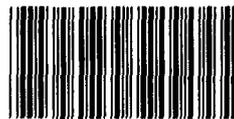


April 1993

# LONG-TERM-CARE CASE MANAGEMENT

## State Experiences and Implications for Federal Policy



148792

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**United States  
General Accounting Office  
Washington, D.C. 20548**

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**Human Resources Division**

B-251992

April 6, 1993

The Honorable Ron Wyden  
House of Representatives

Dear Mr. Wyden:

This report, prepared at your request, reviews the experiences of six states in carrying out case management activities in long-term-care programs for the elderly and discusses the views of case managers on the essential elements of and possible barriers to effective case management. The report also contains a matter for congressional consideration relating to any proposed legislation on long-term care involving case management.

Copies of this report are being sent to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others on request.

Please contact me at (202) 512-7225 if you or your staff have any questions. Other major contributors to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in cursive script, appearing to read 'Gregory J. McDonald'.

Gregory J. McDonald  
Director, Human Services Policy  
and Management Issues

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# Executive Summary

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## Purpose

The number of elderly Americans, those 65 years of age and older, is rising steadily and could exceed 52 million by 2020. This group would then comprise 18 percent of the U.S. population; a 63 percent increase over the current elderly population. As people age they require more health and social services but are often confused about what services they are eligible for and how to obtain them. Case management generally is a process that assists people in defining their service needs, locating and arranging services, and coordinating the services of multiple providers.

Over the past several years a number of bills dealing with long-term care have been introduced in the Congress. Many of these bills promote having a national network of case managers to integrate long-term-care services and assure that beneficiaries receive necessary care and support.

In view of the important role case managers could play in carrying out a federal long-term-care program, Representative Ron Wyden asked GAO to assist the Congress in determining (1) what, in practice, constitutes case management, the roles case managers play and the barriers they face in doing their jobs; and (2) whether standards for case managers would best be defined in terms of professional qualifications, the functions of case management, or performance measures based on the experience of state officials and exemplary case managers.

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## Background

Historically, nursing home care has been the primary option for the elderly in need of any long-term-care services. In recent years, there has been a gradual expansion of in-home and community-based care because most elderly people prefer to remain in their homes and in-home and community-based care is generally less expensive than nursing home care. However, these programs have grown in a fragmented fashion with varying eligibility requirements, and they are often administered by different state agencies. As a result, elderly people may have difficulty locating the services they need. Case management has emerged as a response to this fragmentation.

To assist the Congress in its deliberations on long-term-care legislation, GAO reviewed how six states, considered to have innovative programs for the elderly, use case managers in publicly funded long-term-care programs and how these states are overseeing case management activities. GAO focused on the extent to which the states had developed guidelines or standards that defined the role of case managers and the qualifications of those who perform case management.

GAO interviewed 95 case managers considered by their supervisors or peers to be the best performers in their organizations. GAO obtained their views on how they provide case management services and what barriers or problems they most commonly face.

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## Results in Brief

As generally practiced in the states that GAO visited, case management is a process to coordinate and monitor a wide range of medical and social services to meet long-term-care needs. Case managers generally identify and arrange for needed services. They work for a variety of state, local, and private health and social service organizations. Persons serving as case managers have a variety of educational backgrounds and prior experiences. They also carry out their duties in different ways. Despite these variations, case managers typically perform a common set of functions in the practice of long-term-care case management. These functions include assessment, care planning, service coordination, client monitoring, and reassessment.

Case managers identified knowledge, skills, and abilities critical to conducting their work in an effective manner, such as having detailed knowledge of service providers and being able to manage their time to adequately monitor their clients. They also face several barriers that prevent them from performing their jobs as effectively as they would like. For example, limited availability and varied quality of services constrain case managers' ability to implement effective care plans.

States and local agencies and national associations have established standards addressing the qualifications of case managers and the functions they perform. However, the specifics of each entity's standards differ. Case managers believe that standards are important, but that any federal legislation addressing case management should assure that state and local agencies have flexibility in setting these standards so they best meet their needs.

GAO believes that because of the wide variation in economic situations, geography, client demographics, and organizational structures, establishing national standards for long-term-care programs with a high degree of specificity is not practical. In addition, it believes much of the details concerning how the case management process is to operate are best determined at the state or local level.

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## Principal Findings

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### What Are States' Approaches for Providing Case Management?

Each of the six states GAO visited—California, Connecticut, Maryland, Massachusetts, Oregon, and Washington—has its own unique structure for providing case management to the elderly. These structures differ in terms of the type and number of agencies that provide case management. For example, Connecticut uses one nonprofit agency to provide case management statewide. In contrast, California uses a variety of nonprofit and government agencies to provide case management in different areas throughout the state.

Within and among states, agencies use various approaches to carrying out case management. In some, one case manager performs all functions, while in others, the functions may be split between two case managers, one providing the initial assessment and another arranging the ongoing needs of the client. Some use a case management team, usually a nurse and social worker. In some states, case managers are able to delegate routine tasks, such as filling out paperwork or visiting clients with routine needs, to assistants with lesser qualifications.

No studies or evaluation data exist to demonstrate that one approach to case management is better than another.

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### What Functions Do Case Managers Perform?

GAO found that, regardless of an organization's approach, long-term-care case managers generally engage in a common set of practices: performing a comprehensive assessment of client needs, developing a care plan that meets those needs, coordinating the provision of services by a variety of providers, monitoring the provision of services and client status, and periodically reassessing client needs.

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### What Are the Essential Elements of Case Management? What Barriers Do Case Managers Face?

The case managers that GAO interviewed identified the knowledge, skills, and abilities necessary to perform key practices essential for effective case management. These include the ability to comprehensively assess client needs and manage time to have adequate contact with clients and the knowledge of resources available in the community. They also said it is important to receive continuing training to maintain and improve skills.

The case managers believe that, to the extent there are problems in carrying out these practices, they constitute barriers that could limit program effectiveness. Other barriers generally outside the control of local case management agencies include a lack of financial resources, inadequate availability of services in the local area, and extensive administrative requirements imposed by state administering agencies.

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### What Qualifications Do Case Managers Have?

The qualifications required of case managers vary considerably. Four states require a college degree (generally in social work or nursing) together with experience. The other two states do not have statewide hiring standards, leaving the decision on hiring criteria to local agencies. There are no evaluations that indicate the quality of case management services are better when performed by persons with higher educational qualifications.

There was no consensus among the case managers that GAO interviewed as to what educational or experience requirements best prepared people to be case managers.

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### What Case Management Standards Have Been Established?

Various state and local entities have established standards dealing with the core functions of case management. Many are similar in nature, although they may differ in the specific details. For example, each state that GAO visited required case managers to use a comprehensive assessment form when evaluating client needs. Each form was different but many addressed similar factors. In addition, each state established specific time frames for case managers to monitor and reassess client status. The specific time frames varied from state to state.

Case managers that GAO interviewed said that they had no problem with the standards that had been established by their respective states and/or local case management agencies. GAO believes that because of wide variations in operating conditions within and among states, standards should consider local needs and situations.

Two national organizations, the National Council on Aging and the National Association of Social Workers, have established standards for use by case management agencies that focus on the functions of case management and the qualifications of case managers. These standards provide broad guidance covering key elements that should be considered without specifying how those activities should be carried out.

