclosed. Confidentiality, in general terms, means maintaining the secrets of consumers, but the concept of confidentiality goes beyond just the written record and covers communication between the consumer and the case manager. The purpose of confidentiality is to encourage candor so that the consumer yields more thorough information, thereby promoting better information. This information then benefits the case manager in more accurately targeting services to existing service gaps, thus enabling consumers to remain in their homes. Because case management requires the cooperation of family, friends and a team of professionals, confidentiality may be difficult to maintain. When consumers may not want others to be told of their conditions or their seeking case management services, even if such disclosure would help them gain assistance from others, the case manager should consider the principles of beneficence and autonomy. Related issues involve just how informed a family should be. In non-institutional settings, there can be an overstepping of ethical boundaries as a result of an air of casualness about confidentiality among multiple providers.

The Principle of Fidelity

Fidelity is defined as the quality or state of being faithful or loyal. It implies faithfulness to an obligation, trust or duty. It is a central assumption in covenantal and contractual relationships and is reliant on trust, integrity and conscientiousness. In covenantal relationships, it is assumed that both parties have an ethical obligation to act faithfully with one another. Implicit aspects include a commitment by both the case manager and the consumer to work for change or growth and an acknowledgment that personal concerns of the client are the focus of the relationship. This principle

emphasizes the quality of the relationship the case managers build with the consumer as a primary objective.

Fitting (1984, 1986) considers faithfulness and fidelity to be the canon of loyalty between the consumer and the case manager and on whose basis is the informed consent of the client. Informed consent is a central component of the relationship between consumer and case manager and provides a foundation of trust. The idea of informed consent is a commitment to be equal partners in a collaborative effort, which is where case management differs from the relationships and the practice of acute care medicine.

Dilemmas may arise as case managers seek to live up to the idea of faithfulness. Situations in applied settings are frequently ambiguous, and ethical principles conflict as the case manager attempts to be faithful to consumers' expressed desires and rights while also attempting to act in what is perceived as their best interest. The case manager who views his or her first responsibility as being to the consumer, with everything else being secondary, will experience less conflict with the ethical consideration of fidelity.

Ethical Issues: Dementia

Ethical issues are faced by case managers working with older consumers who are victims of any of the three "D's" of cognition--delirium, depression or dementia. Delirium episodes are often brief, lasting 24 to 72 hours, and are usually self-limiting after metabolic and other medical causative factors are diagnosed. Delirium constitutes an acute medical emergency that should be evaluated quickly and, as such, generally does not present as a case management issue.

Depression constitutes another area of inquiry and is often associated with physical disease in older clients. Depression rarely becomes a major focus of treatment for excess disability, nor does it directly influence the decision about whether a client can or should receive services. The primary implication for case managers working with older clients experiencing depression is that they tend to clearly understand issues even though their responses can reflect deficits in judgment.

Clients with cognitive loss, such as a late-life dementia, do not understand information given to them and lack the ability to make use of it in the process of judgment. The issue of competence in the demented client strikes directly at the tension between the desire to do what is best for the

client and its pejorative extreme, paternalism and the desire to respect the rights and autonomy of that person, which has its disparaging extreme in abandonment. The advances of modern medicine should not mask the fact that the risks of therapy and diagnostic procedures have increased as well. For the case manager, the ability to predict outcomes has not improved for those suffering from any of the dementias. A dementia is truly a chronic condition with increasing disability.

For those with a dementia, and particularly in the initial stages, a fine line exists between considering a consumer's decision as rational and declaring him or her incompetent. Competence rulings by courts tend to hinge around instrumental activities of daily living (IADLs), whereas the helping professions view competence as the ability for self-care (ADLs). These extremes contribute to ethical conflict for case managers. The emphasis on rationality as a criterion for competence has significant limitations. Competence tends to be a specific function; one is competent to dress, groom or make a will, yet not to perform other tasks such as driving a car. Once a judgment of incompetence has been made, not only is it difficult to reverse, its presence will influence all professionals giving care to the consumers for the rest of his or her life.

Written Records as Legal Documents

A person can run a red light every day, and the action is of little consequence until the driver hits or kills someone. Inadequate records or incompetent personnel who are responsible for entries in any record may be of no consequence until a malpractice suit is filed or until a funding source demands a payback. From the first moment of consumer contact the case manager becomes responsible and accountable through their written records, to their profession, the community, the consumers, the payers, co-workers and a legal system that protects the rights of each individual consumer.

Unfortunately, humans have not been able to develop a system of accountability that eliminates documentation. Thus paper work, the least enjoyable aspect of case management service delivery, is necessary. In this day of accountability, the content of each entry is becoming increasingly important. Without sufficient documentation, there is no way another case manager can provide

appropriate intervention when the assigned professional is not available, no way to confirm the rendering of a payable activity and no way an agency can defend itself in the event of a malpractice suit.

Good documentation is based on clear communication - which is a two-way process with someone "speaking" (in writing) and someone "listening" (with eyes). Effective communication is important in the sharing of consumer information with other providers. The fact that a case manager has had a good session with a consumer with respect to communication, does not automatically guarantee an accurate written record. Documents that are legally and fiscally accountable are an integral part of any service. The agency providing the service without proper documentation will ultimately fail. Paper work, which represents quality record keeping, is a legitimate concern for the professional case manager. We cannot expect society simply to hand over funding and provide agencies with unlimited legal protection just because they are providing a high level of service. Any written record is a service tool and also a legal document. If the case manager's notes or plan is illegible, vague or missing, then the record fails to provide accountability and the necessary conformation of good treatment (Mitchell, 1991).

Information in a consumer's file is confidential, however, with proper consent and circumstances will be seen by program directors, auditors, therapists, possibly an attorney and the consumer. Consumers should be informed at the time they sign a *consent form* that they both have a right to know what is in their records and that possibly other providers will have access to the same information. Consumers should be encouraged to help write any documents as that demystifies the notion of what is being maintained. Such involvement takes the edge off of consumer discontent and makes it less likely that documents will ever be subpoenaed during legal action.

Accountability is a concept that has become more prominent. This is due in large part to a demand for some indication that the money's worth was obtained. Because case management services generally depend on public funding, some accounting is required. Funding sources are very cost conscious and unsympathetic to unsupported claims. Third-party payers have a right to demand that case management records (or contractors) verify services for which the agency receives reimbursement.

If credible, professional accountability is to occur, case managers must view their service as an incidence of definable activity. Systematic evaluation requires the ability to state goals in objective, measurable terms. To provide anything less leaves the case manager open to accusations of ineffectiveness. Inadequate records can give others an opportunity to doubt and question the validity of case management intervention.

Case managers need to consider the purpose of any official record. The assigned case manager uses it to assure continuity and adhere to an established treatment plan. A co-worker may be required to provide emergency service because the assigned case manager is out of town or no longer with the agency. Case manager supervisors use consumer records to review a case manager's professional growth, use of time and adherence to a plan. Auditors are probably the most "dreaded" users of written records. The records document a level of compliance with licensure or payer regulations. Their concerns include consumer eligibility, verification of a need for the billed, a current plan of care and the type of professional who rendered a service. The auditors' job is to answer, through the use of the record, any question that would substantiate a reimbursable service as defined by a payer. Therefore, the consumer's record must be a precise reflection of the service, treatment goals and achievement. Precise written information serves to ensure establishing responsible, accountable activity.

Consent Form

Consent forms are important required legal documents for the case manager. On the one hand, the consumer is consenting to receive a service such as "meals-on-wheels." The consent form is part of the intake process with its more important function being the granting of the case manager and his/her agency the right to share personal information with other providers. This sharing of information cannot be carried out without this authorization. Personal information is essential for contract providers to receive payment or if the case manager is assisting the consumer in the application process with an entitlement service such as Title XX programs or community based Department of Human Services' programs. For case managers employed by home health agencies, the consent form is a necessary first step in carrying out the physician's orders. The information from

**Profile of
Typical Case
Management
Consumer**

this form is also required for home health agencies when they release information for billing to third party payers, primarily Medicare. In instances where the consumer is capable of making decisions, yet cannot sign their name, the case manager is cautioned to document this fact.

Show video: *After the Hospital, What's Next?*

Growing Old in a New Age (vol.10 *Illness and Disability*)

either use here or during first session: *No Place Like Home*

Loss is a predominant theme in characterizing the emotional and physical experiences of older people. Losses in every aspect of late life compel older persons to expend enormous amounts of physical and emotional energy in grieving and resolving grief, adapting to the changes that result from loss and recovering from the stresses inherent in these processes.

Essentially, the later years involve a progressive loss of many of the things that make life most meaningful: health, beauty, careers, financial security, status and a stable self-image. The fear of loss of life itself may be another factor. Most individuals endure these losses and creatively adapt to unavoidable changes. Where the losses are light or the individual's total resources for coping are high, mental and physical health can be preserved or even enhanced in the later years. However, many times these losses become crises necessitating the intervention of mental health professionals.

Older people can be confronted by multiple losses that may occur simultaneously: death of marital partner, older friends, colleagues, relatives; declines of physical health and coming to terms with death; loss of status, prestige and participation in society; and, for large numbers of the older population, additional burdens of marginal living standards. Inevitable losses of aging and death are compounded by potentially intensified cultural devaluation and neglect.

Adler (1964) identified three health paths that compensate for a basic feeling of inferiority that is inherent in everyone. The three paths or social ties for the individual are friendship, family and career. A relationship with friends allows one to gain a sense of significance and counteracts feelings that one is inferior or unloved. Conversations with friends show us that all people have problems and reassure that we are not abnormal. The family gives one the

opportunity to be someone very important in the lives of others. A career provides an opportunity for status and achievement along with pride in one's contribution to society.

Inferiority feelings, according to Adler, are widespread among the elderly. These feelings can be engendered by physical decline; by loss of stature, beauty, economic deprivation; or by any combination of factors. Thus the ability to compensate for inferiority feelings has been reduced on all three paths. The number of friendships is reduced as old friends die or move away. Gone are the contacts from work and from many forms of recreation. A reduction in mobility lessens the volume of time spent with friends. Family life is threatened by geographical mobility of offspring. Compensation through career is ended by retirement.

Adler (1964) gave mental health professionals the guidelines for undercutting inferiority feelings by helping the client to develop social interests, cultivate independent behavior and win a sense of achievement. An Adlerian perspective can reinterpret the disengagement issue. The question is not how much social activity a person has, but to what degree his or her activities are guided by social interest.

Butler and Lewis (1982) categorize losses as extrinsic and intrinsic. Extrinsic factors include the losses of marital partners and significant others, status changes in social groups, socioeconomic changes resulting from income declines, unwanted retirement based on outdated policies and cultural devaluation (including a sense of uselessness), therapeutic pessimism and forced isolation. Intrinsic factors include physical disease, sexual losses and physical limitations; age-specific changes such as the increase in time required for certain processes and responses; and changes in body size and appearance.

Becoming old, being old and dying are active physical and emotional processes that test the mettle of each person. Reluctance to accord older people appropriate recognition for their strengths and capacities indicates a failure to understand what is required in being old. It is an odd distortion of reality to depict older persons as weak, unassuming, gently tranquil people who passively wait out their last days. Certain life crises occur in old age regardless of socioeconomic or cultural circumstances and geographic location.

