

PART

# 1

## Introduction to Care Management



© Monkey Business Images/Shutterstock



# Overview and History of Care Management

---

Cathy Jo Cress

## Introduction

What is care management? It is a series of steps taken by a professional care manager to help solve the problems of older people and others facing health care challenges and their families. Care managers also help older people and their families implement these solutions. A care manager, who may be a social worker, a nurse, a gerontologist, or another human service professional, serves aging families. The care manager usually steps in when the older person or family is in crisis in the community. The professional is able to help families by offering solutions to their problems. Care management is also a preventative service that helps older people and their families see the long view of their problems in order to prevent issues before they come up and that advises older people on how to age well through the decrements of life. Service is rendered on demand to increase the quality of older persons' and their families' lives, manage all the players who render services to the older person, and offer assurance and peace of mind to adult children of older individuals.

How does the care manager solve these problems and render these services? The care manager uses classic social work and nursing tools, including client assessment, care planning, service coordination, and referral and monitoring.

## What Is a Professional Care Manager?

Care managers' roles are different from the roles of case managers. Case managers are primarily health centric, and their job is to improve the relationship between the primary care provider and the patient. They help families and patients navigate health and hospital systems. Case managers and care managers use classic tools of case management.

Unlike case managers, who serve all patients, care managers specialize in serving adults aged 65 years and older and their families and offer very personalized services. Historically, care managers have had much smaller caseloads than have public service or hospital case managers (especially those in public case management settings), giving care managers great flexibility in delivering highly individualized services to their older clients. Unlike many case managers in public case management or medical case management settings, care managers are generally available 24 hours a day, 7 days a week, 365 days a year. They respond to older clients' and families' needs at the convenience of the client and family, which enables care managers to cross from public-sector human services into the for-profit service area. The care manager's product is service, and that product must be available at all times to be useful to older people, their families, and third parties, such as trust

departments and conservators/guardians who are willing to buy the product if it is offered in this manner.

Another area in which care managers differ from medical case managers and public service case managers is who pays them. Often, insurance companies or hospitals pay medical case managers, employing policies that encourage the case managers to discharge the patient and ensure the patient stays home and is not readmitted. Public case managers are paid by the nonprofit, government, state, county, city, or business that employs them. Care managers are paid by clients and their families.

Care managers are not classic, anonymous, public-sector case managers delivering impersonal services. They are not medical case managers helping patients navigate a broken healthcare system in such a way as to move high-expense patients through the medical care maze at lower costs than insurance companies normally would pay.

In fact, care managers are a kind of surrogate family member with special expertise in the phases and tasks of care management and a long-standing and personal relationship with clients. Care managers deliver the kind of old-fashioned customer service that many older clients remember with nostalgia. Care managers not only respond to clients' demands but also are proactive, always maintaining a positive attitude.

Care managers actually enter the family to make changes in family dynamics and family systems. Their focus is the aging family. Aging is not really about a single older person but about the entire aging family system. Care managers enter that system to help nearly normal and dysfunctional families better serve their older family members. Care managers show families a path to meet every person's—care providers and aging members—psychosocial and functional needs so they can mobilize and deliver those needs as a unit and a system.

In addition, care managers deliver the high level of service that older clients' and adult children expect. Children in aging families are usually baby boomers from two-income

families in the top 10 percent of earners of household income. They are accustomed to purchasing services (housecleaning, day care, after-school transportation, tax assistance) to help make their busy lives easier. Buying care management services to assist with the problems of their older family members, who frequently live far away, seems logical to these adult children. The care manager is providing time and expertise, neither of which the adult child has. The care manager also sells peace of mind by acting as a surrogate for the family. Most baby boomers do not want to get up in the middle of the night to respond to an older person's crisis, but the care manager will. The adult child may not have enough vacation time to fly to the parent's home to arrange services when an older person gets out of the hospital, but the care manager can do this. Many adult children want assurance that their older family member is cared for and safe, without having to solve the problem themselves. So, the personalized services of the care manager, a surrogate family member, appeal to adult children.