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**Matter for  
Congressional  
Consideration**

If the Congress wishes to encourage more standardized case management by the states as part of its long-term-care initiatives, it should consider establishing broad standards for the core case management functions and case manager qualifications, and defer to state and local discretion such specifics as caseload size, client contact, and required education level and experience.

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**Agency Comments**

GAO did not obtain written agency comments on a draft of this report. However, GAO did discuss its contents with officials at the Department of Health and Human Services and incorporated their comments where appropriate.



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**Abbreviations**

AAA	Area Agencies on Aging
GAO	General Accounting Office
NASW	National Association of Social Workers
NCOA	National Council on Aging

# Introduction

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Improvements in health care and disease prevention have resulted in dramatic gains in life expectancies and a rapid growth in the number of older Americans. Today, more Americans are living to age 65 than ever before. In fact, the elderly population, age 65 and older, has increased more rapidly than the rest of the population for most of this century.

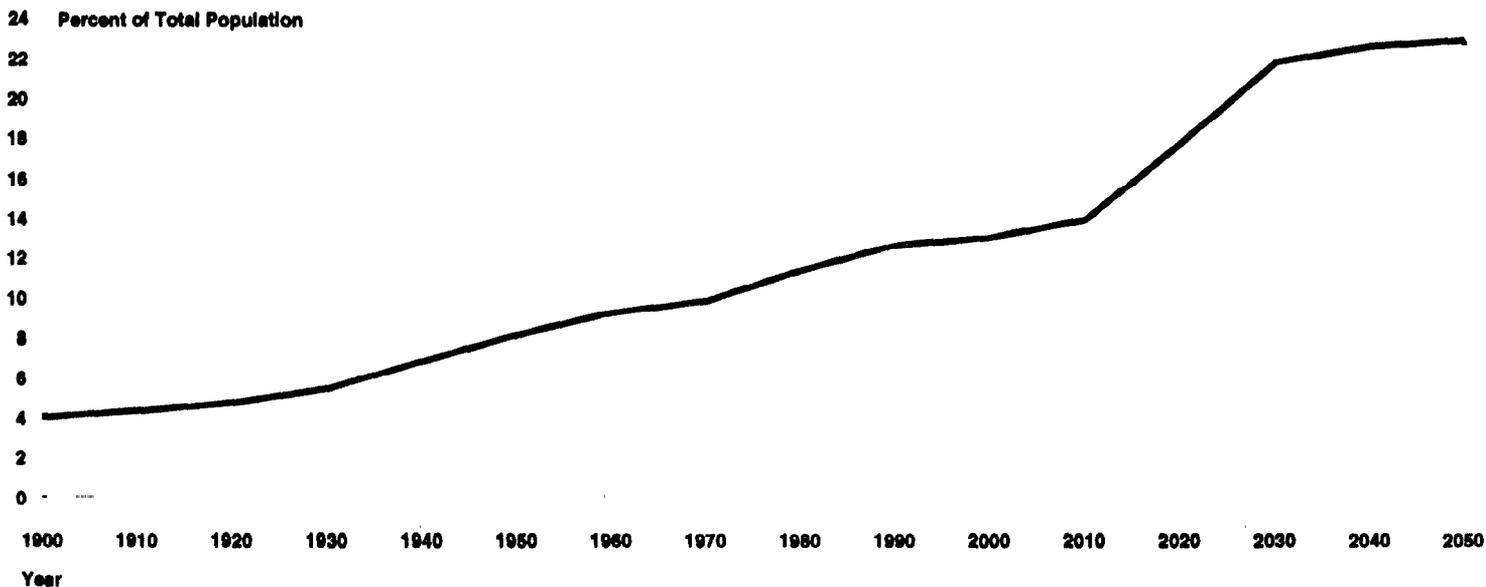
This increase in the elderly population has brought about a greater need for long-term-care health and social services. These services may be provided either in the elderly person's home, a community setting, or in a nursing home. Most elderly people prefer to remain in their homes or communities but many require assistance in obtaining the services they need, which may be offered by a wide array of agencies and providers. Case management—a process which assists people in defining their service needs, locating and arranging for services, and coordinating the services of multiple providers—has emerged as a way to assist the elderly in remaining in the community while also helping to contain costs of long-term care.

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## Background

The current 40-year trend of increases in the elderly population is projected to continue well into the twenty-first century. The number of Americans age 65 and older has increased from 12 million in 1950 to 32 million today. This number is projected to rise to 52 million by the year 2020, a 63 percent increase. The elderly are also increasing as a percentage of the population. In 1990, elderly people represented 13 percent of the total population and by 2020 will account for 18 percent of the total population. (See figure 1.1.)

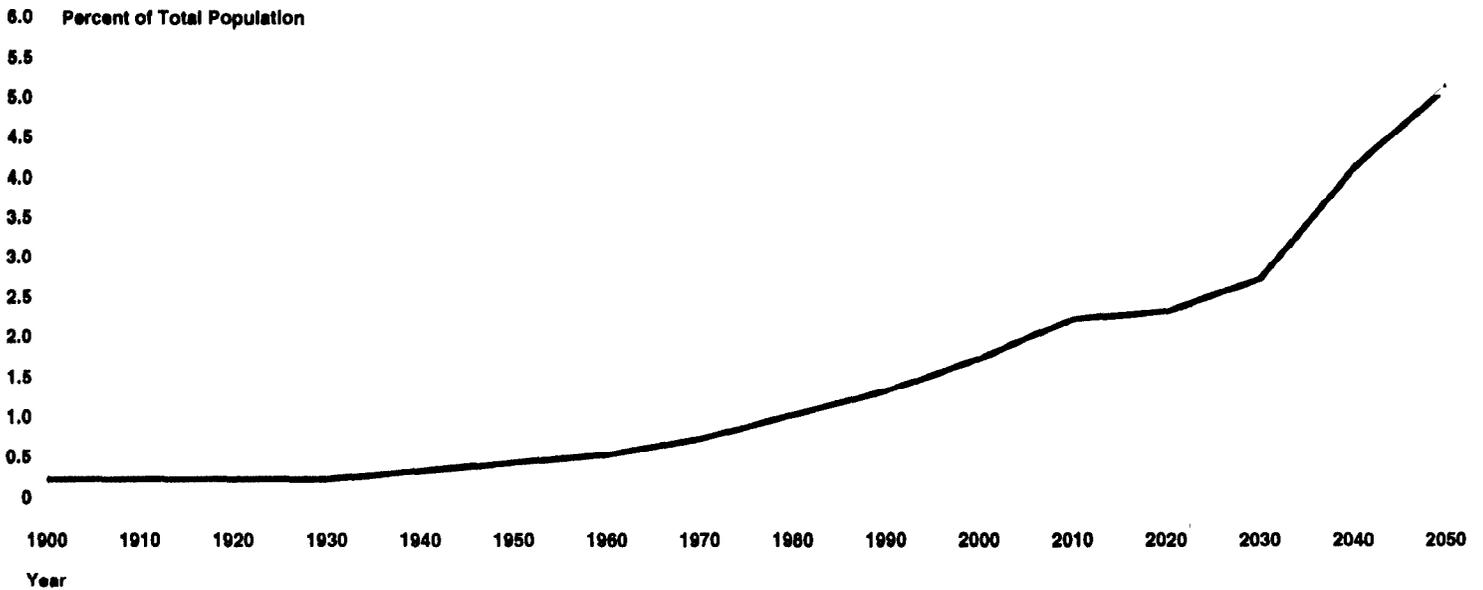
Figure 1.1: Growth of the 65+ Population as a Percent of Total Population



Source: Aging America Trends and Projections, 1991 Edition.