A person who has experienced a loss may overreact. Having experienced one loss, the individual feels more easily threatened and may develop a mental set involving the anticipation of multiple losses (Verwoerdt, 1976). The nature of these anticipated losses is that they are not factually real but have psychic reality, and psychic reality counts with regard

to the development of emotional responses. Losses frequently lead to an all-or-none principle, leaving the older person capable of seeing only black or white and without flexibility to face daily challenges.

Brink (1979) makes the point about losses clear for the mental health professional as he poses that the most significant threats to mental health in later life are not any vague or pervasive fears about death or negative self-image due to ageism. Specific losses, particularly those of health, spouse or career, seem to pose the most serious crises. When these losses occur simultaneously, they mount a formidable assault

on mental health. When the elder lacks financial reserves, access to community services and a confidant relationship, his or her resources for meeting crises are likely to be inadequate. Although the concrete losses of the elderly, coupled with poor resources, do not always produce poor mental health, these facts are the most significant, and the ones with which mental health professionals must concern themselves.

The loss of a spouse represents a major psychological issue and is far more serious than one's own impending death (Edinberg, 1985). The mourning process itself occurs at the same time as the need to make practical though emotion-laden decisions about where to live, what to do with the family home, and how to dispose of the spouse's personal effects. Widowhood frequently is accompanied by economic loss. A psychological vacuum may develop if the deceased was the chief confidant and friend. The timing of the death of the spouse in relation to other events is also significant, such as a man's career ending and the loss of his wife.

Among physical conditions frequently involved in mental health are the effects of sensory declines. Hearing loss is potentially the most problematic of the perceptual impairments. It can reduce reality testing and lead to marked suspiciousness, even paranoia (Butler & Lewis, 1982). Hearing loss contributes to depression because it causes greater social isolation than blindness. Older people with hearing problems are often excluded from activities which are a source of stimulation. Visual losses can lead to specific negative consequences that resemble hallucinations (Butler & Lewis, 1982).

Frequently, the older person seeking case management services will appear to have a high level of anxiety. This anxiety tends to build with the advent of chronic conditions

that undermine illusions of invulnerability built up across the life-span. New modes of adaptation become necessary creating additional anxieties in the face of constant change. Anxiety manifests itself in many forms--fear of being alone, suspiciousness and rigid thinking (only hearing what one wants to hear).

Edinberg (1985) cautions about certain behaviors that might be present at the early stages of case management services, such as resistance and dependency. The tendency to go against help is called resistance. Resistance is considered a stage in which defenses are working against needed change because the consumer does not want to give up the rewards of the problem. Resistance can also signal that the consumer does not believe there is a problem or does not want to admit to one. Dependency is a common issue in mental health practice with persons who are older. Many older people have expectations of dependency when treated for a problem. They fail to take responsibility for their own care while relying unrealistically on the therapist to solve problems for them. Edinberg cautions against an advice-giving approach as it reinforces dependency. Dependency is also fostered because it may be one of the few relationships the older consumer has where intimacy and trust become firmly established.

As a part of understanding the consumer, the case manager needs to explore the consumer's base of experience as a member of a particular cohort. The consumer's perception of what historical events influenced his or her life, what values were and are more important to members of that cohort as opposed to persons born earlier and later and any awareness of these influences on current relationships with family, friends, and neighbors are rich sources of material for understanding the consumer's ideas about self and others (Knight, 1986). Dowd (1986) stresses that a key to establishing rapport with the older consumer is the case manager's genuine willingness to understand the importance of historical events that contributed to the client's belief system.

Loss also contributes to depression. Life changes usually are implicated in the onset of depression. The amount of life change experienced by a depressed person before the onset of the disorder has been found to be greater and more undesirable than that experienced by others (Abrahams & Crooks, 1984). Although no single category of life change consistently predicts depression, depressed people have experienced more losses of others from their lives. Christian and Blazer (1988) stress the need for the case

managers to be aware of cohort differences because the life situation and past history are more likely to predict depression than age per se.

Most disabling conditions that require community-based services disproportionately affect the elderly. The patterns of illness and disease tend to be of a chronic nature. The disabled elderly are categorized into three subgroups, all need community-based services and all have increased dramatically in number. The first group is the growing number of developmentally disabled who are surviving past middle age for the first time and have few residual skills. The second group consists of adults who have experienced trauma at an earlier age and as a result of improved medical care have grown older with a disability. The third and by far the largest group is the elderly who have experienced a disability in late life.

Disabilities can lead to dependence requiring institutionalization. Three major functional losses leading to institutionalization are (1) dementia, (2) loss of mobility and (3) urinary incontinence. Independence is defined as being independent in the six activities of daily living (ADLs): bathing, dressing, transferring, eating, personal grooming and walking across a small room. Dependence is being dependent on the assistance of another person for at least one of these activities. As independence in ADLs decreases, elders living alone decrease. The following are facts as related to disabilities experienced by persons age 65+.

- 40% of all disabled persons are over age 65.
- 75% of all strokes occur after age 65.
- Most amputations occur in elderly people.
- Average age of hip fractures is in the range of 70-78 years.
- 86% of those over 65 have at least one chronic condition.
- 52% of those over age 75 have some limitation in their daily activities.
- 30% of the elderly with disabling conditions experience severe depression.
- 50% over age 65 suffer from osteoarthritis.

- 75% over age 80 suffer from osteoarthritis.
- 40% experience hypertension.
- 30% have a heart condition.
- Heart disease is the leading cause for elderly to seek health care.
- 10% of elderly visits to physicians are for heart problems.
- 18% of hospital bed day usage is for heart problems.
- 1.5 million elderly are institutionalized, with slightly in excess of 50% for a dementia such as Alzheimer's disease.
- Two out of three elderly persons die disabled.
- 70% of all severely visually impaired are over age 65.
- 2,000,000 over age 65 have visual impairments (same number as Alzheimer's Disease).
- One out of six over age 65 is hospitalized once a year.
- Four out of five causes of blindness are age related.
- 60% of 1.5 million in nursing homes have chronic mental conditions.
- 200,000 persons per year suffer a hip fracture, which tends to be a problem of women with osteoporosis.
- 80% over age 65 live independently in the community.
- 45% over 85 years live independently.
- One-third of elders over 85 living in the community are dependent on others.
- 21.6% of those age 85 plus are in nursing homes.

An aging population has gender implications. Women age 65+ outnumber elderly men three to two, with the disparity increasing in the later years in virtually all settings. This occurs despite the fact that the number of male births in a population always exceeds the number of female births. After the earliest ages, the male excess is reduced by higher male mortality, which decreases the relative number of survivors at the older ages. In the advanced years, the number of females far exceeds the number of males. The female population age 65 and over increased 28% from 1980 to 1990, whereas the comparable male population increased only by about 12%. During the decade of the 1970s, the female elderly population increased 25% while older males increased 18%. In 1960, the excess of elderly females over elderly males in this country was less than one million. The U.S. Census Bureau estimates for the year 2000 an excess of 7.6 million women over men age 65 plus.

The Case Manager's Position in the Community

Case management does not exist in a vacuum as an independent entity. Instead, it is embedded in and reflective of a program delivery structure which shapes its operation, and it in turn shapes other community-based providers. Every case management agency must define, through policy, the degree to which it views the goal of community-based long-term care for the elderly as cost-containment or maximizing the well-being of the elderly (and other family members). From a cost-containment point of view, it makes good sense to rely on family members to provide caregiving tasks. They are a volunteer and reserve labor force. However, if the goal is to maximize the mental and emotional well-being of the elderly (and their family members as well), relying on family care as heavily as case managers do is sometimes inappropriate. Often a blend of providers is necessary as the elderly and their family members would likely benefit from such formal services as respite care, personal care aides, transportation services and meal delivery. While these are administrative decisions, case managers must utilize the tools and the resources they have at hand. It is policy specialists and administrators who have the power to shape those tools and values. And, no longer can policy specialists and program administrators save costs by hiding behind the stereotype that elders prefer total family care. There is mounting evidence that such is not the case. Because of the constant interfacing with elderly network

providers, this section is intended to help the case manager understand their desired role in the community.

 overhead - dimensions of authority

Authority, as used in long-term care case management, generally has two dimensions, *scope* and *span*. Scope of authority refers to the breadth of impact the case management agency has in its local delivery system. How much authority does it have over segments of the delivery system not directly involved in the delivery of community-based home care services? For example, a case manager is said to have a broad scope of authority if he or she is responsible for pre-admission screening to nursing homes, if he/she has authority for prior authorization before services can begin to be delivered or if he/she is involved in discharge planning from acute care hospitals.

Span of authority refers to the breadth of involvement a project has in the delivery of a range of services. Wide span would include authority to allocate funds for acute care, home care and nursing home care. The wider the agency's span of authority, the more funding it is likely to control in its local service network. The most broadly conceived agency with the widest span of authority controls all the funding available to the target population from a variety of different sources.

Scope and span of authority are important dimensions to be considered in long-term care service delivery. Authority alone however, will be hollow in the absence of adequate incentives and sanctions which can shape provider behavior in the long-term care delivery system. In the absence of adequate authority and financial incentives and sanctions, case management agencies mainly rely on informal influence, persuasion and voluntary cooperation from the diverse providers involved in long-term care service delivery.

Case management has tremendous potential to influence the character of service delivery by either filling gaps in the continuum of care, by increasing the volume of scarce services or by controlling access to high cost services. Reducing the skewing toward institutional care guarantees that both the non-institutional and institutional market segments will be affected. Therefore, case management alters provider organizations depending on the goal of the agency and its position in the community with other elderly service providers.

It is generally accepted by elderly service providers that organizations seek to protect and expand their autonomy and will resist efforts to increase their dependency on other organizations. Efforts to increase coordination among service providing agencies produces increased interdependence among organizations in a local service network. Such coordination entails a cost to provider organizations. It constrains their capacity to operate independently. It requires interaction and consultation with other agencies. Coordination increases the level of uncertainty for agencies, introducing more or less uncontrollable elements into internal operations. Agencies spend considerable energy and time negotiating their dependencies in their local delivery systems, attempting to minimize potential disruptiveness introduced by environmental uncertainty. Therefore, case management inflicts a price on other providers through the promotion of collective activities. That price is a loss of some discretion and control over their own activities. Case management can be viewed by other providers as causing a partial loss of autonomy when the case manager is, in effect, controlling the utilization of their services. On the other hand, providers know that by sending referrals to a case management agency, they are ensuring additional usage of their services.

It is the intent of this training material to present *outreach* as a distinct section; however, the case manager in training is reminded that the majority of consumers enter the provider network immediately following an acute care episode. Proper community posturing mandates that the case manager have in place a close working relationship with hospital discharge planners. Discharge planners wield considerable power in the determination of services for frail elderly who are in need of supportive services at the time of discharge. Further, practicing case managers report that discharge planners frequently have little knowledge of community-based services. Discharge planners, functioning with the best of intentions, are true gatekeepers with respect to the placement of frail seniors when the acute need is resolved.

