Elder Care Services and Case Management

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The Clientele

Elder Care Services (ECS) is a not-for-profit, inter-disciplinary geriatric care management agency based in Tallahassee, Florida. The agency aims to improve the quality of life (QoL) of seniors in the Big Bend area of Florida through advocacy efforts, primary service provision, and referrals. In 2012 alone, over 8,000 individuals and families received support from ECS through both direct service and collaborations with and referrals to community and state agencies, schools, and other for-profit and not-for-profit organizations. Services provided to clients are wide-ranging and multi-faceted. Case managers (CMs) at ECS may provide clients and their families’ referrals for personal care; this includes contacting local providers to align support with activities of daily living (ADLs) such as bathing, feeding, dressing, or toileting. CMs working with clients at ECS work to ensure that clients have access to homemaker and companionship options if needed, as well. Additionally, CMs may refer clients and their families to caregiver respite and adult day care services. The agency also serves as a broker for services related to nutrition (Meals on Wheels) and transportation (STARS: Seniors Transporting At-Risk Seniors).

ECS obtains new clients in various ways. Clients are most often referred via a local Area Agency on Aging or through the Florida Department of Elder Affairs. The Florida Department of Children and Families, through Adult Protective Services, also
provides referrals. CMs are most often MSWs, although some have had other professional backgrounds, namely psychology and counseling. There are currently two CMs at ECS, and the second author (Rebecca Derrenberger) is of these. Client case-loads typically range from 30 to 50, although much variability exists.

Clients must meet several criteria to receive services from ECS. First, they must reside in the community. Prior to November of 2013, this meant clients must have lived in private residences and were over the age 60. However, insurance companies have recently emerged as the primary payee for services in Florida. The Affordable Care Act (2010) and the privatization of Medicaid in Florida has broadened the service network, which has proven both beneficial and sometimes problematic for CMs. For instance, ECS can now provide services to individuals between the ages of 18 and 60 if they are a) receiving Medicaid, and b) have a complex medical condition. Medicaid is the primary benchmark for client socio-economic status although, limits also exist regarding a client’s assets. They must have less than $2,000 USD in total assets including private savings, stocks, bonds, or equity. Similarly, clients can only receive services if their individual income is less than $2,100 per month. In reality, most clients have incomes far lower than this guideline.

Complex medical conditions of our clients may include a traumatic brain injury (TBI), spinal trauma, or dementia. Recent changes in state and federal legislation have opened the doors to residential nursing and some acute care facilities, which has been helpful for many clients. Therefore, ECS can now provide services to clients across a wide variety of community settings. Thus, some clients may reside in 100-year-old farm houses, others in dilapidated mobile homes, still others in apartment-style or upper middle-class, single-family homes.

Regardless of residence, clients must have been designated formally as “disabled” by the guidelines established through the Florida Department of Elder Affairs. It is common to assume that disability refers to only physical limitations such as restricted mobility, or loss of sight or hearing. However, primary diagnoses for ECS may also include other debilitating, chronic conditions such as amyotrophic laterals sclerosis and multiple sclerosis (ALS and MS, respectively), cerebral palsy, and development disabilities. Clients also often present with co-morbidities. These co-occurring conditions are secondary to the primary diagnosis, and typically include osteo- and rheumatoid arthritis, hypertension, high cholesterol, diabetes, cardiopulmonary disease (COPD), congestive heart failure (CHF), and diabetes. In addition, they may also face mental health diagnoses such as depression, anxiety, or bipolar disorder. There is little distinction regarding ECS client gender and race. Meaning, ECS annually provides services to roughly the same percentage of males and females, and persons of majority or minority descent. As a result of the wide range of both primary and secondary presenting conditions, client demographics, and service options, ECS cases are similarly variable. A typical client receives services for 1 year (52 weeks). Clients are then re-evaluated. If the re-evaluation indicates that services need to be continued beyond one year, services can be provided for an additional 90 days (now 64+ weeks). After this, services can take place for any length of time ensuring approval is granted every 90 days.
Practice Roles and Responsibilities

As a case manager at ECS, the roles and responsibilities are quite broad. Generally speaking, CM responsibilities include three main tasks: 1) assessment, 2) case maintenance, and 3) documentation. First, an initial assessment is completed with the client. The assessment is key to determining the amount of service hours the client is entitled to, so as to ensure her or his QoL. The assessment is completed with other members of the household (if any), to identify any additional gaps and to triangulate information for accuracy. This third-party assessment is particularly helpful if a client presents with any cognitive impairment such as dementia. The questions on the assessment protocols range from gathering contact information, income and asset verification, ADLs, IADLs, medical and mental health diagnoses, behavioral concerns, caregiver assessment, and evaluation of a client’s living environment. The initial assessment takes between 2 and 3 hours, depending on the amount of detail provided by client or caregiver. However, because of the importance of the initial assessment in subsequent service provision and case maintenance, CMs understand that comprehensive evaluations are essential to ensuring client and caregiver support.