Moreover, the number of Americans age 85 and over is increasing faster than the entire elderly population and is one of the fastest growing age groups in the country. The number of people over 85 is expected to more than triple from 2.2 million in 1980 to 8.1 million in 2030 and be almost 7 times as large—over 15 million—by 2050. By 2050, about 5 percent of the total population will be age 85 and over. (See figure 1.2.) This age group will constitute about 22 percent of the elderly population.

Figure 1.2: Growth of the 85+ Population as a Percent of Total Population



Source: Aging America Trends and Projections, 1991 Edition.

Because more people are living longer, there will be an increased demand for long-term-care services, including both community-based and nursing home care. As people move into their 80's and 90's, the probability of decreased function, dependence on others, and risk of institutionalization substantially increases. According to a recent report,<sup>1</sup> total nursing home expenditures will nearly triple, from about \$38 billion in 1990 to \$113 billion by 2020. Home health care costs are also expected to increase from about \$8 billion in 1990 to \$20 billion in 2020. The federal government finances a portion of these costs primarily through the Medicare and Medicaid programs. As a result, federal expenditures are expected to increase from about \$9 billion to \$26 billion for nursing home costs and from about \$4 billion to about \$9 billion for in-home care costs.

<sup>1</sup>Aging America Trends and Projections, 1991 Edition, prepared by the U.S. Senate Special Committee on Aging, the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Administration on Aging. Projections are presented in constant 1989 dollars.

## Emergence of Case Management as a Component of Long-Term Care

Historically, nursing home care has been the primary option for elderly in need of any long-term-care services. However, most elderly people strongly prefer to remain in their homes and receive services in the community. Because in-home and community-based care are generally less expensive than nursing home care, expenditures for long-term-care services can be contained to the extent services can be provided in the home. Consequently, there has been a gradual expansion of in-home and community-based long-term care. However, these programs have grown in a fragmented fashion with varying eligibility requirements and they are often administered by different state agencies. As a result, elderly people may have difficulty locating and obtaining the services they need.

Case management has emerged as a response to this fragmentation and is considered to be one step toward improving the long-term-care system. Since the early 1970s the federal government has funded several demonstration projects to develop community-based long-term-care delivery systems and services. These projects included two common elements: an expanded variety of community-based services and case management. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), authorized the Secretary of Health and Human Services to issue waivers that allow states to use Medicaid funds to provide a variety of in-home and community-based long-term-care services—including case management—to Medicaid-eligible elderly individuals who would otherwise require institutional care. In addition to the waiver program, which is now operated in 42 states, many states also fund broader community care programs that provide services—including case management—to older people who require assistance with such daily living functions as bathing, transferring from a bed or a chair, dressing, getting to and using the toilet, and eating.

Case management is also a component of several recent legislative proposals on long-term care. However, the extent to which case management and case managers are defined varies with each bill. For example, the bills run the gamut from specifying academic and training requirements to those setting experience requirements and providing that other qualification standards may be set by the Secretary of Health and Human Services or the states. In addition, while one bill requires the case manager to review the plan of care within 3 months after initial determination of the need for services and every 6 months thereafter, others merely state that the case manager must review it periodically, at the request of a family member, or at a time specified by the Secretary of Health and Human Services.

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## Case Management Goals

Case management goals may be client-oriented, system-oriented, or both. Client-oriented goals focus on the needs of the individual, emphasizing the importance of providing appropriate care. System-oriented goals focus on the need to reduce unnecessary spending, thus providing long-term care in the most cost-effective manner. Gatekeeping and cost containment are terms frequently associated with system-oriented case management. Experts in the case management field describe these goals as shown below.<sup>2</sup>

### Client-Oriented Goals:

- To assure that services given are appropriate to the needs of a particular client.
- To monitor the client's condition in order to guarantee the appropriateness of service.
- To improve client access to the continuum of long-term care services.
- To support the client's caregivers.
- To serve as bridges between institutional and community-based care systems.

### System-Oriented Goals:

- To facilitate the development of a broader array of noninstitutional services.
- To promote quality and efficiency in the delivery of long-term care services.
- To enhance the coordination of long-term care service delivery.
- To target individuals most at risk of nursing home placement in order to prevent inappropriate institutionalization.
- To contain costs by controlling client access to services, especially high cost services.

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## Case Management Models

Various studies have identified three models of case management—a broker model, a service management model, and a managed care model.<sup>3</sup> Under the broker model, a case manager refers clients to other agencies for specific services they need. Such case managers cannot directly

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<sup>2</sup>Applebaum, R. & Austin, C. 1990. Long-Term Care Case Management: Design and Evaluation, Springer Publishing Co., p. 7.

<sup>3</sup>Applebaum, R., & Austin, C., Long-Term Care Case Management: Design and Evaluation; Austin, C. History and Politics of Case Management in Generations, *Journal of American Society on Aging*, Fall 1988; and Cline, B. Case Management: Organizational Models and Administrative Methods in *Caring Magazine*, July 1990.

purchase any services and, therefore, cannot guarantee that clients actually receive the services to which they were referred. In the service management model, which is used in the Medicaid waiver programs, a case manager negotiates with area providers who will deliver the services the case manager has authorized in each client's care plan. Under the managed care model, which operates like a health maintenance organization, clients pay a predetermined fee. Case managers are then responsible for providing all needed services to clients. Often the managed care agency will control costs by providing the service directly or by selectively contracting with outside providers to offer services to clients at a discounted price.

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## **Case Management Standards Established by Professional Organizations**

The National Council on Aging (NCOA) and the National Association of Social Workers (NASW) have developed standards for case management. The standards focus on the elements of case management and the professionalism of the case manager. NCOA and the NASW developed these standards for case management agencies to voluntarily adopt in order to foster quality case management. (See ch. 4 for further discussion of this topic.)

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## **Objectives, Scope, and Methodology**

In view of the recent legislative proposals for long-term care for the elderly, which include the use of case managers to assess and monitor client needs and coordinate client services, Representative Ron Wyden asked us to assist the Congress in determining (1) what, in practice, constitutes case management, the roles case managers play, and the barriers they face in performing their jobs; and (2) whether standards for case managers would best be defined in terms of professional qualifications, the functions of case management, or performance measures based on the experience of state officials and exemplary case managers.

To assist the Congress in its deliberations on these issues, we discussed case management with a number of experts and practitioners in the field. In addition, we reviewed the manner in which six states are using case management in long-term-care programs for the elderly. We discussed case management activities with the states' administering agency officials, case management agency officials, and selected case managers.

We selected six states—California, Connecticut, Massachusetts, Maryland, Oregon, and Washington—with a reputation for having innovative

long-term-care case management programs and different service delivery systems.

Within each state we reviewed case management operations at three local agencies. We selected agencies on the basis of their geographic location (including both urban and rural areas) and the number of case managers they employed. Furthermore, we selected agencies that administered state-funded programs, Medicaid waiver programs, or both.

At Representative Wyden's request, we agreed to discuss case management practices with case managers who were viewed by their superiors and peers as outstanding performers. For interview selection we asked case management agency directors to identify their five best case managers. To see if there was a consensus among management and case managers about who the best performers were, we also asked each case manager selected by agency directors to identify three co-workers whom they would consider to be among the best case managers. We interviewed additional case managers if they were identified by three or more of their peers. In total we conducted structured interviews with 95 case managers at 16 locations. As shown in table 1.1, many of the case managers selected by agency management were also considered the best by their peers.