An educational approach is recommended as a technique for case managers to inform area discharge planners of their role in securing and arranging a package of services to sustain a senior upon discharge. It is further recommended that this educational approach be ongoing as discharger planners tend to remain in a fluid state of employment. Ideally, the result of such efforts will

indoctrinate the discharge planner to the extent that they automatically extend an invitation to the case manager for each discharge planning session. One method of formalizing this arrangement is through formal agreements. Such agreements can be beneficial for both the hospital and the case management agency. For example, the hospital benefits when, without warning, a physician discharges a patient on a late afternoon and the discharge planner finds comfort knowing that they can pick up the telephone and have assurance that the case management agency can quickly put services in place. Some practicing case managers believe that informal agreements are adequate to accomplish the same outcome.

The above-mentioned positioning with discharge planners has benefits for the case management agency. Through such a process, the agency can ensure both *vertical* and *horizontal* target efficiency. Horizontal target efficiency implies that a high proportion of those for whom the service is the most appropriate mode of care actually receive those services (in this instance, community-based services arranged by a case manager). Vertical target efficiency seeks to ensure that a high proportion of users have the appropriate characteristics for a particular service. The payoff of proper positioning in the community grants to the case management agency the ability to be an actor (active voice) in the selection of consumers as opposed to being a reactor as the result of having potential clients directed to them that are not appropriate because their needs are not within the limits of the services that are available.

There are a number of ways in which case management programs for the frail elderly attain the legitimacy and the authority to make demands upon the local service system on behalf of its consumers. Steinberg and Carter (1988), list four primary bases of authority common to case coordination programs.

 overhead - bases for authority

Mandate by public law is the strongest authority and it is derived by being stated in public law at some governmental level. For example, there are federal mandates for case management to specific population groups through grants-in-aid programs such as assistance to the developmentally disabled. For the multiply impaired elderly, however, the regulations

permit rather than specifically authorize or require case management. Block grant regulations (Title XX of the Social Security Act) permit the use of funds for case management and for protective services without regard to income or assets. To the extent that the target groups and worker functions of these two programs are similar, authority for case management can be claimed by a local agency charged with the administration of other Title XX services. Several state governments have passed legislation mandating some form of case management for the elderly, thus strengthening the authority of local case management efforts.

Mandate by incorporation is a kind of authority that stems from a long history of programs within voluntary agencies such as family service. These are the types of agencies that developed home-care programs such as homemaker services or meals-on-wheels, long before public legislation. They derive their authority from a board of directors within a nonprofit corporation and from membership in a nationwide movement on behalf of better services to seniors. There is a great deal of variation from one locality to another in the degree to which these agencies meet the standards of their national accreditation body with respect to comprehensive case management. The disadvantage tends to be a narrow focus such as providing a counseling service with little attention to medical and instrumental needs of the consumer. Such agencies also have advantages that include having access to well-trained personnel and, at the same time, have experience with the use of volunteers. Further, these agencies are very knowledgeable of the provider network.

Mandate through time-limited funds refers to programs established as special demonstration projects. The development of such programs usually involves obtaining prior interagency agreements to carry out the program should the special funds be obtained. In these programs, the authority radiates from the halo conferred by virtue of having been designated by a federal, state or area agency to conduct a special program. In many cases additional authority comes from funds obtained by the agency for purchasing services from other service providers. This may include

a waiver permitting Medicare or Medicaid funds to be spent for many home services without additional requirements such as previous hospitalization. The disadvantage of these case management programs is that other community-based providers often are reluctant to establish bonds since their funding is time-limited. However, some sixty percent of those established in this manner have continued after the initial funding period (Steinfeld & Carter, 1988).

Mandated by membership groups and associations is a fourth type of authority. The associations call upon their own staff to act as case managers for their more vulnerable members. Such activities are sometimes engaged in by labor unions, professional associations or private companies' counseling programs on behalf of their retirees on an occasional, as-needed basis. Some retirement housing authorities and banks provide select case management for their consumers.

In summary, the relationship with the hospital discharge planner is of utmost importance in the establishment of authority in the community. Discharge planners tend to be turf conscious until rapport is established. Rapport tends to endure once it is established.

Agency Outreach

In the professional area of the delivery of human services, the term *outreach* is used as opposed to *marketing*, however many of the same principles apply. Outreach encompasses those methods employed by human service agencies that seek to increase the availability and utilization of services by ensuring that a particular individual or group is aware of available services and is encouraged to participate. Outreach is the methods used to make information and assistance available to potential inquirers and accessible to specialized populations.

Outreach programs are intended to inform people of available services, help identify needs and overcome barriers or resistance to the utilization of needed services. Outreach is generally categorized separately from *Information and Assistance*. Information and Assistance is required by the Older Americans Act. The Older Americans Act requires Area Agencies on Aging to include in their multi-year plans the techniques they will use in their outreach efforts to

under-served, frail seniors. Outreach can include information and assistance.

Information and Assistance programs assume that the person who has a problem or needs a service will initiate contact if he or she knows whom to contact. Outreach operates under the assumption that people may not know that services exist, may not realize that they need services or may not want to contact either the Information and Assistance service or the potential service provider because of personal, cultural or other factors. Outreach programs have been especially effective in working with isolated and alienated populations, including the rural aged, minorities and social dropouts.

Practicing case managers emphasize the need to identify "high-risk" individuals, such as those living in areas of high concentrations of persons from minority backgrounds, persons in single-person housing units or persons in areas in which houses are geographically isolated. Thus the outreach program can target efforts for neighborhoods where there are likely to be people in need of service. Case managers are advised not to use survey methods to determine need as such methods artificially elevate the participants' expectations of services when in fact those services might not be available.

Outreach is an attempt to legitimize a service and/or its provider. Because potential consumers must accept case managers and other providers and develop rapport with them, outreach workers are sometimes recruited from the target population. If the target population contains many older blacks or Hispanics, efforts should be made to use black and Hispanic outreach workers who know the neighborhood and who will not receive automatic rejection by the hard-to-reach.

Outreach efforts by case management agencies are necessary for a variety of reasons. Professionals in other human service fields frequently lack knowledge of the availability of age-related services that a case manager can mobilize outside their area of specialization or of the regulatory guidelines that govern consumers' eligibility for those services. This is exacerbated by the fact that case management, as well as other community-based programs, sometimes have little incentive to provide outreach because of the existence of long waiting lists for many programs.

Another reason that outreach is essential and must be ongoing is that potential consumers and their family members fail to pay attention to any outreach efforts until a service is needed. Family members generally report frustration just in

uncovering where to go for information. Frequently there is a stigma with aging programs because they are generally thought of as "program" oriented and not specific "people" oriented. Community-based programs are aware of this stigma created by senior centers and work hard to change that image.

Practicing case managers recommend that whatever strategy the agency uses it should incorporate the idea of "one stop shopping" with the case manager as a valuable community resource. It appears that the strategy is not so important as that it be consistent. Case managers believe very strongly that they must participate in any elderly service provider organization, as these efforts offer valuable opportunities for networking with other professionals in the field of human services particularly those in the field of aging-related services. Efforts need to be ongoing to keep the agencies' names in the local newspaper, yet off the front page. Outreach mechanisms can include being listed with an information and assistance agency; making agreements with provider agencies, such as home health agencies, to make referrals to the case management agency; public information campaigns; and being part of a nursing home preadmission screening process. Outreach activities reflect the targeting requirement of the case management program and thus represent the first step toward reaching the program's target population. Additional activities include:

 overhead - special target groups-----

Target group of 60+ with disabilities:

The case manager should attend networking meetings with professionals who serve disabled populations, hospital discharge planners and have relationships in place with disease or health-related agencies and home health agencies. Consumers who are severely disabled usually hear about programs through a third-party, such as other agencies who serve disabled or through caregivers who have heard case managers make a presentation. Keep hospital discharge planners informed about services so that they can pass on information to disabled senior adults. Networking may also include interfacing with multi-purpose clinic staff, physicians, clergy persons and banking staff.

Target group of 60+ with limited English-speaking ability:

The agency should employ one-person in the office who is bilingual. Referral sources should be informed that the case manager staff is capable of serving clients who do not speak English. The case management agency should include sending information to local minority publications.

Target group with Alzheimer's disease and their caretakers:

Frequently consumers are referred to the case management program because of the inability to manage funds due to cognitive impairment. Care should be taken to gather as much information as possible about memory and reasoning from the referral source. Clients with Alzheimer's disease and their family members learn about case management through third parties. Caregivers hear about the program through presentations to civic, church, and other groups. Information should be supplied to the local chapter of the Alzheimer's Association and adult day care programs. The local legal network including lawyers and the probate court, should be informed of case management services since victims of Alzheimer's disease are frequently processed through probate courts.

Target group of 60+ with greatest economic need, including low income minorities:

Case managers should encourage benefits counselors to make presentations to groups which include low-income elderly and professionals who serve low-income frail seniors. Networking is needed with agencies who serve low-income minorities, such as Catholic Charities, Texas Department of Human Services, meal programs and others in the emergency assistance network. Special emphasis should be placed on keeping the discharge planner informed at the local county hospital and other acute care facilities service persons. Economic status presents extra problems at discharge. Case managers can use the most current Census data available to pinpoint geographic areas with the highest concentration of low-income elderly.

Target group of 60+ in greatest social need, including low-income minorities:

Referral sources frequently identify potential consumers who are isolated or have friends or family exploiting them. Case management agencies should include language in their outreach brochures that emphasize targeting those who have no other alternatives for receiving assistance. This literature might also use words like case management is designed to "target consumers who do not have family or friends who can assist in arranging for in-home services.

In summary, case management is a service that offers empowerment to frail seniors. Empowerment implies that they are having a voice in decisions that impact their lives and particularly their living in an independent manner. This mandates that they have information on and access to community-based services. Case managers need to maintain a high level of community involvement, as this is an important first step in establishing credibility and positioning in the community.

**Key Players
in Case
Management**

overhead - key players in case management

This brief section is intended to summarize and to some extent be a duplication of ideas from other sections that focus on the key players that tend to be involved in the majority of case management cases. Certainly there will be exceptions to the limited number provided. However practicing case managers place considerable emphasis on the student being able to synthesize the notion of the role of each of those included, and the importance of the case manager identifying these professionals in order to have in place working, professional relationships that benefit the frail elderly consumer.

The **consumer** and their **family members** must be the first consideration. The goal is to empower them through seeking their cooperation in the process. Case managers should begin each intake process with the idea of "not what I can do for you, but what will you allow me to do for you." This sets the stage for the intake process to **empower** the client. The majority of clients enter the case management process and the accompanying need for community-based

services through the hospital following an acute episode or the onset of a chronic disabling condition that usually requires hospitalization. The family network is a vast reservoir of energy which can be appropriately harnessed if it is given sufficient resources so that it does not deplete its own stock and so that its members have reasonable hopes to meet their expectations for maintenance, a quality of life or achievement.

