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Case Management Services

Case management is a process commonly characterized by a series of activities undertaken to address a client's lack of resources and required services. This section will provide basic information on case management, primarily focusing on services frequently accessed and coordinated by geriatric case managers working in community settings.

MODELS OF CASE MANAGEMENT

Case management is defined by the Commission for Case Manager Certification (CCMC) as a

"collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the clients health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes" (CCMC, 2013). Using a more basic and consumer-driven definition, the Case Management Society of America (CMSA) describes it as follows: "Case managers work with people to get the health care and other community services they need, when they need them, and for the best value" (CMSA 2005, p. 1)

Case management consists of a series of activities that a case manager undertakes together with clients and, in many cases, their caregivers. Core functions of geriatric case management typically include access to the case management program, screening, a thorough multidimensional needs assessment, the development and coordination of a care plan, access and linkage to the required resources, monitoring of the services coordinated, and a regular reassessment (Austin, 2013; CMSA, 2010). Additional case management tasks often include resource indexing, interagency coordination, advocacy, and collection of data on practice

outcomes (Naleppa & Reid, 2003; Rothman, 1994). Clinical case management should be considered a key intervention approach in gerontological social work (Morrow-Howell, 1992).

An extensive range of geriatric case management models exists and has been tested and evaluated during the past three decades. In her comparative analysis of community-based case management models, Hyduk (2002) classifies programs into service provider–initiated models and demonstration models. Examples of service provider–initiated models include health maintenance organization (HMO) case management, community-based long-term care (CBLTC), outpatient geriatric evaluation and management (GEM), postacute case management, and physician practice case management (Hyduk, 2002).

Demonstration projects were created as a response to problems in the service delivery system that included structural fragmentation, duplication and discontinuity of services, and lack of integrating mechanisms. Single-service responses (e.g., acute medical care, skilled nursing facilities, or home health services) alone could not solve the growing problem, which led to the development of several system alternatives of structural integration (merging funding and services into a single system) and service integration (referral systems, care coordination, and case management). A waiver program established through the Omnibus Budget Reconciliation Act of 1981 made it possible to combine health care, personal care, and case management costs (Quinn, 1993). Examples of waiver demonstration projects include the On Lok project in San Francisco and its successor projects (i.e., the Program of All Inclusive Care for the Elderly [PACE]), the Multi-purpose Senior Services Project (MSSP) in California, and the Nursing Home Without Walls project in New York state. Another set of demonstration projects, the National Long-Term Care "Channeling" Demonstrations, were started in 1980 by the federal government in an effort to direct services to elderly persons who were considered at high risk for

entering a nursing home. Two types of channeling projects were implemented. In the basic channeling model, case managers were considered brokers of services, that is, their primary responsibility was to assist elderly clients to access and coordinate services. The financial channeling model, on the other hand, applied pooled funding and financial caps (Applebaum & Austin, 1990).

Another demonstration project, the Social Health Maintenance Organization (S/HMO), began in the mid-1980s. These organizations were created through the Deficit Reduction Act of 1984 (Applebaum & Austin, 1990; Quinn, 1993). Differing from many other demonstration projects, the S/HMOs incorporated acute and long-term care and covered elderly clients with all levels of functioning (Abrahams, Capitman, Leutz, & Macko, 1989). All of the demonstration projects incorporated some form of case management (Applebaum & Austin, 1990; Zawadski, 1984).

In a more recent model, an Accountable Care Organization (ACO) is in charge of the quality and cost of care in a certain geographic locale. As professionals in these organizations, case managers can "potentiate" the success for clients of the program (Mullahy, 2014). In Patient-Centered Medical Homes (PCMH), another medical-based approach that integrates case and care management, a team of specialists, usually led by a physician, focuses on coordinating care in a patient-focused way (Mullahy, 2014)

PROFESSIONAL ORIENTATION AND ROLES OF CASE MANAGERS

While there has been some debate between the social work and nursing professions in the past over the "ownership" of case management, social work, nursing, and other health care workers are the primary professional reference groups of case managers. While licenses are not

mandatory in all states, a growing number of employers require licenses or certification for their case managers (CCMC, 2013).