Next, CMs work to complete a plan of care. The plan includes detailed information about the services being provided to a client, a sort of who, where, what, and when strategy. This information includes a list of the services scheduled to be provided, the number of units of each scheduled service, how long each service would be received, who will provide the service, and the cost of the service. The plan of care is cross-referenced with the assessment for accuracy. As mentioned earlier, ECS may provide services directly, or utilize referrals to community providers. When comparing the assessment and plan of care, the CM will identify a) what services ECS is able to provide, and b) which services may require outside referrals. If services are required that extend beyond the reach of ECS, the plan of care is reviewed by a panel of experts employed by the insurance provider. This interdisciplinary team (IDT) can consist of a variety of professionals, but most typically includes a physician, nurses, and social workers. The IDT in turn, will determine if the client should be provided the additional services and if so, will authorize the “go ahead” to ECS.

Once the plan of care is confirmed and service provision underway, case management (CMG) responsibilities shift toward monthly and quarterly maintenance. A minimum of 1 monthly contact, and a quarterly face-to-face visit is required. Monthly contact can be made via telephone calls or face-to-face. The information gathered must include a status of the client’s health, if the client has fallen in the past month, or had any hospital or ER visits. The client’s emotional well-being is also evaluated on a monthly basis. This is a critical step as some clients may present with mental health conditions that although managed, may not be well enough supported to maintain their QoL. Face-to-face visits are required every 90 days (quarterly), as well. The quarterly assessment is similar to a monthly visit, and includes an update on health and emotional status, falls, hospitalizations, and ER visits. However, this interview also includes both a brief suicide assessment and domestic violence assessment, to ensure the client is safe in her or his living environment. The client’s home environment is
also evaluated for safety and security purposes. After evaluating the client’s home environment to ensure safety, the CM will then review the plan of care in partnership with the client to ensure the proper services are being received. This is also when CMs evaluate if any changes should be made that may further benefit the client.

Finally, CMs are required to completed annual assessments with each client to ensure their continued eligibility. Annual assessments are much like initial assessments and include the completion of assessments, to help re-evaluate the client’s needs, as well as the in-depth domestic violence assessment. The plan of care may then be updated and reviewed again by the IDT, if necessary. Importantly, all paperwork is signed by both the CM and client, and/or caregivers. This includes documents such as the following: a release of information, confidentiality notice, financial information release, and any other assessment reports. All documentation is due to the insurance provider within 24 hours of completion. This deadline is essential for several reasons. First, accurate documentation and subsequent dissemination ensures that others involved in the case, such as ECS supervisors or service providers, have up-to-date and accurate information available to them at all times. Accurate information is necessary to assure timely and targeted care for clients in the maintenance of their QoL and the reduction of risk for both clients and CMs (Rêmer, 2004). This punctuality also applies to all case notes. CMs are urged to complete case notes as soon as possible to avoid a loss of details from the contact, or face-to-face interviews.

As previously noted, contact with the client includes the exploration of reported abuse or neglect. In cases where abuse or neglect is suspected, a CM gathers details from the client, caregiver, or other people involved, and then calls the Florida Abuse Hotline. Importantly, the CM is not charged with completing an investigation or judging if something is in fact abuse. Instead, the CM must only provide the information regarding suspected abuse or neglect to the abuse hotline. Suspected abuse or neglect may manifest in different ways and may be a result of self-neglect or caregiver abuse. This may include questionable injuries, evidence of financial exploitation, and evidence of reduced supervision for a client with dementia. Suspected neglect may also include unsafe home conditions that could lead to injury or poor health (Choi & Mayer, 2000).