The **case manager** acts as the control tower through assessment procedures and generates a package of services depending on existing service gaps. The case manager is involved from front end to closure, seeking to provide the necessary quality and quantity of services needed to sustain the frail senior consumer in the community.

Hospital Discharge Planners play a central role as the majority of clients enter the provider network through the hospital. The relationship between the case manager and the discharge planner must be strong and one of mutual respect. Discharge planners must be indoctrinated/educated with respect to the strengths and limitations of case management and community-based services. The payoff from this relationship will be evidenced through the invitations to discharge planning meetings and their referral to the case management agency.

Home Health Agency management is a key player because the typical consumer will be discharged with Medicare benefits covering skilled nursing. It is important to remember that these benefits are short-term and the case manager has to examine service gaps when home health services are in-place versus when the benefits are exhausted. Home health agencies can also be an excellent source of referrals.

Case workers with the **Department of Human Services** (DHS) are important since many consumers will qualify for their programs. Eligibility must be determined early in the intake process. While the *Community Care for the Aged and Disabled* programs are of lasting endurance, they require the case manager to examine gaps remaining when these programs are activated. DHS case workers can also be an excellent source of referrals.

Benefits Counselors are consulted early in the process to maximize resources for the frail senior needing community-based services. Benefits counselors assist seniors in claiming the various kinds of benefits to which they may

be entitled. Activities may include legal or other assistance in completion of insurance or application documents and assistance with problems with Social Security, Medicaid, pensions or other benefits. Often it is a good practice to have these professionals make a presentation to the consumer or their family members. Case managers need not be the counselor, but they should be aware of when to call on one and be aware of what benefits are available. Further, the case manager needs some idea of the limits of resources available for those benefits.

In summary, case managers not only mobilize key players, they mobilize community resources through accessing community-based programs. Case managers need relationships with other providers that grant them the privilege to pick up the telephone and say "we need your services for a particular client" and expect cooperation. Case managers must be aware of what resources are available in a community and continually cultivate those relationships.

Case Load, Case Mix, and Time Utilization

This section was developed based on the notion that there will be an increase in the population in need of long-term care and the continued emphasis on using case management to package and tailor services that will enable frail seniors to remain in their homes. One recent study (Turner & Louis, 1993) found an extreme variation in the size of case loads as a function of agency, location, demand for services and funding availability (both for case management and the services it could provide).

For those with design responsibilities for long-term care case management programs, the staffing patterns and supervisory approaches are of particular importance. No matter how well case managers are trained, a program with an unrealistic ratio of clients to case managers will experience problems. Aside from a reduced efficiency in monitoring the clients under service, it is the provider who is subject to the larger stresses, of which burnout is a frequent outcome.

There are many situations in which people work intensely and intimately with others. Such intense involvement with people occurs on a large-scale, continuous basis for persons employed in various health and social service professions such as case management. One of the main reasons that very little attention is given to the emotional stresses experienced by the health and social

service professionals is the traditional client-centered orientation shared by these fields. The focus is almost exclusively on the consumer or the person who, in some other way, receives services. Within this framework, the professional is viewed as merely the provider of services whose role and existence is defined by the presence of the clients and is justified only as long as he or she continues to serve, help and provide. It is not the intent of this material to go into considerable detail on the subject of burnout; rather we wish to recognize that all persons in the helping professions are subject to overload and that caution needs to be exercised to prevent well-trained and energetic professionals from leaving the field.

Case Load

Case load size is affected by a number of variables and reflects the agency's assumptions regarding the appropriate number of clients a case manager can handle. Case load size is determined by a combination of factors such as the level of need for case management services existing in a community, eligibility requirements established for entry in the program, support for the case management program in the community and the local availability of long-term care services.

Recommended case load sizes for case managers range from 45 to 75, with variation a result of such factors as the administrative demands of the role, characteristics of clients served, the available clerical support and the environmental and geographical differences of the community. In one study, (Grisham & White, 1982, as cited by Applebaum & Austin, 1990), case managers were asked to specify an ideal case load size. Respondents indicated that 30 to 50 clients represented an ideal number, although many indicated that this was probably unrealistic. Practicing case managers generally agree that handling more than about 55 to 60 cases is extremely difficult. Thus, those designing case management programs must recognize that case load is a critical variable. The ideal number is relevant only to the demands of those clients, hence the case mix should be the determinant of case load (heavy needs/light needs).

Case Mix

Case mix is an important factor in determining case load. Case mix refers to the level of effort and time required on the part of the professional involved as case manager. If

the case manager is carrying a case load of extremely frail consumers, the number of cases he/she can realistically handle is limited. In situations with very impaired clients with the possibility of rapidly changing conditions, a number of fifty may not be feasible. A case load number of fifty or sixty per case manager may not be of great help as an agency-wide case load standard unless there is a classification and distribution of cases according to the amount of work they require. Steinberg and Carter (1988) refer to this as a weighing of cases. For example, one worker with fifty cases that are in the implementation phase, and some that are inactive or require only intermittent monitoring has a case load equivalent of another worker's fifteen new cases, which require intensive activity during assessment, care planning and crisis resolution.

Advocate versus Gatekeeper

A closely related subject that creates controversy for case managers hinges around the dual demands of being both an *advocate* and a *gatekeeper*. Practicing case managers report that the trend in case management has been toward a greater emphasis on their role as a gatekeeper. Case managers are being asked to more closely control access to scarce services. Some case managers are fiscally accountable for the costs of their clients' care plans such as those operating under client and/or agency budget caps. Such a role can alter the nature of the consumer - case manager relationship. The emphasis on cost consciousness for the case manager who is a gatekeeper of long-term care services appears to conflict with goals inherent in consumer advocacy or counseling. Consumer advocacy and counseling may not contribute to cost effective outcomes. For many case managers, it may be unrealistic to expect them to effectively carry out the responsibilities of both roles, although presently most programs include both advocacy and gatekeeping as expectant roles. This dilemma has no easy solution.

Time Utilization

It is the intent of this training material to convey the notion that closely related to the subject of case load and case mix is the idea of time utilization. It appears that it too has no fixed standards, but only guidelines by which the case manager can monitor his/her own activities. The subject of time utilization is relevant because of the dual demands of

involving direct patient contact coupled with meetings with other providers and the large amount of paper work that accompanies case management.

One method of examining how much of a case manager's time is available for client contacts or interactions is to sketch a bar chart of work patterns according to the distribution of time expended among at least three categories: case specific activities, administrative and network activities and personal (illness, vacation, etc). For example, if 10 percent of the case manager's time is spent on personal uses, 50 percent spent on administrative and other professional activities, then only 40 percent can be allocated to specific consumer cases in the case manager's case load.

Practicing case managers believe that approximately 50 percent of the case manager's time should be in direct consumer services. This category includes direct contact with the consumer developing relevant information on the client's situation, mental and physical status, needs and preferences as well as external factors including social supports, environmental, housing and whatever else is required to begin the helping process. The case-specific work functions also include developing the best possible relationship with the client's social support unit, developing a tentative plan for the consumer, getting appropriate approval for authorizing the service(s), maintaining a continuing relationship with the consumer, keeping communication lines open regarding the consumer's utilization of and satisfaction with the service-providing agencies and negotiating any needed service changes or improvements.

Administrative activities that are not case specific are sometimes underestimated as a major drain on the time and skills of a case manager. Such activity includes participating in agency reporting systems, adapting to major changes in policy or procedures, cultivating interagency cooperation, updating information on service standards and speaking or writing for the public, as well as engaging in regular staff meetings, supervisory conferences and/or additional professional development efforts. These demands are all part of being a professional and particularly attending to one's own professional development.

The personal use of time is variable and may include such essentials as vacation, sick leave, personal necessity and participation in professional organizations. When estimating the total number of clients within an agency's number of cases that will constitute the case load of case managers, it is

Hospital Discharge Process

cautioned that these latter two demands on time must be realistically taken into account.

Throughout this training module on case management, the authors have referred to the recipient of services as the *consumer*. The use of this term implies that the person who receives the service(s) is an active participant in all phases and most of all chose to remain in their home and receive community-based services. At the expense of repetition, this section is included so that the student will understand the step-by-step procedure that occurs in the hospital for those persons who need vital services upon discharge.

Some procedures of the discharge planning process differ from facility to facility, yet many facets and players are very similar. The first step in the discharge process is for the attending physician to write an order for discharge planning. Across time, physicians have learned to appreciate and understand the supportive role of community-based services. This order has become an accepted procedure, written shortly after admission, for any at risk hospital patient.

This physician's order gives the hospital social worker/discharge planner permission to screen the potential consumer as to what their functional needs will be upon discharge from the hospital. The majority of discharge planners have a graduate degree in social work. Practicing case managers emphasize the notion that this is the critical entry point for the majority of consumers into case management services. The case manager needs to continuously cultivate their relationship with the discharge planner(s).

The majority of hospitals have a discharge conference once a week for all patients who the social worker, during the screening process, determined to be of "high risk." Examples of high risk could include frail persons without family, those living alone, considerations involving the diagnosis and level of functioning. The social worker assists the consumer with information about their choices of supports and options. The planner decides if skilled home health is needed, and if it is covered under Medicare. This skilled care does not cover many aspects of the care that the client needs. They consider what other functional supports are needed. It is important that the social worker/discharge planner consider at this point the package of services that the case manager can offer and also include this as information passed on to the consumer.

In some hospitals, the discharge conference is a joint meeting held with all providers. Discharge planning stresses a team approach beginning before discharge in order to determine what services are needed to ensure a smooth transition back to the home for those who are fortunate enough to have community-based services available. The hospital social worker/discharge planner makes recommendations to all present with respect to the consumer's needs and preferences. In attendance at these meetings will be representatives from step-down units, rehabilitation units, home health agencies, nursing homes and case managers representing community-based services. It is vitally important that the case manager have the acceptance in the community to be considered a necessary entity at these weekly meetings.

Discharge meetings grant case managers opportunities to interface with other providers as necessary and to coordinate with home health agencies or the Department of Human Services on some aspects of care and timing. Discharge meetings are most critical for case managers as it is only through knowing the key players and the services that they represent that important service needs can be identified.

 overhead - discharge planning; key community programs

 The discharge section requires that the class participants attend one discharge planning meeting for two hours of this 20 hour module. An alternative to class participants attending a meeting could be a discharge planner making a class presentation followed by a question and answering session.

**Case
 Managers
 in a Variety
 of Settings**

The final section in the *foundations* section is offered to assist the case manager in understanding that case management functions differ according to how one implements the plan of care. The case manager needs to understand the type of agency they are in, be knowledgeable of its objectives, know its limitations and therefore not promise the consumer more than can be delivered. Case management, and particularly its component of care planning, is a resource allocation process. The care plan represents a prescription and a specification of services to be used by the

consumer. The underlying structure of a program's financing has a fundamental impact on the kind of care planning provided. Most sources identify three major models of case management:

 overhead - major models of case management

- the case manager as a service broker
- the case manager as a manager of service
- the case manager and managed care

The first case management model is called the *broker* model. Case managers who function as brokers do not have service dollars to spend on behalf of their clients. They develop care plans and make referrals using services funded within the existing service delivery system. There is no guarantee that referrals made by case managers who operate as brokers will in fact be delivered.