A survey of the members of the National Association of Professional Geriatric Care Managers (NAPGCM) indicates that approximately two-thirds of geriatric case managers hold a master's degree (AARP, 2005). The two largest professional groups providing geriatric case management were licensed social workers (37%) and licensed nurses (30%). Several credentials and certifications are available for geriatric case managers (AARP, 2005). The National Academy of Certified Case Managers (NACCM) confers the care manager certified (CMC) credential, and the Commission of Case Management Certification (CCMC) offers the certified case manager (CCM) credential. Both require a postsecondary degree in a field related to the practice requirements, as well as certain additional prerequisites. The National Association of Social Workers (NASW) offers two case management credentials, the certified social work case manager (C-SWCM) for applicants with a BSW degree and the certified advanced social work case manager (C-ASWCM) those with an MSW degree (NASW, 2013).

The roles of case managers and the models of staffing can vary considerably. The most basic case management staffing option is the individual generalist case manager, that is, the same professional carrying out the complete set of functions from intake through service coordination and monitoring, with a high degree of authority. The benefit is that the client has one practitioner to relate to. A second common approach is the multidisciplinary case management team approach, which combines professional expertise from various disciplines. Frequently the multidisciplinary team takes over some case management functions, such as assessment, while linkage and coordination is carried out by one team member. Comprehensive service centers that provide and coordinate a range of services under one roof could be considered a third approach.

Examples of this approach can be found in pioneering case management programs such as On Lok and PACE (Kane, Illston, & Miller, 1992).

The survey by the AARP assessed the services that geriatric care managers directly provide to their clients. The most common services include: finding services for clients (95%), arranging services (94%), family and social support assessment (94%), functional assessment (90%), health status assessment (73%) development of care plans (93%), and management of care plan (90%). Family counseling services were included in the service mix of 70% of the respondents (AARP, 2005).

FINDING A CASE MANAGER

Case managers typically work for nonprofit service providers, private case management agencies, or as self-employed private geriatric case managers. Common nonprofit agencies providing case management include local Area Agencies on Aging, home health care providers, hospitals, senior or family service agencies, and other human services providers such as the Veterans Administration. Private case management agencies and private geriatric case managers provide their services for a fee, while fees for nonprofit providers range from free to integrated with other service delivery costs and fee-for-service.

Professional case mangers as well as referrals for case management or care coordination programs can be found through local Area Agencies on Aging, hospitals and health care providers, senior centers, HMOs, and Medicaid offices. Several online services are available to assist in locating case managers and case management resources, for example, the Web sites of the eldercare locator (*www.eldercare.gov*), Family Care America (*www.familycareamerica*), the Area Agencies on Aging (AAAs; *www.n4a.org*), and the National Association of Professional

Geriatric Care Managers (NAPGCM; *www.caremanager.org*). The NAPGCM website includes a guide for clients and caregivers on how to select and interview geriatric case managers.

COMMON SERVICES IN CASE MANAGEMENT

Many services available to elderly clients residing in the community are created, authorized, and funded through the Older Americans Act (OAA). First enacted in 1965 and signed into law by President Lyndon B. Johnson, the OAA has been amended several times since, most recently in 2000. Some, but not all, of the services coordinated by case managers and presented in this chapter are funded directly or indirectly through the mandates of the OAA. The remainder of this chapter will focus on such services, addressing the areas of personal care, homemaker and chore services, transportation, personal emergency response systems, information and referral programs, financial assistance, and nutrition programs.

PERSONAL CARE SERVICES

According to the Administration on Aging (AoA), approximately 27% of the elderly population living in the community have problems with performing at least one activity of daily living (ADL). Moreover, approximately every third elderly person experiences one or more disability (AoA, 2011). Consequently, a great need exists for services that assist elderly individuals who are residing in the community with home and personal care tasks.