**Table 1.1 Summary of Selection of Case Managers, by State**

Basis for selection	California	Connecticut	Maryland	Massachusetts	Oregon	Washington	Total
Management only	•	5	7	4	4	5	25
Management + 1 peer	1	4	5	7	6	3	26
Management + 2 peers	3	4	3	1	4	•	15
Management + 3 peers	1	2	•	•	•	2	5
Management + 4 peers	•	1	•	3	1	•	5
N/A*	10	•	•	•	•	5	15
Peers only	•	•	3	1	•	•	4
<b>Total for state</b>	<b>15</b>	<b>16</b>	<b>18</b>	<b>16</b>	<b>15</b>	<b>15</b>	<b>95</b>

\*At three agencies, we did not obtain peer selections from the case managers because there were relatively few case managers in the agency.

Our analysis of the structured interviews showed no difference among responses from those who were selected (1) only by management or (2) by management and their peers or by peers only.

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The purpose of our work at both the state and case management agency level was to obtain descriptive information about how the case management program operates including how case management is defined, the services case managers provide, their qualifications, and the number of clients they serve. We also obtained the views of case management agency officials as well as individual case managers concerning what they considered to be essential to case management and what barriers were impeding their ability to perform their job as effectively as they would like. Furthermore, we obtained the views of case managers on those areas where they believe standards are essential. Their views are summarized in chapters 3 and 4.

We conducted our work between July 1991 and November 1992 in accordance with generally accepted government auditing standards.

# Case Management Practices Vary but Most Involve Common Functions

Many different organizations are involved in long-term-care case management. Each of the six states we visited had its own unique organizational structure for providing case management to the elderly. In addition, the number and types of agencies providing case management varied considerably. Moreover, agencies used different approaches to the practice of case management and had different qualification requirements for case managers. Despite these differences, we found that case managers performed a common set of core functions in all the states we visited.

## Various Organizational Structures Used to Provide Case Management to the Elderly

The states we visited offered similar long-term-care programs to the elderly. Five of the states operated both a Medicaid waiver program and a state-funded program. The sixth state, Maryland, did not operate a Medicaid waiver program but had two state-funded long-term-care programs.

The states used different organizational structures to provide long-term-care case management to the elderly. Furthermore, the degree to which long-term-care programs were consolidated at the state level varied.

Oregon consolidated all long-term care responsibilities, including both institutional and community-based care, under a single agency, the Department of Human Resources. This agency managed Medicaid payments to nursing homes, Medicaid in-home and community-based waivers, the Older Americans Act,<sup>1</sup> and state general revenue funds earmarked to community care for the elderly. It also determined eligibility of elderly persons for public benefits, such as food stamps. Washington also consolidated its long-term-care programs under one agency, the Department of Social and Health Services.

In California and Massachusetts, the state Medicaid agencies have given day-to-day operating authority of the waiver program to other state agencies administering the state-funded long-term-care programs. In California, the Department of Health Services wrote the waiver for the Medicaid waiver program, implemented the program, and then, through an interagency agreement, gave day-to-day operating authority to the state Department of Aging. The state Department of Aging also administered California's state-funded community-based long-term-care program. In Massachusetts, the Medicaid agency, the Department of Public Welfare,

<sup>1</sup>The Older Americans Act of 1965 requires states to designate Area Agencies on Aging (AAA). These agencies provide various federally funded services to the elderly including information and referral, service coordination, outreach, and nutritional programs.

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**Chapter 2  
Case Management Practices Vary but Most  
Involve Common Functions**

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**granted the Executive Office of Elder Affairs day-to-day administering authority for the Medicaid waiver program. The Executive Office of Elder Affairs also administered the state-funded program in Massachusetts.**

**Both Maryland and Connecticut administered their programs through separate state level agencies.**

**Several different types of agencies provided case management services at the local level. These included Area Agencies on Aging (AAA), branches of state agencies, city and county agencies, private nonprofit organizations, and university affiliates. The number of agencies involved also varied. For example, in California five different types of agencies provided case management while in Connecticut one agency provided case management for the entire state. (See table 2.1.)**

**Chapter 2  
Case Management Practices Vary but Most  
Involve Common Functions**

**Table 2.1: State Community-Based  
Long-Term-Care Structures**

<b>State administering agencies</b>	<b>Long-term-care programs</b>	<b>Case management agencies</b>
<b>California</b>		
Department of Aging <sup>a</sup>	Medicaid waiver <sup>b</sup>	5 AAA, 6 county agencies, 9 private nonprofit agencies, and 2 universities
	State-funded <sup>b</sup>	3 AAA, 8 private nonprofit agencies, and 2 local agencies
<b>Connecticut</b>		
Department of Income Maintenance	Medicaid waiver	1 private nonprofit agency used by both departments
Department on Aging <sup>c</sup>	State-funded <sup>c</sup>	
<b>Maryland</b>		
Department of Human Resources	Both agencies	24 state branch offices of Department of Human Resources used by both agencies
Office of Aging	State-funded	
<b>Massachusetts</b>		
Executive Office of Elder Affairs <sup>a</sup>	Medicaid waiver State-funded	27 private nonprofit agencies (20 are AAA)
<b>Oregon</b>		
Department of Human Resources, Senior and Disabled Services Division	Medicaid waiver	11 AAA, 6 state agency branches
	State-funded	18 AAA
<b>Washington</b>		
Department of Social and Health Services, Aging and Adult Services Administration	Medicaid waiver State-funded	13 AAA

<sup>a</sup>Agency has been granted day-to-day administering authority by the state Medicaid agency.

<sup>b</sup>Programs do not operate statewide.

<sup>c</sup>The Department on Aging stopped enrolling new clients indefinitely in the spring of 1992. Clients enrolled at that time continue to receive services through the Department of Income Maintenance. Regulations for the state-funded program are currently being revised.

In addition, within each state, case management agencies may operate differently. Although the 27 case management agencies in Massachusetts

were of the same type, there were differences among them. For example, one of the case management agencies was unionized. The union negotiated a caseload size limit of 70. Other agencies in the state had no limit on caseload size. In addition, the AAA in Washington had the authority to contract the case management activities to other entities completely. As a result, the AAA that administered case management services were not necessarily providing them directly.

Agencies that performed case management were also involved in a variety of other activities. Case management agencies that were also AAA carried out Older Americans Act functions, such as providing information and referral services, facilitating development of senior centers, and coordinating transportation and nutrition programs. Other activities performed by agencies we visited included the licensing of care facilities, such as adult foster homes, and training home care providers and operating special programs, such as adult abuse and neglect investigations and outreach initiatives for minority or isolated communities. The degree to which case management agencies were involved in these other functions depended on the type of agency, its size and budget, community needs, and the requirements and authority granted by state and federal legislation.

We were unable to identify any comprehensive studies or evaluations showing that one system for providing long-term-care case management is more effective than another.

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## **Approaches to Case Management Vary**

The case management agencies we visited used different approaches to carry out the case management functions, including teams of social workers and nurses, specialized case managers, and case assistants.

Nurses and social workers may work as teams in Connecticut, California, Massachusetts, and Maryland. In general, teams conducted the assessment and developed the care plan together, and then one team member would take sole responsibility for carrying out the care plan, consulting with the other team member as needed. The case would be assigned to either the nurse or social worker based on whether the client's primary needs were medical or social. However, due to budget constraints and the high cost of employing nurses, some case management agencies did not assign nurses to manage ongoing caseloads. Thus, the social workers assumed the role of case manager. For example, in California, nurses were primarily used to conduct medical assessments and periodic level-of-care recertification.