The *service management* model of case management is based upon care planning that operates within specified fiscal limits. The funding source is the basis for a case manager's power to authorize services and his or her designation as the fiscally accountable person. In the service management model, case managers develop care plans within predetermined cost caps, usually a specified percentage of the cost of nursing home care. The service management model is found in the Home and Community-Based Waiver programs funded through Medicaid. Area Agencies on Aging use a similar model as they contract with the Texas Department on Aging to supply a finite number of units of a particular service. For a given funding period, such as one fiscal year, the AAA is locked into that level of units with little deviation.

The *managed care* model is the newest approach and is based on prospective financing. Prospective financing creates "provider risk" where financial responsibility and liability for expenditures are shifted to provider agencies. Providers are at risk for expenditures that exceed the prepaid amount and can create a surplus if costs are kept below the capitated payments the agency receives. This puts additional pressure on the care planning process, creating incentives for the provider to control total costs, to provide and promote prevention oriented services and to substitute lower cost services wherever possible without sacrificing quality or under-serving clients.

The prevailing direction in the development of contemporary case management programs is toward more service management and managed care. As funding sources are structured to promote cost containment through prospective payment and target budgets, case managers will become more and more involved in accountability for fiscal decisions made during care planning and for aggregate costs in their programs and agencies. This is not to suggest that client advocacy will be overlooked, but that the case management job is becoming more complex, involving not only advocacy and service coordination, but also financial responsibility and gatekeeping functions.

The mechanism within which case management is embedded is ultimately more important for understanding how to structure the case manager's role than an analysis of case management variations. Variations in the way case management is implemented have their roots in the following four basic programmatic features (Applebaum & Austin, 1990):

 overhead - case management types based on-----

- **Financial/reimbursement** mechanisms are the foundation of long-term care service delivery. The present funding system is fragmented; thus allowing providers to charge the service costs directly to the various programs for which the consumer is eligible. Fragmentation makes it difficult to control costs and hold any single provider accountable for the total costs associated with the care plan. Examples of financial mechanisms are pooled and prospective funding. Health maintenance organizations combine aspects of both pooled and prospective funding. Case managers are likely to control only a portion of the resources for any given client.
- **Targeting** involves the specification of subgroups within a population whose members are seen as the most appropriate recipients of services. For example, some community-based long-term case programs have targeted services to vulnerable, frail individuals, i.e., those persons "at risk" of nursing home placement.
- **Gatekeeping** mechanisms are designed to control the number and types of clients or consumers who have

access to services, especially high-cost services such as institutional care. A case manager's authority to purchase services is determined by the range of services that can be authorized, the availability of these services in the local delivery system and the designation of the case manager as the fiscally accountable person.

- **Organizational auspices** address what kinds of delivery systems should provide case management services. Without question, the choices here are expanding from social service agencies, to insurance agencies, to Area Agencies on Aging. Case management can also be provided from a variety of bureaucratic/geographic levels - state, regional, and local. There is no clear evidence suggesting the best organizational location for effective case management. It is important to realize that the case management role and how it is performed will be directly influenced by the organizational setting. When a case management program is administered from a state level agency, the program can be more systematically designed and implemented throughout the state. A state level location also enhances the potential to facilitate coordination among multiple state agencies involved in long-term care. When a case management agency operates from the local level there is a great chance that the program will be perceived as part of the local delivery system. In this instance, case managers may be in a better position to form partnerships with providers. It is not clear that one organizational location is any more superior than another.

TOPIC

B. THE INTAKE INTERVIEW

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

OBJECTIVES

1. Demonstrate the skills used during intake interview.

The intake interview is a problem-solving exercise. Many problems (telephone calls) are minor. The case manager needs to pay close attention to what the person is saying. This is

where you need knowledge of Information and Assistance. The intake interview needs to gain information regarding the consumer's finances; if not, this becomes an assessment issue.

2. Understand the basic processes involved in screening to ensure the proper mix of available services with client needs.
3. Understand the basic eligibility determination for TDHS services:
 Eligibility for TDHS services examines: (1) Household income which for one person must be under \$1305. This is accomplished by asking the potential consumer if they are over or under this figure. A second reason for asking this is that they may be eligible for some public benefits that would help address some of their needs. Tell them why you are asking. (2) Resource determination seeks to find out the level of resources and whether net resources are under or over \$2,000. Eligibility is also a function of physical or mental impairments. Eligible consumers need assistance with 2-4 ADLs. Further, eligibility can be very subjective.
4. Understand the primary purpose of the intake interview which is a procedure of determining if the intake process needs to be taken another step.

Professional gerontology is rooted in a concern for the welfare of older people, social justice and raised awareness of their vulnerability. Professional gerontology emphasizes relevance, assistance and intervention; and, as such, the intake interview is an initial step that will improve the quality of life of frail older persons. The case manager should enter the intake process knowing that for many cases, this is the beginning of a long relationship, as case management is part of long-term care. The intake process sets the stage for **empowering** the consumer. The intake interview is a problem solving exercise.

The frail older person is unlikely to be the one applying for case management services. The typical consumer is often inarticulate about their problem(s), but is also likely

Basic Interviewing Skills

to make a specific request, for example, help in meal preparation. Not infrequently the older person's requests are inappropriate or illogical, but the case manager should be alert to the fact that they may well mask other problems and anxieties or have symbolic meaning in terms of the consumer's fears about his or her diminishing capacities. Through gaining insight into functional abilities and tasks left undone, the case manager may be able to establish the kind of relationship through which he or she can move the consumer into the case management experience. Frail older persons tend to have multiple functional problems. They are "hard to reach" in that they approach receiving services with reluctance and with a feeling of loss of status, but they are not hard to reach in terms of relationship, after initial resistances are worked through.

Although the case manager may move with considerable rapidity in relating to a frail consumer as a person, the tempo of gaining a relationship with some older persons may be very slow. It requires special tolerance, for example, to work with stroke patients suffering from aphasia. The case manager may need to slow his or her usual pace, speak more distinctly and adjust the length of the interview in accordance with the consumer's reactions. In some instances the caseworker will have to gather information largely on what is observed and on the basis of the pressures of the immediate circumstances.

While this material has emphasized the role of intake through the hospital discharge process, a visit in the home at intake has developed as a most useful and, in fact, often an indispensable means of gaining insight into the consumer. Certainly viewing the home is an indispensable component of the assessment process as it reveals to the case manager the quality of the neighborhood, the quality of the consumer's housing, the cleanliness of the quarters and its general state of repair. A home visit can provide clues about the consumer's ability to function in his or her own setting and care for themselves. Moreover, a home visit may require the client to mobilize his or her capacity to face the self-evaluation that he/she knows will occur. The principle to be followed in deciding whether an interview should take place by telephone, in the hospital the home, or with family members, is that the location should serve the needs of the consumer and the goals of the case management contact at intake. Use of the telephone seems to be a common mode in many programs as it is more cost effective than in-person prescreening.

The accuracy of the entire case management process depends on the information gathered. The process of collecting information should include obtaining information on eligibility for Medicaid programs or the availability of long-term insurance for community-based services. Mullhay (1995) suggests that a frequent short-coming in the intake process is that case managers act like reporters first, at the expense of the flow of information being two ways. This is to say that the intake process is more than writing a documentary about a consumer, but includes advising the consumer about the role of the agency. A frequent criticism of consumers is that the case manager is viewed as an observer of care rather than a contributor to the care plan. Case managers must be observers, however they must be much more as well. Case management is more than asking, "What is wrong with this picture?" rather, "What can I do working with the consumer to improve this picture, to better the consumer's conditions, support the family, stretch the dollars, tighten up the plan and coordinate the activities of the providers?"

Practicing case managers use the acronym *R.I.P* in viewing the intake process. "*R*" is for rapport, the essential connection made by the case manager with the person being interviewed. In the initial stage of intake, consumers are dependent on readily accessible, descriptive clues to judge the trustworthiness of case managers. For example, many consumers are likely to find case managers trustworthy, at least initially, because of the status of their role in society. That connection, which can last 10 seconds or 30 minutes, might take the form of a brief chat and pleasant introduction, a quick statement of propose or a warm comment or observation about the individual or his or her home. The "*I*" in *R.I.P.* refers to information as well as the purpose of the communication. Information needs to flow both ways with the consumer being informed about the case management agency, including its goals and its limitations. The case manager is cautioned not to promise more than can be delivered. Even if the involvement of the interviewed party or family members is minimal, the conversation should not end before they completely understand that the reason for them giving information to the case manager is for the purpose of creating the care plan, or the "*P*" of *R.I.P.*

Empathy, or accurate understanding

It is the authors' intent to convey the notion that empathic techniques should be incorporated into the case

manager's interviewing skills. Empathy may be described as the ability to understand people from their frame of reference rather than your own. Case management is a dual process involving both the providers and the consumer. Likewise, an empathic approach reflects an attempt to think *with*, rather than *for* or *about*, the consumer. Generally empathy is useful in influencing the quality and effectiveness of the consumer/case manager relationship. The following are ways of conveying empathy:

overhead - techniques for conveying empathy

- *Show a desire to comprehend.* It is necessary, not only to convey an accurate understanding from the consumer's perspective, but also to convey your desire to comprehend from the consumer's frame of reference. This is evidenced by statements indicating your attempts to make sense of the consumer's world and by clarification and questions about their experiences.
- *Discuss what is important to the client.* Show by your questions and statements that you are aware of what is most important to the client. Respond in ways that relate to the consumer's basic needs. This should be a brief statement that captures the thoughts of the consumer and one that is directly related to their concerns.
- **Use verbal responses that bridge or add on to implicit consumer messages.** Empathy involves comprehension of the client's innermost thoughts and perspectives, even when these are unspoken and implicit.

In addition to the use of verbal messages, empathy is conveyed by attentive nonverbal behaviors such as direct eye contact. Case managers should develop a natural style of eye contact with a consumer. Caution should be exercised to neither stare nor avoid a consumer's gaze. Brief eye contact breaks may occur when either the case manager or consumer is thinking and when natural breaks in the discussion occur. The use of natural eye contact indicates that you are focusing on and are interested in what a consumer is saying. The case manager must not be **mechanical**, rather utilizing natural

movements while the interview is in process. Practicing case managers believe that this is how you convey the notion of "not what I can do for you, but what will you allow me to do for you." Further, this helps set the stage for **empowering** the client.

Cultural issues in interviewing

The intake interview requires that case managers be sensitive to cultural differences as patterns of communication vary from culture to culture. In American culture the reflective/listening approach is the predominant mode of communication when issues and concerns are discussed without haste and in detail. Certain patterns of verbal and nonverbal behavior are normative. For example, the interviewer should lean toward a client and maintain eye contact and that consumer and case manager should be at least an arm's length apart.