Our social work skill set is a critical component to assuring effective CMG at ECS and provides us with several strengths. As previously noted, proper recording and documentation is essential to each of the roles and responsibilities for CMs at ECS. Each client is required to have different forms of documentation. Clients always have access to their documentation and if they consent, or a caregiver has power of attorney (POA), some caregivers may also have access to documentation. Such documentation includes assessments, case notes, release of information, income verification, notice of privacy practices, notice of abuse reporting, grievance procedures, and the plan of care. Each year, the State of Florida conducts an audit of client files to ensure proper documentation is being maintained, and they are able to access a random sampling of client files. Outside of these, other paperwork is only reviewed as needed by support staff. The information is kept confidential and under lock and key to ensure the privacy of these reports. It is important to maintain the confidentiality of the information as some information includes health diagnoses (for example HIV), or financial
information which is very sensitive. In order to build rapport and help clients, he or she must be assured that the information shared with the CM will not become public. Each CM is trained on how to maintain proper documentation, although many of the core elements of clinical recording are imparted in BSW and MSW social work education.

Additional important social work skills include the capacity for supportive interviewing, and active listening. For instance, active listening is an essential element of conducting good assessments. This may include seeking clarification to ensure understanding, or simply paraphrasing or parroting client concerns to ensure their accuracy. This can be crucial when clients face speech impairment due to disease progression. It also provides a sense of empowerment, supporting clients in the midst of an interview and empowering them to tell their “story.”

CMs are also charged with facilitating client advocacy. Embedded within the National Association of Social Workers’ (NASW, 2008) Code of Ethics is the mandate to advocate. Social workers value social justice and are called to “challenge social injustice” (NASW, 2008, para. 15). CMs at ECS serve as advocates who challenge the injustices facing our clients. Persons with disabilities, chronic illness, or terminal prognoses often face stigmatization or are “pushed away” or isolated from family, friends, and communities by the use of stereotypes and labels (Green et al., 2005). It is further possible that those outside the client family, including health care professionals, assume that a client with disabilities has a negative affective state (e.g., depression, anxiety) or lower QoL based solely on their illness, or less than able-bodiedness (Wright, 1983). CMs in turn, have the essential role of “building clients up”—ensuring that the vulnerable are not minimized or marginalized. CMs must also work to dispel false expectations and assumptions with family, friends, and even professionals during their ongoing client work.

Similar advocacy is necessary when working to ensure client independence. The mission of ECS is to strive to support the client to reside within the community in a safe and secure manner. However, clients may face pressure from friends or family to seek a residential placement, against their wishes. It is here that CMs can provide validation to clients regarding their concerns and to strive to connect clients to appropriate resources, so as to maintain the highest level of independence in the least restrictive setting. It is also essential that CMs always assert client self-determination when it comes to all decision-making. Family and friends may be reticent to support their loved one when the client’s decision conflicts with their own preferences (e.g., remaining at home, continuing to smoke etc.)—a critical contention that CMs must seek to explain and ensure.

CMs should also maintain current knowledge of services available in the local community, a general understanding of both physical and mental health diagnoses and medications, as well as signs of suicide ideation and abuse. Many of these skills are essential components of an accredited MSW social work curriculum. In addition to the inherent strengths grounded in the profession’s curriculum, social work CMs also face several barriers or limitations to providing effective CMG. These barriers are best understood from an ecological or systems perspective, where individuals are considered to be nested within multiple and multi-systemic environments (Allen-Meares & Lane, 1987). Individual, micro-, or home-level barriers might include
unmet transportation needs for clients in rural areas, or medication management for clients who are unable to read. Some clients might view CMs as super heroes, per se. For example, clients sometimes ask CMs to create their living will, prepare taxes, take them to the store, locate missing items, or stop crime in their neighborhoods. Another example of a micro-level barrier is phone calls. On a given day a CM may receive one phone call, or have ongoing telephone interactions with clients. Some have brief questions about services, while others speak to the CM for 30 minutes to an hour about her or his day, and different events of value to the client. It is difficult to find time to complete needed tasks in order for clients to receive their services, and to give each client the full respect needed during their telephone calls.

Additional barriers are related to agency, organization, or community features. There are a variety of services that ECS can offer to clients, like personal care and homemaking, but sometimes funding limits the number of services that can be provided, or a community may not have a service available to client at a fee the client can afford. Assessments, re-assessments, and necessary documentation are also very time consuming responsibilities for CMs at ECS. We consider this to be the most problematic mezzo-level barrier. The aforementioned importance of accurate documentation cannot be understated, as it remains crucial to assuring access to appropriate services, ensuring payment is made, and keeping the client and ECS informed. As previously noted, assessments are completed for federal, state, and agency purposes. However, this often results in much content overlap that subsequently leads to a seemingly endless duplication of bureaucratic information.