In addition to handling client assessment, care planning, service coordination, and referral and monitoring, the care manager keeps track of the giant web of senior services that makes up the continuum of care. Care managers are like Charlotte, the friendly spider in *Charlotte's Web*. They run back and forth across the web, linking services, repairing gaps, spinning new solutions to problems, and coordinating answers. At the root, care managers are problem solvers.

This chapter offers an overview of what a care manager does and discusses the history of the profession.

## History of Care Management

Care managers are now relatively familiar participants in the world of senior services and health care. But what conditions led to the rise of care management? This section discusses the history of this important profession.



## The Origins of Case Management

In a seminal study of care management, Secord and Parker note that case management itself, the root of care management, has its foundation in the provision of social services for new immigrants and other poor people that emerged in the late 1800s.<sup>1</sup> At that time, urbanization and industrialization had left so many people poor and homeless that churches and local communities were paralyzed and unable to care for everyone in need. Social service bureaucracies began to arise, which led to the beginning of case management. Secord and Parker hypothesize that the core elements of today's case management were born by "helping the client find the least costly, most appropriate services to meet his or her needs."<sup>1</sup> Since then, government and community agencies, social workers, hospital discharge planners, and case coordinators have provided the services we now call case management.

No one group or movement was solely responsible for the emergence of case management. In the arena of early social services, in 1833 Joseph Tuckerman organized a group of churches to help needy families. The Settlement House movement at the turn of the 20th century is another example of early case management. The Settlement House movement established institutions called settlement houses in which settlement workers resided and tried to improve living conditions in local neighborhoods. Most settlement houses had social workers on staff.

Many charity organizations and societies coordinated assistance for children and families. Eleanor Roosevelt, future wife of President Franklin Roosevelt, joined the Junior League at 18 years of age and taught at the Rivington Street Settlement House in New York. She introduced her husband to and educated him about the brutal poverty of the New York slums. Eleanor brought him to the settlement house, an unknown environment for either of the two. In this way,

she prepared him to conceive of the social services offered in the New Deal.<sup>2</sup>

A case management program was set up by the Massachusetts Board of Charities in the mid-1800s. The roots of case management can also be found in early workers' compensation programs of the 1940s.<sup>3</sup>

In the medical world, case management appeared in the treatment of chronically ill and long-term care populations, including children, people with disabilities, substance abusers, and people with acquired immune deficiency syndrome. As acute care costs skyrocketed in the United States after World War II, case management techniques developed to lower costs. Case managers appeared in institutional settings and followed patients into the community to coordinate care for high-cost, high-risk individuals. At the same time, private medical case managers appeared to respond to the needs of patients, insurers, and medical providers by helping these constituents make difficult decisions (e.g., Is a medical procedure appropriate? Is there a less costly alternative? Can a patient spend recovery time at home?). Today, the medical case manager makes a path for the patient through the maze of the healthcare delivery system, coordinates a plan of care, and offers support from family agencies, suppliers of health care, and healthcare entities.<sup>4</sup>

## Growth of Case Management for Older People

According to Parker and Secord, case management for older people emerged because of two factors. The first was the rapid growth of the older population in the United States. The second was the increased cost of health care, especially Medicare, in the United States. At the time of their study in 1987, Secord and Parker reported that Medicare expenditures totaled \$83 billion in 1981 and were projected to increase to \$200 billion in the year 2000.<sup>1</sup> In 2013 they were 3.5 trillion.<sup>5</sup>

When healthcare costs exploded in the 1950s and 1960s, and the number of older

people grew, a national governmental effort was made to stem the fiscal bloodletting. This was true especially with nursing home expenditures, which ate up a large part of public funds, mostly through Medicaid payments for older people. In the 1970s and 1980s, many states developed nursing home preadmission screening programs in an attempt to reduce nursing home placement. In other states, a moratorium was placed on nursing home bed construction. People realized that nursing home placement was not only costly but also often unnecessary or inappropriate; many older Americans could be cared for in their own homes.