What is considered correct in one culture cannot be assumed to be appropriate with all people. For example, eye contact among some Eskimos or Inuit is considered inappropriate and distracting. While there are not many Eskimos in Texas, the analogy is similar to eye contact patterns with Blacks. Individuals from the Middle East stand closer to each other when they talk than do people in the United States, therefore, interviewing at what is considered normal distance for Americans would be uncomfortable for individuals from Egypt or Lebanon. The direct approach of focusing on one topic may be inappropriate for some Asian populations who may prefer more indirect, subtle approaches.

Practicing case managers report that for beginning interviews, white males tend to ask many more questions than their female counterparts. White females use more reflective listening responses such as paraphrasing and reflection of feeling. The same sources report that Blacks tend to give more directions and advice than Whites. Members of different racial groups, religious groups, socioeconomic classes, regions of this nation or parts of the world respond differently to interviewing. Case managers should be sensitive to individual and cultural differences when interviewing any senior whose background differs from their own. All cultures use listening skills, but they use them in different ways. The case manager's task is to learn how listening skills are used in different settings and to make appropriate adjustments in order to communicate with others.

Minority elderly suffer from multiple jeopardies of being old and non-white. Several characteristics may define minority groups: a shared culture and cultural traditions; a common language (usually not the language of the dominant culture); common customs; a particular set of role relationships for men, women, children and families; a shared history; and a psychological sense of belonging to the group, reinforced by cultural behavior that sets the group apart from the dominant culture.

The effects of historical racial discrimination, lack of opportunity and mental and physical oppression of these non-white populations warrant a greater understanding of the factors that compound their unique situations and concerns. In order to acquire the skills to be successful in providing services to elderly non-whites, the case manager should be cognizant of their uniqueness. The aging population is very heterogeneous, and the case manager with versatility will be more resourceful with elderly non-whites. Title VI of the Civil Rights Act of 1964 states:

No person in the United States will, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Despite the above guarantees, there is compelling evidence that the utilization of needed services by the four largest categories of elderly ethnic minorities--Blacks, Hispanics, Native Americans, and Asian Americans--is extremely low compared to their percentage of total elderly population. Numerous reasons for this underutilization by minorities have been advanced, including lack of minority service providers, preference for informal help systems and negative stereotyping by non-minority mental health professionals. Practicing case managers generally believe that minority elderly do not often receive community-based services because of cultural barriers reflected in their attitudes toward providers or in the attitude of case managers toward elderly minority members.

The disadvantages of minority elderly mean neither that they are all alike nor that a minority background is somehow inferior to that of mainstream American culture. Minority groups vary considerably in their values, roles, language, history and customs. These differences are often

more pronounced among the elderly, many of whom were born and raised in other countries. Within a cultural group there can be subgroups with differences in almost any area of normative behavior (Jackson et al., 1990).

The lack of economic resources tends to plague minorities of all ages because of educational, occupational, and income-related factors. This has implications for those in the retirement years, as Jackson et al. (1990) states that 65% of Hispanic men and 90% of Hispanic women have median annual incomes below \$5,000. The figures for poverty status among minorities indicate significant hardships compared to the general elderly population. This is a result of members of all four above-mentioned minority groups holding lifetime jobs that are significantly lower in status, income, security and benefits. Members of these groups have to work past normal retirement ages because of minimum Social Security and lack adequate private retirement incomes. The implication for the case manager is that the disparities listed contribute to a decline in life satisfaction, not as a function of ethnic differences but of socioeconomic status.

In the past two decades, we have witnessed an increased interest of those in the behavioral sciences to investigate minority populations. Much of the research has approached the subject of ethnicity and mental health from the perspective of "social stress." The social stress or social causation perspective is commonly advanced because the poor are not only exposed to a great number of stresses, but they also have fewer psychological and social resources for coping with stress. Similarly, members of ethnic minority groups can be expected to exhibit greater levels of mental disorders because they experience more stressful events and have fewer resources for dealing with stress. The perception of fewer available resources contributes to a significantly higher incidence of depression.

Empowering elderly minority clients to take or maintain control of their lives is an important goal for the case manager. For persons with strong feelings of powerlessness, such as minority members experiencing emotional problems, there is a heightened possibility that even successful modification of problems will be viewed as something done to or for them rather than something they control. This may be better than the continuation of problematic behavior such as poor personal hygiene, but far less than could be accomplished through some additional consideration of increasing positive response from others through enhancing social participation.

It is generally agreed among case managers that a greater reduction of powerlessness will occur if the individual is responding to societal expectations rather than to internal expectation.

The component of needs fulfillment refers to Abraham Maslow's hierarchy of needs theory. His general motivational hierarchy, from lower-level to higher-level needs, includes physiological needs, safety needs, social needs (approval, recognition, respect) and self-actualization needs. Maslow stresses that lower-level needs must be met before higher-level needs can be successfully addressed. For individuals to develop to their fullest potential, lower-level needs (such as food, shelter and safety) must be met in ascending order. A person who is starving is not concerned with other needs.

Movement through Maslow's hierarchy is not linear and permanent, but fluid. It involves progression and regression as a function of needs being met. For many minority members, during their working years their income level was sufficient to slightly exceed basic needs, and they could strive for higher needs. However, for the vast majority of minority older persons, retirement brings a severe reduction in income, and they are forced to revert to focusing a majority of their efforts on lower-level needs. For most elderly non-whites, nearly all of their income is absorbed in caring for the physiological needs of food, water, and basic comforts. It is commonplace for elderly non-whites to be victimized by crime more than white elderly persons. Social rejection, coupled with a lack of tolerance displayed by younger members of their own group, reinforces feelings of worthlessness in many elderly non-whites.

A major consideration of interviewing older minority consumers is the need for the professional to project a reduced social position or to convey the impression that consumer and counselor have a perceived equal status. There appears to be a testing that occurs in a therapeutic encounter in which the consumer attempts to determine whether the case manager has the expertise to help with a particular problem. Minority clients who are older give professionals permission to be an influence in their lives based largely on the closeness of social position. The minority elderly consumer will tend to be from a lower socio-economic class background where success for the consumer is measured in personal characteristics such as warmth and ability to communicate effectively, and not in credentials, degrees or licenses.

Screening for Eligibility

While the intake interview seeks to gather information utilizing a basic form, it also serves as a screening mechanism to determine consumer eligibility. A standard instrument that is considerably shorter than a comprehensive assessment is generally used to screen potential applicants. The screening process is designed so that only those clients whose needs and circumstances appear to meet the program's eligibility criteria receive the more lengthy and costly comprehensive assessment.

Screening is a preliminary assessment of the consumer's circumstances and resources that is done to determine presumptive eligibility and appropriateness for a case management program. Different case management programs utilize different combinations of prescreening criteria depending on their goals, resources and the length of their waiting lists. At an early stage, a program tends to have broad criteria that are liberally interpreted in order to accept as many new consumers as possible. After a program and referring agencies gain more experience and the flow of appropriate consumers is established, the trend is to narrow the criteria and encourage personnel to screen out clients who may not be the most needy or who cannot benefit most from the package of services that the case manager could provide. Examples of prescreening criteria for targeting and referral of people for case management include the following (Steinberg & Carter, 1988):

overhead - examples of prescreening criteria

- Is the person about to enter institutional care?
- Is the person suffering from a recent loss of a spouse or significant other?
- Do the person's needs for assistance in daily living tasks exceed the supply of help available from the natural support system?
- Is the person seeking service for the first time?
- Does the person need two or more services or have multiple or complex problems?
- Is the person home-bound, and can they be seen only at home?
- Does the person have a 3-inch thick medical record?

- Is the person's behavior regarded by others as too deviant to tolerate?
- Does an information and assistance worker note that information alone will not meet the consumer's needs?
- Does the information and assistance worker sense that something is wrong with the situation, or can the worker not get a clear picture of the situation?
- Has a guardian or conservator been appointed?

Depending on whether they are relevant to eligibility requirement or priority populations, prescreening criteria may also include income level, disabilities, place of residence, ethnicity or age. Practicing case managers report that far more referrals are not accepted because the needs are insufficient than being excessive. An example of an insufficient need or a minor functional problem is a senior who suggests that all they really need upon returning home from the hospital is assistance with a meal. In this and many other instances, the case manager acts in the capacity of information and assistance, perhaps helping arrange the meal service, yet the senior is never accepted into agency service. In such instances, case managers report that they monitor the consumer for a period of one month.

Eligibility is a function of the agency employing the case manager. For case managers employed in the Texas aging network and under the guidelines of TDoA, the following guidelines are included:

overhead - target groups for case management services

Target groups for case management are persons age 60 plus and, or their spouses who:

- are functionally impaired in their ability to perform regular activities of daily living such as bathing, dressing, meal preparation and therefore need at least two in-home or community-based services; or
- who may be likely to require nursing home care if appropriate in-home or community-based services are not available through community support as identified by the case manager; or

- who need additional attention during recuperation stages after hospital discharge; and
- who need and request the assistance of a case manager to obtain necessary services to resolve the identified problems.

In most instances, eligibility (item number 1 above) requires the applicant need assistance with two basic activities of daily living.

overhead - items to include in intake interview

Most commonly intake is seen as the starting of a case record (or activating an old case record) with implied consent of the consumer. Intake should include:

- learning the client's expectations (how do they believe they will benefit from services);
- a conveyance of the program's respect for and interest in the older person(s);
- explanation of what the program can offer, how it work and what conditions or responsibilities will have to be accepted by the consumer;
- assurance to the person or kin of rights of choice and control;
- obtaining the person's agreement to become a consumer;
- confirming to the consumer that the program has accepted responsibility and will do its best;
- assessing the relative urgency of the case and characteristics that may influence which worker will best fit;
- arranging appointments for routine next steps; and
- notifying other previously involved agencies.

Summary:

The case manager should enter the intake process from the prospective of, "not what I can do for you," but, "what will you allow me to do for you." Pay close attention to what the person is telling you. This is where you need knowledge of Information and Assistance. In the instance of the home-delivered meal, there is no assessment. The intake interview

**TDHS
Eligibility
Requirements**

needs to work through the consumer's basic finances. Find out if the consumer is currently receiving Medicaid benefits. If they have been through the process, they are eligible for an array of services.

The case manager needs to have an understanding of basic eligibility determination as set forth by the Texas Department of Human Services:

- (1) household income - of \$1305 as a start - then ask them if they are over or under. A second reason for asking this is that they may be eligible for some public benefits that would help address some of their needs. Tell them why you are asking.
- (2) find out level of resources. Whether under or over \$2,000.
- (3) Eligibility is a function of physical or mental impairments. The consumer usually needs assistance with 2 to 4 activities of daily living (ADLs). Portions of the prescreening can be very subjective.

The **intake interview** is the first major component involving the proposed consumer. Frequently this is done by way of the telephone. It is crucial at this interview that rapport be established that will establish the nature of a healthy professional relationship for the duration of the consumer/case manager relationship. One approach is to guide the interview by means of a standardized list of questions from an intake form. This not only assures that all relevant topics are covered, but also organizes the answers so that they may be more readily accessed later by other personnel. The intake process is a **screening** process. Important information to be gleaned from this interview includes a determination of:

- basic eligibility both functional, including an examination of activities of daily living (ADLs), instrumental activities of daily living (IADLs) and financial;
- services currently being provided by the family;
- where the gaps in service exist;
- what are the consumer's/consumer's family's expectations (engage client in process); and
- referral to proper agencies when client does not qualify for case management, e.g. meals-on-wheels.