An older adult's need for assistance with personal care can range from light household chores to specialized personal care. Professional and trained nonprofessional workers are involved in the delivery of personal care. *Homemakers* assist with household chores, cleaning, laundry, errands, and shopping (see also the following section). They do not provide any health care–related services. A *personal care aide* will assist with household chores, personal care, and

ambulating. The *home health aide* may assist with household chores but can also provide personal care, medication management, and monitoring of medical status. *Licensed practitioner nurses* (LPNs) *and registered nurses* (RNs) monitor vital signs, dispense medication, and provide other skilled nursing services.

CHORE SERVICES AND HOMEMAKER SERVICES

It is common for elderly clients to need support with home maintenance and housecleaning. Problems with heavy housecleaning are frequently encountered with clients who are otherwise independent enough to continue living on their own. Several approaches can be taken to address this need. Informal support systems, such as family members or local community groups, are often relied on for help with both light and heavy housecleaning. Professional cleaning services, some specializing in housecleaning for elderly persons, may also be available. Case manager tasks include reviewing informal support systems for possible help with housecleaning, trying to enlist help from the informal support network, and educating clients about formal service options for housecleaning.

Chore and *homemaker services* are generally offered by religious groups, nonprofit agencies, and private agencies and usually require a fee for service. Chore services typically provide assistance with heavy housework, such as snow shoveling, mowing, and small home repairs, while homemaker services help with light housework, such as laundry, cleaning, and sometimes cooking.

Elderly clients are often unable to carry out parts of regular maintenance or required repairs, which can lead to safety problems and deteriorating conditions that may lead to the condemnation of the house. Common reasons for not undertaking needed maintenance include high costs, inability to repair due to poor health, and not knowing how to undertake repairs. Not

only low-income but also middle-income elderly often require assistance. Types of formal assistance with repairs include neighborhood conservation programs, emergency repair programs, repair and maintenance programs, and weatherization. However, many smaller repair and maintenance jobs may be undertaken by local private businesses.

TRANSPORTATION AND ESCORT SERVICES

Transportation and *escort services* encompass a wide variety of service options that aim at increasing the mobility of older adults living in the community. Transit services range from the regular bus or train system to specialized senior transportation. The most common transportation service options include regular bus service (fixed-route system), deviated route systems, paratransit or demand-responsive systems, incidental transit, and escort services (Naleppa & George, 2013).

Funding and legal authority for transportation services are provided through the mechanisms of a wide variety of laws and regulations. The Social Security Act, Title 19 (Medicaid) regulates the transportation of low-income elderly persons to and from medical appointments. The OAA, Title 3, provides funding for transportation to senior centers, congregate meals sites, and medical appointments. Title 3 of the Intermodal Surface Transportation Efficiency Act of 1991, also called the Federal Transit Act, mandates reduced off-peak fares for elderly riders and provides capital purchase assistance for operators transporting elderly and disabled riders. The most important legislation impacting the transportation of older adults, however, is probably the Americans with Disability Act of 1990 (ADA), providing protection from discrimination against persons with disabilities, including elderly persons with a disability. The ADA mandates, for example, that all new buses must be

wheelchair accessible. Fixed route systems are must be offered to persons with disabilities who are unable to use the regular bus system by providing a comparable paratransit system.

In a *fixed-route system,* public transportation or traditional transit services follow a predetermined route and schedule. The *deviated-route system* describes a transit system that generally follows a fixed route but will deviate from this route if a qualified rider requests it.

Paratransit describes transportation services that use smaller buses and vans and provide transportation to older adults and persons with disabilities. Usually they follow a *demand-responsive* approach, that is, a rider makes a request for transportation by phone and is either picked up in front of the home (curbside or at the door) or, in some cases, inside the home. Some demand-responsive systems require an advance request up to a day ahead of time, while others respond in an immediate time frame.

Incidental transit describes the transportation services provided by social service agencies to their clients, such as an adult daycare center that operates a van to transport its clients to and from the program site.

Escort and errand services are usually offered through private and nonprofit providers. In addition to personal transportation, they often provide other services as well, such as accompanied walks, companionship, and light housekeeping.

A wide range of transportation services have been described in this section. At the same time, the National Cooperative Highway Research Program (NCHRP) estimates that close to 90% of older adults rely on automobiles, as driver or passenger, for transportation. In rural and suburban areas, about two thirds of older adults depend on driving themselves (NCHRP, 2006).