In addition, services for older people were expanding. This growth was driven (after World War II) by five major federal programs with mandates to finance gerontological services: Title VIII of the Social Security Act (Medicare), Title XIX of the Social Security Act (Medicaid), Title XX of the Social Security Act, the Older Americans Act, and the Department of Veterans Affairs<sup>6</sup>

As a result of these developments, in the 1960s and 1970s a plethora of community care senior programs blossomed in the United States. These services included home care, homemaker services, chore services, housing alternatives, transportation services, adult day care, and in-home meals. These senior services, all of which helped keep seniors in their own homes, were not coordinated. Some services emerged from states, some from the federal government, and some from the local community. Because this fragmented system was difficult to navigate, it did not serve older people well.

To help with this fragmentation and lack of a single point of entry into the web of senior programs, many public and private programs developed aspects of case management. In the 1970s, Medicare funded a number of Medicare waiver programs to find out whether older people could remain more independent when provided with community-based coordinated care. Case managers guided older people through the complex web of senior services

and decided which services were appropriate for each individual.

A case manager might help in the following way. Suppose an older person who lives alone at home and who is very lonely becomes depressed enough to stop eating on a regular basis. The nutritional deficit can lead to confusion, which makes it more likely that the older person will not take needed medications. If these medications, say, are for high blood pressure, the unmedicated older person may have a stroke and need to be hospitalized, and then placed in a nursing home. This eventual nursing home placement could be avoided if the older person had a case manager who knew that depression might lead to this outcome and who understood that a regular friendly visitor could allay the depression. The case manager might also suggest regular visits to a senior center as a way for this person to reenter the world. The case manager might talk to some of the older person's friends and encourage them to visit more frequently or to have a weekly meal together so that the older person has company and something to look forward to each week. The case manager might also arrange for the older person to visit his or her physician so medications can be monitored and arrange for prepared meals to be dropped off daily by Meals on Wheels. Thus, the case manager could help avoid an unnecessary hospitalization or nursing home placement by helping the older person navigate and then access the very confusing continuum of care.

The Medicare waiver programs of the 1970s included Connecticut Triage on the East Coast, the Multipurpose Senior Services Project on the West Coast, the National Long-Term Care Channeling Project, the 2176 Medicaid Waiver Programs, and the Community Nursing and Home Health programs. Case management was viewed as central to these Medicare waiver programs. In addition, these programs allowed older people to purchase items they normally would not be able to buy through Medicare, such as medications and eyeglasses. This was done on an experimental

basis to see what mix of services would help keep older people out of nursing homes and in the community.

Out of these very experimental programs of the 1970s and 1980s emerged the classic model of case management.<sup>7</sup>

## The Emergence of Professional Care Management

The frail elderly have historically been the prime consumers of case management services. They experience functional and cognitive impairments that demand a wide array of informal and formal services. Case managers are expert in brokering these services. The publicly funded case management programs of the 1970s and 1980s demonstrated that case management was an ideal tool in negotiating these formal and informal services and in helping older people remain in the community. Years of studies showed that older people wanted to stay at home and that they could remain at home with coordinated in-home and community-based services. The key was case management. Many factors came together to encourage the development of care management, which was at first a specialized form of case management.

One factor that contributed to the rise of care management was the emergence of a new pool of qualified professional case managers interested in pursuing a slightly different type of work. Many case managers from public case management programs were burned out by working in the public system. They wanted more independence in their jobs while still doing good and working with older people. Others from the helping professions (nurses and social workers) had not worked in public case management programs but had experienced burnout and wanted a different, perhaps more exciting, career path where they would still be helping others.