Macro-level barriers are also real considerations for our CMs. State and federal legislation, as well as insurance provider barriers have a direct impact on the CMs’ ability to meet client needs and ensure their QoL. Some services are also not approved to be provided. For example, if a client has not exhausted the physical therapy available through Medicare, it may not be paid for by Medicaid as Medicare is a “primary payer”—an important consideration for many of the dual eligibility clients served by ECS. Likewise, durable medical equipment such as hospital beds, bedside commodes, and wheelchairs should be ordered through a doctor’s office before trying to order them through programs like Long Term Managed Care, although this requires a doctor’s appointment and the necessary physician’s order. Clients may also not be able to receive services because they no longer qualify. If a client’s health improves to the point where they have no diagnoses or he or she is independent in ADLs and IADLs, then the client will not qualify for our program. This can be problematic particularly if the client still needs support, but does not meet minimum benchmarks for service eligibility.

There are some programs with more stringent financial qualifications than others. For example, in the Medicaid program, a client must meet all the eligibility criteria to maintain her or his Medicaid status. If the client were to re-finance their home, and therefore had several thousand dollars available to them, he or she would not qualify for Medicaid. This may force the client to transition to a waitlist for another program for people with assets. If this happens, it is possible that new, incoming clients will be assessed as requiring greater and more immediate services, potentially delaying the previous client’s re-entry.
Role Development Potential

Serving as a CM at ECS provides many opportunities for both role development and skill refinement. CMs must stay current with political changes at the local, state, and federal levels as policy impacts services for the aging population. This heightened awareness also helps to maintain their necessary advocacy skills. CMs also need to take topical continuing education courses, which help to ensure they remain current about the ever-changing landscape of health conditions and service practices. Further, CMs must be aware of client changes (e.g., mood, excessive physical bruising) so as to detect potential abuse or neglect.

The BSW social work curriculum provided us with the basic framework for many of the roles and responsibilities associated with CM at ECS by covering several job-related essential educational content areas. For instance, courses related to interviewing and recording prepare students for CMG by giving future social workers the foundation in how to engage with a variety of clients in non-judgmental and accepting ways, while simultaneously acquiring accurate and important information. Crisis intervention coursework is also critical to CMG. Courses involving crisis intervention help enhance social work students’ ability to think quickly when faced with a pressing dilemma that requires safe and timely decisions and solutions. As previously noted, CMs at ECS complete several assessments related to abuse and neglect concerns. As a result, curricula focused on family and intimate-partner violence (IPV) assists social workers by providing basic knowledge regarding the screening, prevention, and protocols associated with investigation of abuse and neglect. Education focused on specific disabilities or physical and mental health concerns support social work students by learning about the causes, consequences, and treatments associated with these and other conditions. Such knowledge is also a foundation for learning about varying diagnoses, and the evidence-based practice process. For CMs at ECS, elective courses related to gerontological social work would prove to be very helpful. Course work regarding the aging process and older adults are important to expose students to developmental psychology, normal and “abnormal” aging, ageing-in-place, and death and dying. Importantly, clinical internships and field placements provide necessary, real-life experiences of working with actual clients and allow students the opportunity to overcome their fears in a safe, supervised, and supportive environment.

Concluding Remarks

Although practice wisdom is ever refining, several suggestions for future CMs in similar fields can be made. First, working with older adults or clients facing chronic and terminal illness can be stressful. However, the rewards far outweigh the stress. It is also important to be willing to work “outside of the box,” and outreach to various agencies to get your client their needed services. It is possible that CMs may sometimes be the only advocate the client has, and the CM’s efforts may be the difference between a client’s life and death. It is also important to not take offense when a client...
or caregiver says things in a harsh or abrupt way. This is a reflection of professionalism—remember that clients are receiving services because of their crises. It is the CM who is charged with directly supporting the client and working to help alleviate their crises. Further suggestions here are related to potential professional burnout. Remember to always take a step back and seek peer and supervisor support. Also, try to maintain an outlet for yourself outside of work, to help with or wind down after work—take the long way home and listen to the radio, walk around the mall, do a craft or work on a hobby, or participate in a religious or community group. Similar to the common directives provided by in-flight attendants, “place your oxygen mask on before helping others.” CMs must take care of themselves to ensure the client always receives the best services possible. This is what we were called on to do in our noble profession.