**Primary issue
of the Intake
Interview**

The over-riding issue in the intake/prescreening interview is that it is the process of determining if the admission process needs to be taken another step. If the answer is yes, then the formal assessment is the next step. Admitting the consumer into the program system initiates both agency and client responsibilities. Case accountability begins here. It is important for the case manager to allow enough time for intake so that consumers are not made to feel that it is a test of their competence or compliance, or that their individuality is being reduced to bureaucratic case numbers.

class activity: divide class into small groups and utilizing the standard intake form have them interview each other.

TOPIC

C. PRACTICUM

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**RESULTS FROM INITIAL
DEMONSTRATION PROJECTS OF
COMMUNITY-BASED SERVICES (1973-1985):**

- **Community-Based Services must be Directed toward Those Persons who Would Otherwise Use Institutional Care.**
- **Community-Based Services must not be Accepted as a Substitute for Care Currently being Provided by the Informal Network.**

CURRENT FACTORS DRIVING CASE MANAGEMENT MOVEMENT:

- **Demonstrations have Proven that Qualified Case Managers can Effectively Coordinate a Package of Community-Based Programs.**
- **Expressed Desire of Frail Seniors to Remain living in Their Homes as long as Possible.**
- **Additional Funding at various levels for Community-Based Programs and Services.**

ESSENTIAL CRITERIA FOR SUCCESSFUL CASE MANAGEMENT

- **Capacity of Organization and Skills Level are Appropriate for Target Groups.**
- **Utilization of Orderly Procedure for Client Screening.**
- **Proven Expertise in Mobilizing Services and Resource Options.**
- **Utilization of a Holistic Approach to meeting Client's Needs.**
- **Well Defined Assessment Procedures.**
- **Care Plans Accurately Reflect Client's Conditions and Needs.**
- **Case Reflects Appropriate Action Steps.**
- **Provision for Supportive Relationship and Timely Reevaluation.**
- **Agency is Involved in Interorganizational Linkages with other Providers.**
- **Personnel have Deep Sense of Commitment to Improving Long-Term Care and Individual Client Goals.**

**FEATURES NECESSARY
FOR CASE MANAGEMENT TO
BE A STRONG COMPONENT IN
LONG-TERM CARE SYSTEM:**

- **Case managers and the Services They Control
Must meet High Standards.**
- **Case Managers Must Maintain Linkages with all
Providers Including Those Providing Institutional
Services.**

**KEY FEATURES OF
COMPREHENSIVE LONG-TERM CARE
CASE MANAGEMENT:**

- **Intensity**
- **Breadth of Services**
- **Duration of Services**

TYPES OF GERONTOLOGICAL INSTRUCTION

- Liberal Arts
- Scientific
- Professional

MAJOR COMPONENTS OF CASE MANAGEMENT

- **Intake:**
Case Finding, Outreach, Prescreening;
- **Assessment:**
Physical, Mental, Economic Status
Physical Environment, Nutritional
Status, Self-Care Capacity, Services
Presently Received;
- **Care Plan Development;**
- **Implementation of Care Plan;**
- **Monitoring, Reassessment, and Closure.**

INFORMATION NECESSARY FROM INTAKE INTERVIEW

- **Basic Eligibility both Functional, Including an Examination of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), and Financial;**
- **Services Currently Being Provided by the Family;**
- **Where the Gaps in Service Exist;**
- **What are the Consumer's/Consumer's Family" Expectations (engage client in process);**
- **Referral to Proper Agencies when Consumer does not Qualify for Case Management, e.g. meals-on-wheels.**

ROLES PLAYED BY CASE MANAGER

- **Validating the Provider Agency is Delivering the Quantity and Quality of Service that it has Promised;**
- **Provide Moral and Technical Support to the Provider in Solving Specific Problems;**
- **Verification that the Consumer is Using the Service as it was Intended;**
- **Teaching the Consumer to Monitor their own Caregivers;**
- **Evaluating the Effectiveness of Service Delivery.**

REASONS FOR REASSESSMENT

- **Standardized Intervals Prescribed by Agency Policy;**
- **Schedule Written into the Care Plan;**
- **New Case Manager is Assigned to the Case;**
- **The Presenting Problem has been Resolved, Alleviated, or Redefined;**
- **When a Planned Service is Discontinued by the Service Provider or the Client;**
- **Planned Withdrawal of a Service and a need to help the Consumer to see the Change in a Positive Light;**
- **Unanticipated Crisis or Impairment Befalls the Consumer;**
- **Agency Pressure to Terminate Improved or Stable Cases to make way for new, waiting Consumers;**
- **Change in the Living Arrangements e.g., Consumer is placed in a Hospital or Nursing Home.**

COMMON REASONS FOR CASE CLOSURE

- **The Consumer Himself/Herself Terminates,**
- **Principal Service Provider Recommends Termination,**
- **A Single Service Provider Accepts Comprehensive Responsibility for Care,**
- **The Consumer enters another Living Arrangement,**
- **The Consumer Insists on Services that the Case Manager thinks will be Counterproductive or Refuses Recommended Services,**
- **The Presenting Problem has been Alleviated,**
- **Demands for Services and Scarce Resources make it Necessary to set Priorities among Consumers.**

PRINCIPLES OF SOCIAL SECURITY

- Participation is Compulsory for Covered Groups; hence, it is an Earned Right.
- Benefits are Related to Covered Earnings.
- It is intended as one of Several Potential Sources of Income Maintenance, offering a Floor of Protection.
- Funds come from Payroll Taxes.
- Benefits are Weighted to Provide Higher Relative Returns for Low-Income Workers, and Wages above a Cutoff point are not Subject to Tax.
- A Person must be Retired in order to draw Benefits.

THREE TIER STRUCTURE PROVIDED BY OLDER AMERICANS ACT

- **National Level - Administration on Aging (AoA)**
- **State Level - State unit on Aging, e.g., Texas
Department on Aging (TDoA)**
- **Regional Level/Local Level - Area Agency on
Aging (AAA) and/or local contractors**

POLICY OBJECTIVES OF OLDER AMERICANS ACT

- 1. Adequate Retirement Income;**
- 2. Physical and Mental Health Services;**
- 3. Suitable Housing;**
- 4. Restorative Services;**
- 5. Employment Services;**
- 6. Retirement with Health, Honor, and Dignity;**
- 7. Meaningful Activity in Civic, Cultural, and Recreational Opportunities;**
- 8. Efficient Community Services;**
- 9. Immediate Benefit from Research Findings; and**
- 10. Freedom in Planning and Managing One's Own Life.**

CLUSTERS OF REQUIRED SERVICES OF THE OLDER AMERICANS ACT

- Access Services
 - Transportation
 - Outreach, and
 - Information and Assistance
- In-Home Services
 - Homemaker
 - Home Health Aides
 - Visiting
 - Telephone Reassurance
 - Chore Maintenance
 - Respite Services (Adult Day Care & In-Home Care)
 - Minor Home Modifications
 - Support Services for Families of Elderly Victims of Alzheimer's Disease.
- Legal Services

TEXAS DEPARTMENT ON AGING (TDoA)

Primary Services

Adult Day Care	Case Management
Chore Maintenance	Congregate Meals
Health Screening	Home Delivered Meals
Home Health Aide	Home Maker I Services
Home Maker II Serv.	Inform. & Assistance
Legal Assistance	Ombudsman
Outreach	Residential Repair
Senior Center Oper.	Telephone Reassurance
Transportation	Visiting

Secondary Services

Advocacy	Discount
Emergency Response	Escort
Health Maintenance	Hospice
Income Support	Instruction & Training
Letter Writing/Reading	Mental Health
Nutrition Consultation	Physical Fitness
Employment Placement	Volunteer Placement
Housing Placement	Recreation
Shopping	Respite Care
Services in Care Providing Facilities	
Support Services - Alzheimer's Disease Victims	

CASE MANAGERS SEEK TO FILL

GAPS IN SERVICE

- What Tasks can the *Informal Network* (Family-Friends be Counted on to Continue to Perform? What are the Remaining GAPS in Service?
- Does the Consumer Qualify for Texas Department of Human Services' *Community Care for the Aged and Disabled* (CCAD) Program? What are the Remaining GAPS in Service?
- Does the Consumer Qualify for *Medicare* Benefits in the Home such as Skilled Nursing? If yes, how long will those Benefits last, What are the GAPS Remaining when Receiving those Benefits and what will the GAPS be when those Benefits expire?
- Which of the *Title III* Services are Appropriate in filling the GAPS from the above Programs?

BASIC TENETS OF A FAMILY SYSTEM

- **The Total System is more than the Sum of its Parts.**
- **To Understand the Individual Requires an Understanding of the Total System and its Relationships.**
- **Relationships and Behaviors are Interactive; that is, All Events are part of a Sequence. A Response is also a Stimulus for Another Response from other Family Members. To think of any Family Member's Behavior as Simply a Response is Inaccurate.**
- **To Change Individual Behavior, the System's Patterns, Styles, or Motivation must also be Altered as Systems Work to Maintain Themselves at a Current Level of Functioning.**

**ISSUES CASE MANAGERS SHOULD
KEEP IN MIND WHEN OBTAINING
INFORMATION FROM FAMILY MEMBERS**

- **Is the Current Problem a New One?**
- **Who is Disturbed About the Problem?**
- **Is the Family Talking About the Problem?**
- **Is the Family Supplying Accurate Information?**
- **What is the Family's Historical Pattern of Offering Assistance?**

INFORMATION NEEDED ON EACH FAMILY

- **What Tasks are the Family Doing at Present?**
- **What Tasks can They be Counted on to Continue Performing?**
- **What Service Gaps Exist in Meeting Present Needs?**
- **What are the Expectations of the Family?**
- **Will the Provision of Respite Service Extend the Informal Caregiving Effort? If so, at what Frequency?**

DIMENSIONS OF AUTHORITY

- **Scope** **The Degree of Impact the Case
Manager Has on Local Service
Delivery**

- **Span** **The Range of Services the Case
Manager Has at His/Her Disposal**

BASES FOR AUTHORITY

- **Mandate by Public Law**
- **Mandate by Incorporation**
- **Mandate through Time-Limited Funds**
- **Mandate by Group Membership**