At the same time, the voluminous and very fragmented web of senior services continued to expand, tangle, and unravel, with no central point of entry and mind-boggling rules

at the federal, state, and local levels. Contemporaneously, the number of older people was increasing. Because long-term care management and chronic care management were not covered by Medicare, these types of care were considered discretionary purchases. In addition, many older people had large enough incomes and enough assets to be ineligible for publicly funded and community-based programs.

From the beginning of the field to the present the over-65 cohort was and is an affluent age group. The 55+ age group controls more than three-fourths of America's wealth (ICSC):<sup>8</sup> Seventy-eight million Americans who were 50 years or older as of 2001 controlled 67% of the country's wealth, or \$28 trillion.<sup>9</sup> Baby boomers and seniors have seen a decrease in their median family net worth; however, they still have a net worth three times greater than younger generations.<sup>10</sup> Baby boomers' median household income is 55% greater than post-boomers and 61% greater than pre-boomers. They have an average annual disposable income of \$24,000.<sup>11</sup> The 50+ age group has \$2.4 trillion in annual income, which accounts for 42% of all after-tax income.<sup>11</sup> Adults 50 years and older own 65% of the aggregate net worth of all U.S. households.<sup>11</sup> Households headed by persons older than 65 years have considerable purchasing power. Therefore, older people and their baby boomer families needed and could afford care management services.<sup>12</sup>

Two other factors contributed to the development of care management. First, more women began working out of the home. Women have accounted for a significant percentage of the workforce since the 1950s. They entered the workforce as a reaction to change, including the women's movement and the fact that families began to need two incomes to stay afloat. According to the Bureau of Labor Statistics, 57.7% of women were working out of the home by 2012.<sup>13</sup> Yet women were the principal informal caregivers in the United States. A 2011 Bureau of

Labor Statistics report showed that 39.6 million people older than age 15 had provided unpaid care to someone older than 65 years “because of a condition related to aging.” A majority of those providing care—56%—were women, which was a smaller majority than past research had found.<sup>14</sup> The 57.7% who work today leave not only children but older adults in need of care. Despite the crushing emotional, physical, and financial burdens of elder care, the U.S. family has not abandoned its elders. A study done in the 1990s by the U.S. House of Representatives showed that the average woman spends 17 years caring for her children and 18 years or more caring for her older parents. Piggybacked on this is another startling statistic: For the first time in U.S. history, Americans today have more living parents than they have children.<sup>15</sup>

The second factor that contributed to the development of care management was that most Americans tended to live far from their older family members. The United States is a mobile society. Individuals no longer stay where they grew up. They may work in many different locations while their parents stay in the hometown. According to a study by the AARP, one-third of all adult children in the United States live at least 30 minutes away from their aging parents.<sup>16</sup> Because the main system of support was still the family, this left older people vulnerable if they had a crisis. If the family lived far away, a crisis could turn into a megacrisis if there was no one to offer assistance.

All of these factors led to the need for care management. Public and private case managers as well as nurses and social workers who chose to leave the system saw a wonderful niche to fill. They understood how to provide care professionally. Many understood case management. And they saw the frustration of many older people—who had the money to purchase services but who were unsure which services to choose—and of families, usually adult daughters, who were overworked and lived far away. In addition, adult children realized they could do for their aging relatives’

health care what they already did for the provision of housecleaning and other services: They could outsource help for their parents.

## The Birth of Care Management Organizations

Care management became a profession gradually. Because the people who started the profession came from diverse fields, in the beginning they had no central meeting ground. Social workers belonged to the National Association of Social Workers, whereas nurses belonged to many different associations, including the American Nurses Association. To work on common goals and interests, the new care managers started several organizations. The most important early ones were the National Association of Professional Care Managers (NAPGCM) now called Aging Life Care Association (ALCA), and the Case Management Society of America (CMSA).

### NAPGCM

The first 12 care managers, who were scattered across the country, were originally drawn together through a 1984 article in the *New York Times*.<sup>17</sup> Care managers from different areas were surprised to learn that other people were doing what they were doing. Social workers who were interviewed in the article were asked to join a coalition. In January 1985, the first meeting of what would become the National Association of Professional Care Managers was held in the home of Adele Elkind, a social worker who was the founding force of the organization.