Case managers may specialize based on the functions they perform or the type of caseload they carry. Case management agencies in Maryland as well as two of the three agencies we visited in Oregon, divided the case management functions between two case managers. An intake case manager assessed the client's needs and developed the care plan. Then an ongoing case manager assumed responsibility for implementing the care plan once a client's immediate needs had been met. Case managers may also develop expertise in working with specific types of cases, such as respite care or protective services. Case management agencies in Massachusetts and Washington used respite care case managers to arrange short-term services for an elderly person whose caregivers are temporarily unable to provide care. In addition, case management agencies in Maryland, Massachusetts, and Oregon also used protective services case managers to investigate instances where elderly people may be subject to abuse. These case managers provided various services to elderly clients who had been subjected to abuse, neglect or financial exploitation. Specialized case managers may have smaller caseloads because their work tends to involve short-term crisis-oriented situations that demand constant attention.

Case management agencies in Washington used one case manager to perform all case management functions. These agencies hired both nurses and social workers as case managers.

Case management agencies in Connecticut, Oregon, and Washington employed case assistants to perform routine tasks, including arranging services or monitoring clients. Generally, case managers who had assistants told us that this practice was very helpful and allowed them to concentrate on the more complex aspects of their jobs, such as performing assessments, dealing with sudden changes in a client's condition, or helping the client cope with the loss of a caregiver.

We found no studies that compared the effectiveness of different approaches to case management.

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## **Commonality Within Case Management Functions**

Although the six states we visited had various organizations and approaches to carrying out the process of case management, we found that case managers in each state performed a common set of five core functions: (1) performing a comprehensive assessment of the client's needs, (2) developing a care plan based on the needs identified in the assessment, (3) arranging services to meet those needs, (4) monitoring

**Chapter 2  
Case Management Practices Vary but Most  
Involve Common Functions**

client status through regularly scheduled contacts, and (5) reassessing the client's needs and care plan periodically. Table 2.2 describes these functions.

**Table 2.2: Case Management Core Functions**

Assessment	Identifying a person's physical, functional, cognitive, social/emotional, environmental, and financial needs. Assessment also considers the availability of an informal support system and involvement of other agencies.
Care Planning	Developing a plan to meet the needs identified in the assessment with the most appropriate services. A written care plan establishes 1) what services will be provided, 2) who will provide them, 3) when they will be provided, and 4) who will pay for them.
Arranging Services	Negotiating with and securing service providers from a wide range of community resources to implement the care plan.
Monitoring Clients	Contacting the client, family, caregivers, and providers regularly to ensure that services are being provided in accordance with the care plan. Monitoring includes regularly scheduled in-person visits.
Reassessment	Reviewing on a regularly scheduled basis the client's status to determine if any changes have occurred which would require amending the care plan.

In addition to the core functions, case managers may perform other functions that are specific to their own agency. These additional functions may include:

- screening a client to determine functional and financial eligibility for case management;
- authorizing the start-up and/or payment of services;
- monitoring organizations providing homemaking, nursing, personal care, and other services;
- providing outreach services, such as informing the general public and other service providers about the benefits of case management, to assure appropriate referrals and coordinate service delivery in the community;
- providing support, assistance, and information to the family members to help them care for their elder relative and cope with the stresses of caregiving; and
- planning for program termination when a client no longer requires case management.

Some case managers also identified advocacy as an additional and important function that they regularly performed on behalf of the client.

Others stated this was a role they periodically assumed. As an advocate, the case manager assures that the client receives appropriate services of high quality and seeks to locate additional services not readily available in the community.

In some case management agencies, these additional functions may be performed by persons other than case managers. For example, Connecticut, Massachusetts, and Washington employed intake workers who screen each referral to ensure that only those who actually need and are eligible for case management enter the program.

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## **Case Managers Arrange Similar Services**

Case managers at the programs we visited arranged a variety of services for their clients. Generally, these services were similar across the six states. Under the Medicaid waiver program as well as state funded programs, case managers typically coordinated the delivery of many long-term care services, including:

- homemaker/chore services,
- personal care services,
- home health aide services,
- skilled nursing and rehabilitation,
- adult protective services,
- adult day health,
- home delivered meals,
- transportation services, and
- respite care.

These services were often provided by several different long-term-care providers. Generally homemaker/chore and personal care services were the most frequently authorized services.

# Essential Elements of and Barriers to Case Management

Case managers need the following knowledge, skills, and abilities to carry out their jobs in an effective manner:

- skills to comprehensively assess the client for both medically and socially oriented needs;
- detailed knowledge of the service providers in their area and the quality of care they provide; and
- ability to manage their time effectively so they can visit with their clients and monitor their progress, the quality of service delivered by providers, and changes in client condition which may require a change in the care plan.

Case managers also need on-going training to maintain and improve their performance.

Shortcomings in any of the above may create barriers that could prevent case managers from performing their jobs as effectively as they might like. Other barriers generally outside the control of the case management agencies, which can significantly impact on the case management process, include: (1) lack of financial resources, (2) inadequate availability of services and (3) extensive paperwork or documentation requirements of state administering agencies.

## Case Management Should Be Holistic and Involve the Client

The case management process should focus on meeting the client's medical as well as social needs. A number of the case managers we interviewed told us that

- using a standard assessment form which covered the client's functional, medical and social status, is one way of assuring that each client receives a comparable, comprehensive evaluation.
- it is essential that they develop a care plan that meets all the needs of the client and continually review this plan.
- assessment and care planning should involve the client as much as possible and the assessment should be completed in the client's home to accurately assess the actual living conditions and health and mental status of the client.
- it is important to obtain the client's, as well as the family's, acceptance of the care plan to enhance the success of the program.

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**Knowledge of  
Providers Aids  
Service Coordination**

In order to efficiently coordinate services for the elderly client, it is essential that case managers be aware of the providers in the area and the quality of the services they provide. Many of the agencies we visited maintained a resource file that identified area providers, as well as a record of their past performance, which was available to case managers in the agency. Other agencies used less formal mechanisms, such as posting pamphlets on bulletin boards, to disseminate this information to the staff.

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**Reasonable Caseloads  
Promote Adequate  
Time for Monitoring  
Clients**

Large caseloads limit the ability of case managers to give clients sufficient attention to assure that clients' needs are being met and services are being provided adequately. Other effects of large caseload sizes include limited time available to spend with each client, and an increased risk of burnout for case managers.

Case managers recognized the difficulty in keeping caseload sizes small. For example, in California, the number of eligible older persons was continuing to rise while funding for case management activities was not. In Maryland, case management agencies were required to serve all eligible clients that entered the system, which could result in increased caseloads, reducing the time available to adequately serve each client. In Massachusetts, over the past 3 years, the number of case manager positions was reduced by approximately 200 positions. As a result of situations such as these, some case managers in the states we visited were carrying caseloads that exceeded state standards and which could impact on the quality of case management services they were providing.

In addition, several case managers responsible for large rural areas in some states we visited spent considerable time traveling to see their clients, which limited the amount of time they could spend visiting clients. Sometimes, due to the long distances between clients, case managers could not visit clients in rural areas as often as those clients who reside closer to the case management agency.