PERSONAL EMERGENCY RESPONSE SYSTEMS

Personal emergency response systems (PERS) are devices that can be activated and send a signal to an emergency contact if a person is in distress. A trained professional answers the distress call immediately, usually over a speaker system integrated into the transponder unit in the home. The responder assesses the situation and activates the appropriate emergency response. If there is no response by the elderly person, an emergency response team is dispatched to the person's home. Two types of PERS are common, a push button worn around the neck or wrist or a push-button or pull-cord device placed on the wall, usually in the bedroom or bathroom.

Two additional procedures can provide added security to older adults living at home. Telephone reassurance is a procedure in which a volunteer makes a daily phone call at a predetermined time to ensure that the elderly person is well. In case the person does not respond, a call is made to an emergency contact. A so-called vial-of-life can provide vital information about the person to the emergency responders. A sticker is positioned at a place that will be seen by an emergency response professional when entering the home, alerting him or her to the fact that a small vial with vital information such as blood type, chronic health problems, and medications used can be found inside the refrigerator.

INFORMATION AND REFERRAL

In 1965, in an effort to improve the knowledge of resources available to older adults living in the community, a mandate by the OAA, funded through OAA, Title 3-B, created information and referral (I & R) services. The goals of these services can be summarized as follows: offering up-to-date information on local services for older adults; providing information on assistive technology; assessment and linkage to appropriate services; monitoring service delivery; and a focus on all older persons living in the community (Wacker & Roberto, 2014).

Local AAAs implement and coordinate I & R services in different ways, with some offering the services themselves and others contracting with outside providers. Some communities house their I & R efforts in public libraries or government institutions. In other communities, I & R services are provided through private or nonprofit organizations.

Examples of I & R efforts on the national level are the 2-11 Initiative, the Eldercare Locator, and the National Center for Benefits Outreach and Enrollment (NCBOE). The 2-1-1 initiative, modeled after the 9-1-1 emergency phone number, is a program with the goal of making information and referral data on health and human services available to callers on an around-the-clock basis (Wacker & Roberto, 2014). Using the Eldercare Locator, a consumer can easily obtain information about services in his or her community by providing the ZIP code and type of need for which services are requested. The NCBOE aims at helping low-income seniors and persons with disabilities to locate and access benefits and services (Wacker & Robert, 2014).

FINANCIAL MANAGEMENT AND LEGAL ASSISTANCE

Daily money management is a service that assists older persons in managing their finances and coordinating other paperwork. Daily money managers (DMMs) help with balancing checkbooks, paying bills, reconciling medical statements, and organizing personal records. They ensure that bills are paid in a timely fashion and intervene on their client's behalf in Medicare and health insurance matters. Some DMMs also provide accounting and income tax preparation, as well as relocation management.

Eldercare attorneys are licensed attorneys who specialize in legal services for older adults. On a fee-for-service basis, they assist elderly clients and their families with estate planning, preparing wills and trusts, establishing a durable power of attorney and advance health care directives, long-term care planning, guardianship, and Medicare and Medicaid issues. The

American Bar Association provides lawyer referral and information services and volunteer lawyer panels.

NUTRITION PROGRAMS

Nutrition programs for older adults include nutritional screening, home-delivered meals and meals-on-wheels, food stamps, congregate meals, emergency food services, and food banks, as well as shopping assistance programs and grocery delivery. The goal of these nutrition programs is to provide older adults with a healthy diet and to prevent malnutrition and inadequate food intake. Several of the nutrition programs are administered through the OAA (originally OAA, Title 4, and now OAA, Title 3).

Wacker and Roberto (2014) summarize factors that affect the nutritional status in elderly persons as physical (e.g., cognitive status, chronic and acute illness, oral and dental health problems, medication usage, digestive system) and psychosocial (economic status, ethnicity, social supports, access to nutrition programs, advanced age). Moreover, age-related changes to taste and smell may impact food intake.