Professionals who had expertise in this relatively new area began to share information to help each other run better businesses. They agreed that if they could help each other, they could help the public. They put together a brochure to describe their services and moved on to develop criteria to decide who could be a member of the group. They formalized their network into the Greater New York Network on Aging (GNYNA) and began to refer cases to



each other. Sarah Cohen, a founding member, suggested the radical idea that the fledgling group have a national conference; in 1985, 100 human service professionals gathered in New York City to take part in the first National Conference of Private Care Managers. The gathering was hosted by GNYNA, which was by then a growing group of social workers, psychologists, nurses, and clinical gerontologists. This group had the vision of forming a national association dedicated to private care management.<sup>18</sup>

In 1986, this vision became a reality when the same group held a conference in Philadelphia, adopted membership standards, and unanimously voted to found the National Association of Private Geriatric Care Managers.

In 1993, in recognition of the fact that non-profit agencies and baccalaureate-prepared individuals also practiced care management, the NAPGCM membership voted to change the association's name from National Association of Private Geriatric Care Managers to National Association of Professional Geriatric Care Managers and to expand the voting membership base to include individuals who provided care management in all practice settings (public, private for-profit, or private nonprofit) and who had attained a baccalaureate degree or higher education.

NAPGCM changed from being a trade association with a primary mission of promoting member practices to a professional association with a primary purpose of advancing the profession.

Together with Connecticut Community Care, a large care management organization, NAPGCM worked to create a credentialing program for care managers. In 1996, they developed and initially funded the National Academy of Certified Care Managers (NACCM) to advance the quality of services provided by care managers through certification.

Fragmentation of the care management profession occurred as the healthcare environment changed. As managed care increased and assisted living facilities began to offer services that competed with those provided by nursing homes, healthcare providers began to form

coalitions to adapt to work within or outside of the managed care market.

In 2015, NAPGCM changed its name to the Aging Life Care Association.<sup>19</sup> The association began with 50 members; currently, it has 2,000. It has been able to bring unity and consistency to care management by configuring an information base for aspiring and practicing care managers.

In 30 years of meetings, its members have been able to gather a body of research about the care management field. This body of knowledge has been presented in yearly national and regional conferences and in the *Care manager Journal*. The journal, in existence since 1990, publishes research and topical information about the field and addresses points of interest to care managers, including business practice and clinical issues.

On its website, the association offers a new Education Central feature for members. It also includes a resource called "Find a care manager," where clients can locate a care management professional anywhere in the United States, and an email list through which care managers can communicate with others from around the country. The association has committees that benefit individual members and the whole care management field, including marketing and public relations committees that create national marketing and public relations tools to promote care management through the media and articles published across the country. The Public Policy Committee answers to the board of directors and deliberates on and recommends pertinent issues to address. The association has nine regional chapters that can provide members with peer support and supervision, business and professional development, educational opportunities, clinical information, leadership training, networking, and joint marketing opportunities. Each chapter has a website, and many allow members to advertise care management job opportunities. The association's online store offers many products that are helpful to care managers who are starting a care management business.

## Benefits of Membership

For new care managers, spending time with other members of the profession can help them learn what to look for and what to avoid as they enter the field. Care managers who have practiced for any length of time have expertise and opinions in many areas, including whether becoming a care manager is a good idea. They can provide tips about billing, setting up an office, hiring staff, conducting assessments, using form templates, and other challenges in running a small business. As for any new professional, new care managers can learn from those with experience in their chosen field, and an association is a good place to find knowledgeable people who might even become mentors.

A rich body of information exists in the field of care management. This information is still mainly available through conferences, webinars, and journals, all of which are part of the benefits of belonging to the NAPGCM. Increasingly, educational institutions are also offering courses that provide certificates and degrees in care management.