Face-to-face visits are essential for case managers to accurately monitor their clients. However, as a result of time constraints exacerbated by large caseloads, some case managers found it difficult to meet agency standards on face-to-face visits for all their clients. For example, one case manager in Massachusetts said her caseload was too high to provide the level of services clients needed. She was forced to deal with clients' crises only and could not maintain regular contact with all of her clients. Another case manager in Massachusetts said that with average caseloads running as

high as 90 cases, it was impossible to manage all the telephone calls, progress notes, visits, meetings, and training that the job required.

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## **On-Going Training for Case Managers Is Important**

On-going training is essential for quality case management. It expands case managers' knowledge of the aging process and the medical and social problems the elderly encounter; introduces them to techniques, such as time management, to help them be more efficient; and enables them to keep abreast of regulatory changes. Most of the case managers stated that up to 5 days of training per year were needed to maintain and improve their skills.

Case managers stated that training in the following areas was helpful:

- family dynamics;
- stress and time management;
- computers;
- interviewing and interpersonal skills;
- medical issues, such as terminology, medications, and diseases;
- legal issues, such as elder abuse and guardianship;
- the aging process and aging myths;
- substance abuse; and
- cultural and spiritual diversity.

All of the agencies we visited offered their case managers training. The training provided covered many of these areas.

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## **Barriers Case Managers Face**

In addition to problems caused by shortcomings in the above areas, case managers faced other barriers that may have prevented them from performing their jobs as effectively as they might like. These barriers can be grouped into three categories:

- lack of financial resources,
- scarcity of services, and
- excessive administrative requirements.

Unlike the areas discussed above, however, case managers had little control over these barriers.

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**Lack of Funding**

Lack of sufficient funding for long-term-care programs was a major concern of case managers in all states we visited. For example, Massachusetts had the lowest salaries for case managers among the states we visited—\$16,500-\$20,500. The other states starting salaries ranged from \$21,000 to \$29,000, and maximum salaries ranged from \$32,000 to \$49,000. A Massachusetts official told us that there was a high turnover rate among case managers, which was primarily due to the low salary. In California, neither the Medicaid waiver program nor the state funded program was offered statewide because of limited state funds. This made it difficult to serve the entire elderly population and those elderly who moved to other parts of the state could quite possibly lose their services. Furthermore, California was anticipating further budget reductions and officials stated that some services may be taken away from certain clients as the eligibility requirements become stricter due to the smaller budget. Connecticut was also experiencing financial difficulty. The Connecticut state legislature discontinued additional client intake for its state-funded home care program. Although some of the program's clients will continue to receive services, no new clients will be admitted to the program. All of these financial limitations create gaps in the long-term-care service delivery system.

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**Scarcity of Services**

A second type of barrier was a scarcity of services, both in terms of the quantity and quality of services. For example, California's long-term-care programs required the use of a particular state-funded home care program for services such as personal care and housekeeping. Through the home care program, clients of all long-term-care programs in the state were allotted a certain number of home care hours each month. Use of this program was mandatory. However, the number of hours of home care provided often fell short of clients' needs, and case managers had to supplement services provided by this program with those of other programs whose workers were paid up to five times as much.

Case managers told us that workers in the mandatory program were paid minimum wage, not adequately trained, and generally of low quality. Because of the variation in quantity and quality between the mandatory and supplemental program, case managers in California had no control over the quality of services provided. Case managers in Washington and Oregon reported similar quality problems with low-paid under-trained home care providers.

Several case managers in Maryland, Massachusetts, Washington, and Connecticut said that the lack of available services made it difficult to provide clients with adequate support. In addition, one case manager in Washington told us that there was a lack of culturally sensitive services, such as special meal programs for Asian elders. As a result, outreach programs to attract these minorities to the programs were ineffective because the services did not meet the cultural needs of the population groups.

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**Administrative**  
**Requirements**

Case managers also faced many administrative requirements that required large amounts of their time, thus limiting the amount of time available for direct client contact. Many case managers in all states told us that the paperwork requirements from both federal and state sources were overwhelming and in their opinion burdensome. For example, case managers in Massachusetts said their assessment form was too long and cumbersome and the information collected did not always relate to the clients' actual needs. Although case managers generally recognized the importance of documenting clients' status, extensive paperwork or documentation requirements decreased the amount of time case managers could spend either visiting their clients or working on their plans of care.

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# Standards Established for Case Management Activities

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State and local agencies along with other organizations, such as the National Council on Aging (NCOA) and the National Association of Social Workers (NASW), have established a number of case management standards. These standards typically address the core functions of the case management process, caseload size, and case manager qualifications. However, the standards often vary in specifics, such as what a care plan should cover, what constitutes a reasonable caseload size, and what level and type of education case managers should have. The case managers we interviewed generally had no problem with the standards that had been established by their respective state, case management agency, or both. They indicated the standards contributed to their ability to maintain an adequate level of efficiency, quality, and professionalism in the case management field. However, they expressed concern that if the Congress enacts some form of long-term-care legislation, which provides a specific role for case managers, it should not establish overly prescriptive national standards that would uniformly apply to all states.

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## Standards for the Core Functions

Each state we visited had established several standards for the core functions of case management—assessment, care planning, service coordination, monitoring, and reassessment. As discussed below, the specific requirements varied from state to state.

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## Client Assessment

Each of the six states we visited required case managers to use a common assessment form when conducting a comprehensive needs assessment. In each state, the assessment forms addressed six main topics: medical needs, functional capacity, cognitive abilities, safety and environmental considerations, financial situation, and social needs. Although the forms differed, the specific information to be collected was basically the same and allowed case managers to identify a client's medical and social needs. In addition, case managers in all states were required to conduct a home visit during the assessment process.

Virtually all the case managers we interviewed told us that it was important to have standards, such as those discussed above, for the assessment process. These standards help ensure that sufficient and relevant information is collected and a client's needs are identified accurately and promptly. Furthermore, because case managers determine eligibility using the results of the assessment, a standard form also helps to ensure equitable access into the program.

**Care Planning**

In all 6 states, case managers were required to obtain input from clients and, whenever possible, their families and service providers, when developing a care plan. In addition, the states required case managers to complete preparation of the care plan within a certain period of time. Five of the states established time frames for initiating the assessment and completing the care plan; one state established only a time frame for completing both functions. (See table 4.1).

**Table 4.1: State Standards for Initiating Assessment and Completing the Care Plan**

<b>State standards</b>	<b>Maximum time frame to initiate the assessment</b>	<b>Maximum time frame to complete the care plan</b>
California	Within 2 weeks of initial contact	Within 2 weeks of assessment
Connecticut	Within 7 days of initial contact	Within 1 week of assessment
Maryland	Within 5 days of referral	Within 30 days of application date, the case manager must complete the assessment and care plan
Massachusetts	Within 10 days of initial contact	Within 30 days of initial contact
Oregon	None; one standard established for both functions	Within 45 days of initial contact, the case manager must complete the assessment and care plan
Washington	Within 5 days of referral	Within 30 days of the initiation of the assessment

Virtually all of the case managers stated that standards for developing a care plan were essential. These standards help improve the care planning process by gaining clients' and families' acceptance of the plan and helping to ensure that clients receive services they need within reasonable periods of time.

**Service Coordination**

In coordinating services identified in the care plan, states generally gave case managers authority to purchase services with specified funding limits as illustrated in table 4.2.