The *National Nutrition Screening Initiative* is a program offered by organizations such as the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging to improve the nutritional status of older adults (Wacker & Roberto, 2014). A widely used and well-established screening instrument for nutritional assessment among older adults is the Mini Nutritional Assessment (MNA), which comes in a 6-item and an 18-item questionnaire format (Bauer, Kaiser, Anthony, Guigoz & Sieber 2008). Nutrition programs that receive funding through the OAA require a nutritional screening, and certain nutritional standards apply. For example, hot meals offered at congregate meals sites and

through home-delivered meals programs should provide at least one-third of the recommended daily nutritional allowance for adults.

The OAA, Title III, established the *Elderly Nutrition Program,* and it provides funding for congregate nutrition services and home-delivered meals. *Congregate meals* programs funded through the OAA provide one hot meal per day for at least 5 days a week. Only a few congregate meals sites offer breakfast or dinner. Congregate meals programs can be found in a range of community settings such as senior centers and churches. Many congregate meals sites provide nutritional screening, information, and education, and other community-based long-term care services. They also serve an important social function for their visitors.

Meals-on-wheels and *home-delivered meals programs* are offered by community, county, and nonprofit providers. They are targeted at older adults who cannot prepare meals themselves and are not able to visit a congregate meals site. Home-delivered meals programs receiving funding through the OAA; they must provide the delivery of at least one meal per day to the person's home for at least 5 days a week. According to Wacker and Roberto (2014), the costs of these meals are covered by a little over one-third through OAA funding and about two-thirds through other funding such as local, state, and federal sources and private donations. Volunteers deliver meals to the elderly person's home. Home-delivered meals programs usually ask for a donation and have a sliding fee scale.

Food stamps are an income-based nutrition program available to low-income older adults. The aim of food stamps is to reduce malnutrition among all low-income populations. Any person receiving Supplemental Security Income benefits also qualifies for food stamps. Food stamps can be used in regular grocery stores, and, with the exception of some items, the person can decide what to purchase with them.

Emergency food services and *food banks* are also targeted toward low-income populations. Food banks receive food donations from a variety of sources and distribute them to those in need, including older adults. The Emergency Food Assistance Program (TEFAP) and the Commodity Supplemental Food Program (CSFP) are administered by the Department of Agriculture's Food and Nutrition Service. Both programs provide low-income persons with basic food items such as butter, flour, cereal, rice, and vegetables at no cost.

Shopping assistance programs and *grocery delivery* aim to help older adults who are living independently but lack transportation or have mobility problems. A variety of shopping assistance programs have been established by communities, volunteer organizations, and similar groups. In most programs, a volunteer escorts the older adult to the store, assists with shopping, and then accompanies his or her home. A growing number of grocery stores also provide grocery delivery. Usually the elderly person calls in his or her order or orders online, and the groceries are delivered the same day by a volunteer. Some grocery stores offer grocery delivery to all customers for a fee.

This chapter focused on an overview of some of the primary services coordinated through geriatric case management. Additional information on some of these programs can be found in chapters in this section.

REFERENCES

Abrahams, R., Capitman, J., Leutz, W., & Macko, P. (1989). Variations in care planning practice in the Social/HMO: An exploratory study. *Gerontologist, 29,* 725–736. http://dx.doi.org/10.1093/geront/29.6.725

Administration on Aging (2011). *A profile of older Americans: 2011.* Washington DC: Author.

American Association of Retired Persons. (2005). *Geriatric care managers: A profile of an emerging profession.* Washington, DC: Author. Available: *http://re-search.aarp.org/il/ dd82_care.html*.

Americans with Disability Act of 1990, 42 U.S.C. §12101 et seq.

Applebaum, R. A., & Austin, C. D. (1990). *Long-term care case management: Design and evaluation.* New York: Springer.