Case Example

I have had the unique opportunity to work in a wide variety of residences. Some have been small trailers with so many cockroaches crawling on the floor, that I had to keep moving my feet to prevent them from crawling up my legs. Other homes have been pristine—located in upper-middle class neighborhoods with landscaped lawns and gated driveways. Most often however, homes are comfortably furnished, without roaches, and are located in typical lower-middle-class neighborhoods.

One such home belonged to an older adult client who grew up in Germany during World War II. She experienced many personal crises during the war including relocation of her family and several near death experiences. Her life continued along a path of different crises, and eventually she moved to the United States. She worked hard her whole life and maintained a great sense of pride. However, due to the variety of traumatic events in her past, she lived in a world of fear and anxiety. She constantly remained concerned there were people in her home taking items from her. As a result, she pushed most people away from her. For some reason, the only people she remained in contact with were her CMs.

She was open about her history and frequently needed to take the time to share her stories in detail over the phone. As a CM, I was able to be a part of her remarkable life. Even through the challenge of finding services in which this client was comfortable, we were able to help her remain as comfortable as possible in her home. Her case is one that I will never forget because it was one of the most challenging and most rewarding at the same time. CMG need not revolve around unending assessments and documentation, it can instead help to shape a CM to be a more knowledgeable, compassionate, and supportive individual capable of balancing agency demands, while simultaneously building supportive, working relationships with clients so as to meet their needs and ensure their quality of life and independence. It is both this case, and many others, that have helped me to refine my professional social work skills, undergo positive personal growth, reflect about myself, and support my clients in meeting their needs in the least-restrictive, community-based setting at ECS.
References


Ancillaries

Internet Resources for Additional Readings

2. Elder Care Services, Inc. Retrieved from http://www.ecsbigbend.org/
6. 2-1-1 Big Bend Human Service Information and Assistance. Retrieved from http://211bigbend.net/

Hard Copy References for Additional Readings


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**JOB SUMMARY:** Creates and manages care plans for clients and their caregivers.

**KNOWLEDGE, SKILL, AND ABILITY REQUIREMENTS**

- Bachelor’s degree in social work, sociology, psychology, or related field
- Two years of CMG experience
- Excellent computer, written, and verbal communication skills
- A reliable personal vehicle available and a good driving record
- Successful completion of Area Agency on Aging for North Florida Case Manager certification
- Available to work hours beyond the usual workday of 8:00 a.m. to 5:00 p.m. when necessary

**DUTIES AND RESPONSIBILITIES**

1. Process referrals and complete initial client assessments in order to identify:
   - Problems and immediate needs of the client
   - Client’s strengths and ability to cope with his or her limitations
   - Caregivers and/or agencies providing assistance
   - Gaps requiring intervention

2. Assist client enrollment in appropriate program:
   - Educate client about programs available and qualifications
   - Assist client in completing appropriate application/paperwork for enrollment/yearly qualifications
   - Ensure client enrollment requirements are met (including Medicaid approval, LOC, 3008, quarterly income trusts, background checks, etc.)

3. Provide information and counseling as needed to client and caregiver

4. Involve the client in the care plan development

5. Develop care plan and ensure care plan approval is obtained

6. Arrange, coordinate, and monitor client services outlined in care plans either through ECS or outsource provider

7. Review care plans with other professionals involved with service provision to the client (outsource providers, senior companions, etc.)

8. Provide follow-up (as per program requirement) to ensure client satisfaction

9. Complete client visit and contact as per program requirements and time frames

10. Review the service delivery impact on the client as per program requirement, but at a minimum of quarterly for MW clients
11. Complete a written client reassessment (701 B and other United Health Care assessments) annually (within 365 days)
12. Complete annual paperwork in timely manner (within 365 days)
13. Complete case notes
14. Assist clients in obtaining equipment and supplies (including ordering supplies in a timely manner)
15. Advocate for the needs of clients and caregivers

Note: This job description is not intended to be all-inclusive. Employee may perform other related duties as negotiated to meet the needs of the organization.

16. Maintain confidentiality and security of Protected Health Information (PHI) according to HIPAA guidelines
17. Receive and respond to referrals from CARES and Adult Protective Services in required time constraints
18. Perform other duties as assigned by the Division Director for Home and Community Care and/or the President/CEO