**Table 4.2: Case Managers' Authority to Purchase Services**

<b>State</b>	<b>Authority</b>
California	Two agencies placed financial limits on entire caseload size; one agency established monthly spending limits for each client
Connecticut	Case management agency established annual spending limit for each client
Maryland	Case managers do not purchase services directly but refer clients to service agencies
Massachusetts	Limited number of service hours per client
Oregon	No assigned budget per client but amounts spent per client cannot exceed certain service limits without prior approval from agency or state management officials
Washington	Limited number of service hours and monthly spending limits per client

Some Maryland case managers said that having the ability to authorize services within specific funding limits would give them greater control over the implementation of the care plan and greater assurance that needed services would be provided. Case management agency officials in California told us that spending limits based on average expenditures allowed case managers more flexibility to arrange services for clients whose needs exceeded the average for a short period of time, such as when they enter the program. One agency official in Washington said he would prefer that spending limits be based on average expenditures to increase flexibility.

**Client Monitoring and Reassessment**

States had also established standards for monitoring and reassessing clients. These standards essentially addressed the frequency with which clients were to be contacted. The standards generally provided for at least a monthly telephone contact and face-to-face visits at some less frequent interval. However, the specific time frames varied among states. (See table 4.3). For example, case managers in Massachusetts had to reassess their clients every 6 months while case managers in California reassessed their clients annually. Several case managers told us that they usually contacted clients more frequently than the state standards required to assure that the client's condition was stable.

**Table 4.3: Requirements for Frequency of Client Contact**

	California	Connecticut	Maryland	Massachusetts	Oregon	Washington
Telephone contact	Monthly	Monthly	No requirement	No requirement	No requirement	Monthly
Face-to-face visits	Every 3 months	Every 6 months	Every 3 months	Every 6 months	Every 6 months	Every 6 months
Reassessments	Annually	Annually	Every 6 months	Every 6 months	Every 6 months	After initial 30 and 90 days; annually thereafter

Case managers stated that requirements for monitoring and reassessing clients, similar to those already established, were essential. Face-to-face visits help ensure that clients' social and health status are periodically reviewed for changes and that information gathered from the clients over the telephone—or from their families or providers—is accurate. Furthermore, scheduled reassessments assure that changes in the client status are accurately reflected through revisions to the care plan.

## Standards for Caseload Size

Each of the six states we visited had established standards for caseload sizes. However, due primarily to differing fiscal and operating conditions, there was wide variation among these standards.

In Oregon, because case managers were responsible for clients in various settings, the state had established several standards for caseload size depending on the type of client. For example, because clients in a nursing home typically require less assistance from the case manager than a community-based client, the caseload standard for nursing home clients was significantly higher than that for community-based clients—130 and 69, respectively. Furthermore, for clients in other types of less comprehensive institutions, such as adult foster homes, the caseload standard was slightly lower at 79. Case managers in Oregon maintained caseloads that represent a mix of these client types. Table 4.4 lists caseload size standards for the states we visited.

**Table 4.4: State Standards for Caseload Size**

State	Caseload Standard	
	Client type	Size
California	Community-based	40
Connecticut	Community-based	70 <sup>a</sup>
Maryland	Community-based	50
Massachusetts	Community-based	65 <sup>b</sup>
Oregon	Community-based	69
	Adult foster homes	79
	Residential care facilities	100
	Nursing homes	130
Washington	Community-based	50

<sup>a</sup>This is not a state standard, but a standard set by the case management agency.

<sup>b</sup>This is a recommendation, not a standard. Because of budgetary constraints, Massachusetts is unable to hire enough case managers. Therefore, the Executive Office of Elder Affairs in Massachusetts only recommends a caseload size of not more than 65.

The number of cases assigned to a case manager often exceeded the standard. For example, although in Massachusetts the Executive Office of Elder Affairs recommended a maximum caseload of 65, case managers we interviewed said their caseloads were running as high as 90. In addition, Connecticut's case management agency set a standard caseload size at 70. Case managers we interviewed said their caseloads were running as high as 85.

Similarly, the California standard for caseload size was 40, but it was common for case managers to have up to 48 clients. The standard was developed with the understanding that the nurse case managers on staff would be carrying caseloads. However, because of the high cost of employing nurses, nurse case managers in California did not typically carry a caseload; rather they assessed and reassessed all clients and provided input to client care on an as-needed basis. As a result, the social work case managers typically carried caseloads higher than the state standard to account for cases that would have been assigned to a nurse.

Although most case managers stated that a limit on the number of cases that could be assigned to them was necessary to maintain the quality of case management services, they did not agree on what the standard should be, even within agencies. Many case managers were content with the standards already established by their agency, while others stated the standard should be lower. Case managers stated that the reasonableness

of the caseload size is dependent on the needs of the clients and the amount of resources, such as case assistants, that are available.

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## **Qualification Standards**

Some states we visited had established specific statewide educational and experience requirements for case managers. Others allowed case management agencies to develop their own hiring requirements.

Washington, Maryland, California, and Connecticut all had statewide education and experience requirements. Generally, these states required a degree in a human or social services field with relevant experience. For example, the state of Washington required a case manager to possess the following:

- a master's degree in a behavioral or health related science and 1 year of related work experience; or
- a bachelor's degree in a behavioral or health related science and 2 years of related work experience; or
- a bachelor's degree in any field and 4 years of related work experience.

In contrast, Massachusetts and Oregon did not have statewide educational requirements. The local case management agencies could establish their own requirements. For example, the requirements for one local agency in Massachusetts stated that a degree in a human services field was preferred but equivalent experience with the elderly or in case management could be substituted. In Oregon, case managers worked for either the state or for local agencies. Case managers seeking employment with the state had to complete a detailed application describing their experience and knowledge of specific subjects, including clients' rights, confidentiality, resource coordination, communication, and advocacy. Agencies in Oregon employing their own case managers set their own hiring requirements.

States also have established hiring requirements for the knowledge, skills, and abilities applicants must possess. Typically, these requirements were consistent across the states. Examples of qualifications in these three areas used by states are shown below.

Knowledge:

- community resources,
- medical terminology and disease processes affecting the elderly,
- case management principles and practices,
- clients' rights, and
- state and federal laws for public assistance.

Skills:

- time management,
- assessment/evaluation,
- interviewing, and
- listening.

Abilities:

- preparing care plans,
- coordinating delivery of services,
- advocating for the client,
- communicating both orally and in writing,
- establishing and maintaining cooperative working relationships,
- maintaining accurate and concise records,
- assessing medical and social aspects of each case and formulating service plans accordingly,
- problem solving, and
- remaining objective while accepting the clients'/families' lifestyle.

Officials from California and Washington told us that due to lack of qualified applicants—especially nurses—the agencies occasionally encountered difficulties in recruiting people who met these standards. On occasion, local case management agencies in those states were granted waivers from the state to allow them to hire case managers who did not meet the state standard.

In practice, the case managers we interviewed represented a wide range of academic backgrounds. (See table 4.5). Moreover, case managers often had social service experience before becoming case managers.