Austin, C. D. (2013). Case Management. In E. Capezuti, E. L. Siegler, & M. Mezey (Eds). *The encyclopedia of elder care: The comprehensive resource on geriatric and social care (3rd ed.).* New York: Springer

Bauer, J. M., Kaiser, M. J., Anthony, P., Guigoz, Y. & Sieber, C. C. (2008). The Mini Nutritional Assessment: Its history, todays practice, and future perspectives. *Nutrition in Clinical Practice, 23,* 388-396. Doi:10.1177/0884533608321132

Case Management Society of America (2005). *Case management leadership coalition adopts consumer definition of case management.* Little Rock: Author. retrieved 5-12-13 http%3A%2F%2Fwww.cmsa.org%2FIndividual%2FNewsEvents%2FPressReleases%2Ft abid%2F267%2Fctl%2FViewPressRelease%2Fmid%2F1004%2FPressReleaseID%2F19 %2FDefault.aspx&anno=2

Case Management Society of America (2010). *Standards of practice for case managers.* Little Rock: Author.

Commission for Case Manager Certification (2013). Growing trend: Case management licensed required and paid for by more employers. Issue Brief 1, 1-6. Retrieved 5-12-13 from http://ccmcertification.org/sites/default/files/downloads/2011/3.%20Growing%20trend% 2C%20case%20managers%20desired%2C%20volume%201%2C%20issue%201.pdf

Commission for Case Manager Certification (2013). Philosophy and definition of case

    management. Retrieved on 5-12-13 http://ccmcertification.org/about-us/about-case-

    management/definition-and-philosophy-case-management

Deficit Reduction Act of 1984, P.L. 98-369 (98 Stat. 494).

Hyduk, C. A. (2002). Community-based long-term care case management models for older

    adults. *Journal of Gerontological Social Work, 37,* 19–47.

    http://dx.doi.org/10.1300/J083v37n01_03

Intermodal Surface Transportation Efficiency Act of 1991, Pub. L. No. 102-240, 105 Stat. 1914.

Kane, R., Illston, L., & Miller, N. (1992). Qualitative analysis of the Program of All-inclusive Care for the Elderly (PACE). *Gerontologist, 32,* 771–780.
http://dx.doi.org/10.1093/geront/32.6.771

Morrow-Howell, N. (1992). Clinical case management: The hallmark of gerontological social

    work. *Journal of Gerontological Social Work, 18,* 119–131.

    http://dx.doi.org/10.1300/J083v18n01_08

Naleppa, M. J. & George, M. (2013). Transportation. In E. Capezuti, E. L. Siegler, & M. Mezey

    (Eds). *The encyclopedia of elder care: The comprehensive resource on geriatric and*

    social care (3rd ed.). New York: Springer

Naleppa, M. J., & Reid, W. J. (2003). *Gerontological social work: A task-centered approach.*

    New York: Columbia University Press.

National Association of Social Workers. (2013). *NASW professional social work credentials and*

    advanced practice specialty certifications. Washington, DC: Author. Retrieved 5-12-13

    from: *https://www.socialworkers.org/credentials/*

National Cooperative Highway Research Program (2006). *Estimating the impacts of aging*

    population on transit ridership. Fairfax: ICF.

Older Americans Act of 1965, Pub. L. No. 89-73, 42 U.S.C. §3001 et seq., as amended or

reauthorized.

Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357, 5 U.S.C. §8340 et

seq., as amended.

Quinn, J. (1993). *Successful case management in long-term care.* New York: Springer.

Rothman, J. (1994). *Practice with highly vulnerable clients: Case management and community-

based service.* Englewood Cliffs, NJ: Prentice Hall.

Social Security Act of 1935, 42 U.S.C. §301 et seq., as amended.

U.S. Census Bureau. (2000). *The Census 2000 Brief Series: Population change and distribution:

1990–2000* (C2KBR/01-2). Washington, DC: U.S. Government Printing Office.

Available: *www.census.gov/prod/ 2001pubs/c2kbr01-2.pdf*.

Wacker, R. R., & Roberto, K. A. (2014). *Community resources for older adults: Programs and

services in an era of change* (4th ed.). Thousand Oaks, CA: Sage.

Zawadski, R. T. (1984). Research in the demonstrations: Findings and issues. *Home Health Care

Services Quarterly, 4,* 209–228. http://dx.doi.org/10.1300/J027v04n03_12