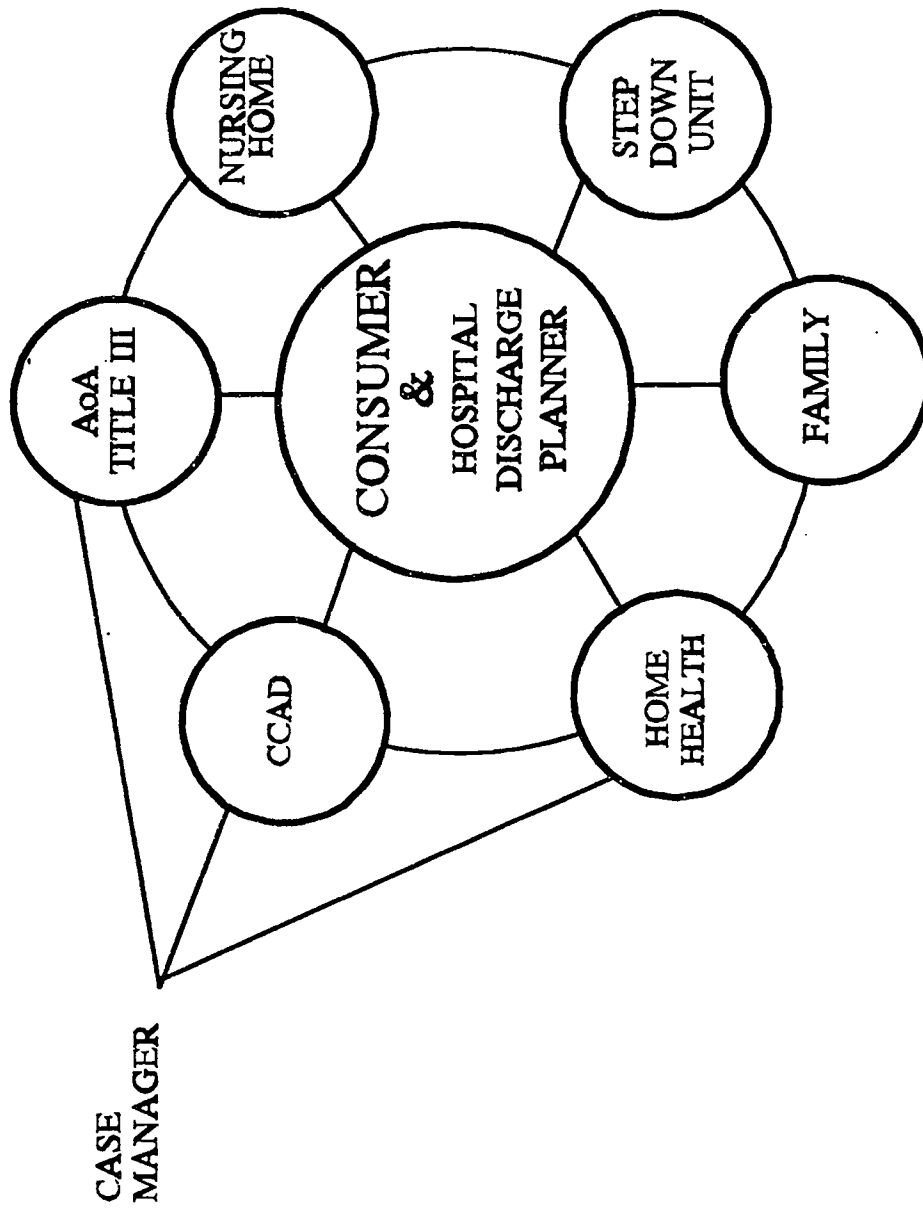
SPECIAL TARGET GROUPS FOR CASE MANAGEMENT SERVICES

- **Persons Age 60+ with Disabilities**
- **Persons with Limited English-Speaking Ability**
- **Persons with Alzheimer's Disease and Their Caretakers**
- **Persons Age 60+ with Greatest Economic Need, Including Low-Income Minorities**
- **Persons Age 60+ with Greatest Social Need, Including Low-Income Minorities**

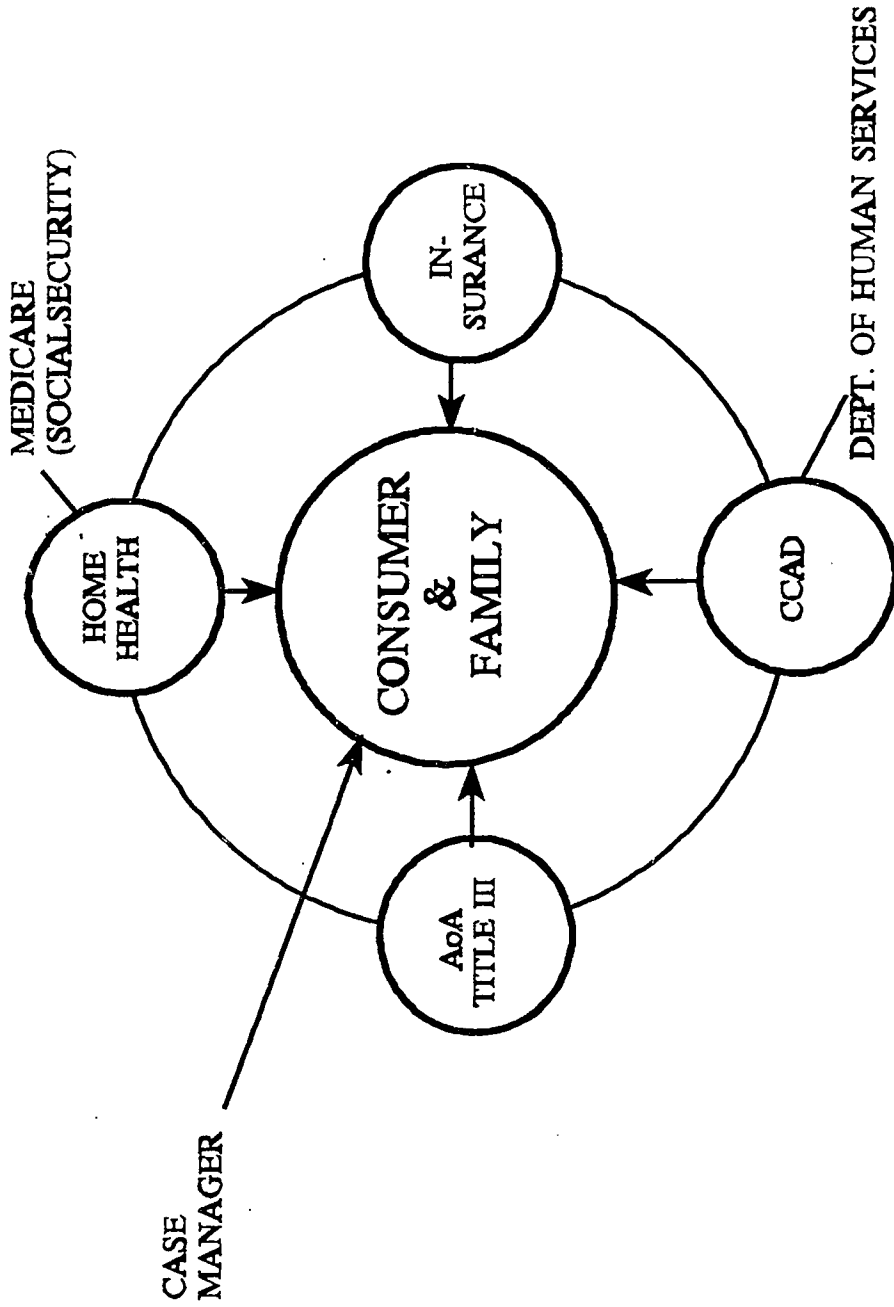
KEY PLAYERS IN CASE MANAGEMENT

- **Consumer and His/Her Family**
- **Case Manager**
- **Hospital Discharge Planner**
- **Home Health Representative**
- **Department of Human Services Representative**
- **Benefits Counselor**

DISCHARGE PLANNING (Prior To Hospital Discharge)



KEY COMMUNITY PROGRAMS



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MAJOR MODELS OF CASE MANAGEMENT

- **Case Manager as Service Broker**
- **Case Manager as Manager of Services**
- **Case Manager and Managed Care**

CASE MANAGEMENT TYPES BASED ON PROGRAM FEATURES

- **Financial Mechanisms (Pooled or Prospective)**
- **Targeting Specific Sub-Groups**
- **Gatekeeping Mechanisms by which the Case
Manager is Fiscally Accountable**
- **Organizational Auspices (e.g., AAA or Social
Service Agency)**

TECHNIQUES FOR CONVEYING EMPATHY

- ***Show a Desire to Comprehend.*** Gain an Understanding from the Consumer's Perspective, but also to Convey Your Desire to Comprehend from the Consumer's Frame of Reference.
- ***Discuss What is Important to the Consumer.*** Show by Your Questions and Statements that You Are Aware of What is Most Important to the Consumer.
- ***Use Verbal Responses that Bridge or Add to Implicit Consumer Messages.*** Empathy Involves Comprehension of the Consumer's Innermost Thoughts and Perspectives, even When These Are Unspoken and Implicit.

EXAMPLES OF PRESCREENING CRITERIA

- **Is the Person about to Enter Institutional Care?**
- **Is the Person Suffering from a Recent Loss of a Spouse or Significant Other?**
- **Does the Person's Need for Assistance in Daily Living Tasks Exceed the Supply of Help Available from the Natural Support System?**
- **Is the Person Seeking Service for the First Time?**
- **Does the Person Need Two or More Services or Have Multiple or Complex Problems?**
- **Is the Person Home-Bound and Can He/She be Seen only at Home?**

EXAMPLES OF PRESCREENING CRITERIA (continued)

- **Does the Person Have a 3-Inch Thick Medical Record?**
- **Is the Person's Behavior Regarded by Others as too Deviant to Tolerate?**
- **Has an Information and Assistance Worker Noted that Information Alone Will Not Meet the Consumer's Needs?**
- **Does the Information and Assistance Worker Sense that Something is Wrong with the Situation, or Can the Worker Not Get a Clear Picture of the Situation?**
- **Has a Guardian or Conservator Been Appointed?**

TARGET GROUPS FOR CASE MANAGEMENT SERVICES

Persons Age 60+ and/or Their Spouses Who

- **Are Functionally Impaired in Their Ability to Perform Regular ADLs such as Bathing, Dressing, and Meal Preparation and Therefore Need at Least Two In-Home or Community-Based Services; or**
- **May be Likely to Require Nursing Home Care if Appropriate In-Home or Community-Based Services Are Not Available through Community Support as Identified by the Case Manager; or**
- **Need Additional Attention During Recuperation Stages after Hospital Discharge; and**
- **Need and Request the Assistance of a Case Manager to Obtain Necessary Services to Resolve the Identified Problems.**

ITEMS TO INCLUDE IN INTAKE INTERVIEW

- **Learning the Consumer's Expectations;**
- **Conveying the Program's Respect for and Interest in the Older Person;**
- **Explaining What the Program Can Offer, How It Works, and What Conditions or Responsibilities Will Have to be Accepted by the Consumer;**
- **Assuring the Person or Kin of Rights of Choice and Control;**
- **Obtaining the Person's Agreement to Become a Consumer;**

ITEMS TO INCLUDE IN INTAKE INTERVIEW

(Continued)

- **Confirming to the Consumer that the Program Has Accepted Responsibility and Will Do Its Best;**
- **Assessing the Relative Urgency of the Case and Characteristics that May Influence which Worker will Best Fit;**
- **Arranging Appointments for Routine next Steps;**
- **Notifying Other Previously Involved Agencies.**