## Academic Programs in Care management

In the past few years, several academic courses and certificate programs and one master's degree program have emerged in care management. These programs offer a career path for students heading into the care management field or for care managers who want further education in the business. Among the many programs are the San Francisco State University Gerontology Graduate Program (Master of Arts); the University of Florida graduate certificate and specialty master's degree in care management; the Brookdale Center for Healthy Aging Certificate in Care management (a professional credential recognized by practitioners in the gerontological field); the University of Utah Gerontology Interdisciplinary Program for

registered nurses; a care management mental health certificate from Misericordia University, Temple University, and the University of Wisconsin at Madison; the University of Missouri online care management certificate; and the University of La Verne, Los Angeles, certificate in care management. Many more schools offer or will soon offer care management certificates, undergraduate degrees, and master's degrees.

## Conclusion

The care management profession developed in response to a societal need: A wide array of fragmented senior services was available, but older people and their adult children had trouble figuring out which senior services would be helpful. Care managers are problem solvers for aging families. They match older people to the appropriate senior services and monitor their clients' care. Professionals who provide this very personalized service have organized into associations to help define and advance the care management field.

## References

1. Secord LJ. *Private Case Management for Older Persons and Their Families: Practice, Policy, Potential*. Excelsior, MN: InterStudy Center for Aging and Long-Term Care; 1987.
2. *Biography of Eleanor Roosevelt*. Franklin D. Roosevelt Presidential Library and Museum. Hyde Park, NY: National Archives. Accessed June 15, 2015.
3. Klein SM. *A National Agenda for Geriatric Education: White Papers*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions; 1998.
4. Mullahy CM. *The Case Manager's Handbook*. 5th ed. Burlington, MA: Jones & Bartlett Learning; 2014.
5. The Facts on Medicare Spending and Financing. *KFF.org*. Kaiser Family Foundation, June 28, 2014. Accessed June 15, 2015.



6. Kaye LW. The evolution of private geriatric care management. *Journal of Case Management*. 1992;1(4): 103–107.
7. Cress C. Care management news takes hold in long-term care. *Ageing International*. 1992; 19(3):1–38.
8. ICSC.org. International Council of Shopping Centers, 2015. Accessed June 22, 2015.
9. Census.gov. United States Census Bureau. Accessed June 22, 2015.
10. EPI.org. Economic Policy Institute, 2015. Accessed June 22, 2015.
11. Consumer Expenditure Survey. BLS.gov. U.S. Bureau of Labor Statistics. Accessed June 22, 2015.
12. 50 Facts and Fiction: Size, Wealth and Spending of 50 Consumers. *Immersion Active*. March 9, 2015. Accessed June 15, 2015.
13. Women in the Labor Force: A Databook. BLS.gov. U.S. Bureau of Labor Statistics, May 1, 2014. June 15, 2015. [http://www.bls.gov/opub/reports/cps/womenlaborforce\\_2013.pdf](http://www.bls.gov/opub/reports/cps/womenlaborforce_2013.pdf). Accessed June 15, 2015.
14. Unpaid Eldercare in the United States—2011–2012: Data from the American Time Use Survey. BLS.gov. U.S. Bureau of Labor Statistics, Sept. 18, 2013. <http://www.bls.gov/news.release/pdf/elcare.pdf>. Accessed June 15, 2015.
15. Kilborn B. Eldercare: Its impact on the workplace. *Update on Aging*. 1990;6(2).
16. Administration on Aging. *A Profile of Older Americans: 1998*. Washington, DC: AARP Fulfillment, 1998.
17. Collins G. “Long-distance care of elderly relatives a growing problem.” *NYTimes.com*. The New York Times; Dec. 29, 1983. Accessed June 15, 2015.
18. Elkind A. Development and growth of a regional network. GNYNA: The first two years, joys and growing pains. *Geri Gazette*. 1986;1: 1–4.
19. AgingLifeCare.org. Aging Life Care Association. Accessed June 15, 2015.