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**Table 4.5: Qualifications of 95 Case Managers**

Highest degrees held	No. of managers	Work experience	No. of managers
<b>California</b>			
Doctorate - other <sup>a</sup>	1	Work with elderly	7
Master's - social work	5	Social services work	7
Master's - human services	2	No relevant experience	1
Bachelor of Science - nursing	4		
Bachelor's - human services	2		
Bachelor's - other <sup>a</sup>	1		
<b>Connecticut</b>			
Master's - social work	5	Work with elderly	15
Master's - human services	6	Social services work	1
Bachelor of Science - nursing	4		
Bachelor's - human services	1		
<b>Maryland</b>			
Doctorate - law	1	Work with elderly	7
Master's - social work	6	Social services work	5
Master's - human services	1	No relevant experience	6
Master's - other <sup>a</sup>	2		
Bachelor of Science - nursing	1		
Bachelor's - human services	7		
<b>Massachusetts</b>			
Doctorate - law	1	Work with elderly	13
Master's - human services	1	Social services work	3
Master's - other <sup>a</sup>	1		
Bachelor's - human services	4		
Bachelor's - other <sup>a</sup>	1		
Associate's - human services	2		
High School	6		
<b>Oregon</b>			
Doctorate - human services	1	Work with elderly	11
Master's - human services	1	Social services work	1
Master's - other <sup>a</sup>	1	No relevant experience	3
Bachelor's - human services	9		
Bachelor's - other <sup>a</sup>	1		
High School	2		

(continued)

**Chapter 4  
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<b>Highest degrees held</b>	<b>No. of managers</b>	<b>Work experience</b>	<b>No. of managers</b>
<b>Washington</b>			
Master's - social work	4	Work with elderly	11
Master's - human services	2	Social services work	2
Master's - other <sup>a</sup>	1	No relevant experience	2
Bachelor of Science - nursing	1		
Bachelor's - human services	5		
Bachelor's - other <sup>a</sup>	2		

<sup>a</sup>Other may include education, science, communications, business, divinity, or liberal arts degrees.

Case managers stated that some hiring criteria were essential to promote consistency in the quality of case managers. However, there was no consensus as to what educational or experience requirements best prepared people to work as case managers. Educational requirements suggested by case managers ranged from a high school diploma to a master's degree. Some case managers told us that they felt prior experience was not necessary while others felt at least 2 years experience working with the elderly was essential. Generally, case managers felt that some combination of degrees and experience in the social service field was necessary.

We found no evaluations that indicate that the quality of case management services are better when performed by persons with higher educational qualifications.

## **Federal Standards Not Desired**

While case managers believed standards addressing the core functions of case management, caseload size, and the qualifications of case managers were important, they generally considered the standards established by their respective states or organizations to be adequate. A number of case managers believed that specific federal case management standards should not be included in any long-term-care legislation, but that state or local agencies should be given the flexibility to develop their own standards and determine how to best meet them. Others stated that the federal government could provide state and local entities guidelines regarding where standards should be established which could be used by these entities to establish specific standards.

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## **Case Management Standards Established by Professional Organizations**

NCOA and NASW have established standards for case management. NCOA's standards cover the following:

- goals of the case management process;
- roles of the case manager;
- elements of the process, including intake/screening, assessment, care planning, service delivery, monitoring, reassessment, discharge or termination
- outreach;
- case manager qualifications;
- caseloads;
- training;
- supervision;
- record keeping; and
- evaluation and quality assurance.

According to NCOA, the standards are purposely generic and applicable to all types of long-term-care management operating in various organizations and settings. NCOA's standards relating to each of the above areas vary considerably in level of specificity. For example, NCOA standards for the assessment process discuss what should be covered by the assessment process and provide that the process should use a standardized tool, be conducted by trained persons and be done within a minimum timeframe. The NCOA standards do not prescribe how to carry out the assessment process, the specific tools to be used, the types of training to be provided, or the timeframes for completing the assessment.

NASW has developed guidelines that call for (1) a multidisciplinary assessment of client needs, (2) development of care plans that incorporate client expectations and agreed on goals, (3) arranging a continuum of informal and formal service and ensuring that these services are effectively used, and (4) periodic monitoring of the care clients are receiving. NASW guidelines are not specific as to how these activities are to be carried out or the timeframes for completing each task.

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## **Conclusions**

Standards are important and can provide a framework useful in overseeing the case management process. Our review suggests that standards might best be defined in terms of the five core functions of case management, recognizing the knowledge, skills, and abilities case managers need to perform their job. Because of variations in state and local organizational structures, economic situations, geography, and client demographics, we

believe that, if the Congress desires to have federal standards, broad standards similar to those already established by organizations like NCOA or NASW would be most appropriate. We believe that specific details concerning how the case management process is to operate and the qualifications case managers should possess are best determined at the state and local level.

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**Matter for  
Congressional  
Consideration**

If the Congress wishes to encourage more standardized case management by the states as part of its long-term-care initiatives, it should consider establishing broad standards for the core case management functions and case manager qualifications, and defer to state and local discretion such specifics as caseload size, client contact, and required education level and experience.



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# Agencies Visited

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## California

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### State Agencies

Department of Health Services, Sacramento  
State Department of Aging, Sacramento

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### Case Management Agencies

County of Santa Cruz Human Resources Agency, Santa Cruz  
San Francisco Institute on Aging, San Francisco  
Sonoma County Area Agency on Aging, Santa Rosa

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## Connecticut

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### State Agencies

Department of Income Maintenance, Hartford  
State Department on Aging, Hartford

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### Case Management Agency

Connecticut Community Care, Inc., Bristol

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## Maryland

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### State Agencies

Department of Human Resources, Baltimore  
Office on Aging, Baltimore

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### Case Management Agencies

Baltimore City Department of Social Services, Baltimore  
Montgomery County Department of Social Services, Rockville  
Prince George's County Department of Social Services, Landover

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## Massachusetts

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### State Agencies

Department of Public Welfare, Boston  
Executive Office of Elder Affairs, Boston

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**Appendix I  
Agencies Visited**

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<b>Case Management Agencies</b>	<b>Central Boston Elder Services, Boston Elder Services of the Merrimack Valley, Lawrence Mystic Valley Elder Services, Malden</b>
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<b>Case Management Agency Association</b>	<b>Massachusetts Home Care Association, Burlington</b>
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**Oregon**

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<b>State Agency</b>	<b>Department of Human Services, Senior and Disabled Services Division, Salem</b>
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<b>Case Management Agencies</b>	<b>Multnomah County Aging Services Division, Portland Mid-Willamette Valley Senior Services Agency, Salem Washington County Department of Aging Services, Hillsboro</b>
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**Washington**

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<b>State Agency</b>	<b>Department of Social and Health Services, Aging and Adult Services Administration, Olympia</b>
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<b>Case Management Agencies</b>	<b>Lewis-Mason-Thurston Area Agency on Aging, Olympia Seattle King County Division on Aging, Seattle Southwest Washington Area Agency on Aging, Vancouver</b>
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# Tables Supporting Figures in Report

**Table II.1: Growth of the 65+ Population as a Percent of Total Population (Data for Fig. 1.1)**

Year	Percent of population
1900	4.0
1910	4.3
1920	4.7
1930	5.4
1940	6.8
1950	8.1
1960	9.2
1970	9.8
1980	11.3
1990	12.6
2000	13.0
2010	13.9
2020	17.7
2030	21.8
2040	22.6
2050	22.9

**Table II.2: Growth of the 85+ Population as a Percent of Total Population (Data for Fig. 1.2)**

Year	Percent of population
1900	0.2
1910	0.2
1920	0.2
1930	0.2
1940	0.3
1950	0.4
1960	0.5
1970	0.7
1980	1.0
1990	1.3
2000	1.7
2010	2.2
2020	2.3
2030	2.7
2040	4.1
2050	5.1

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# Major Contributors to This Report

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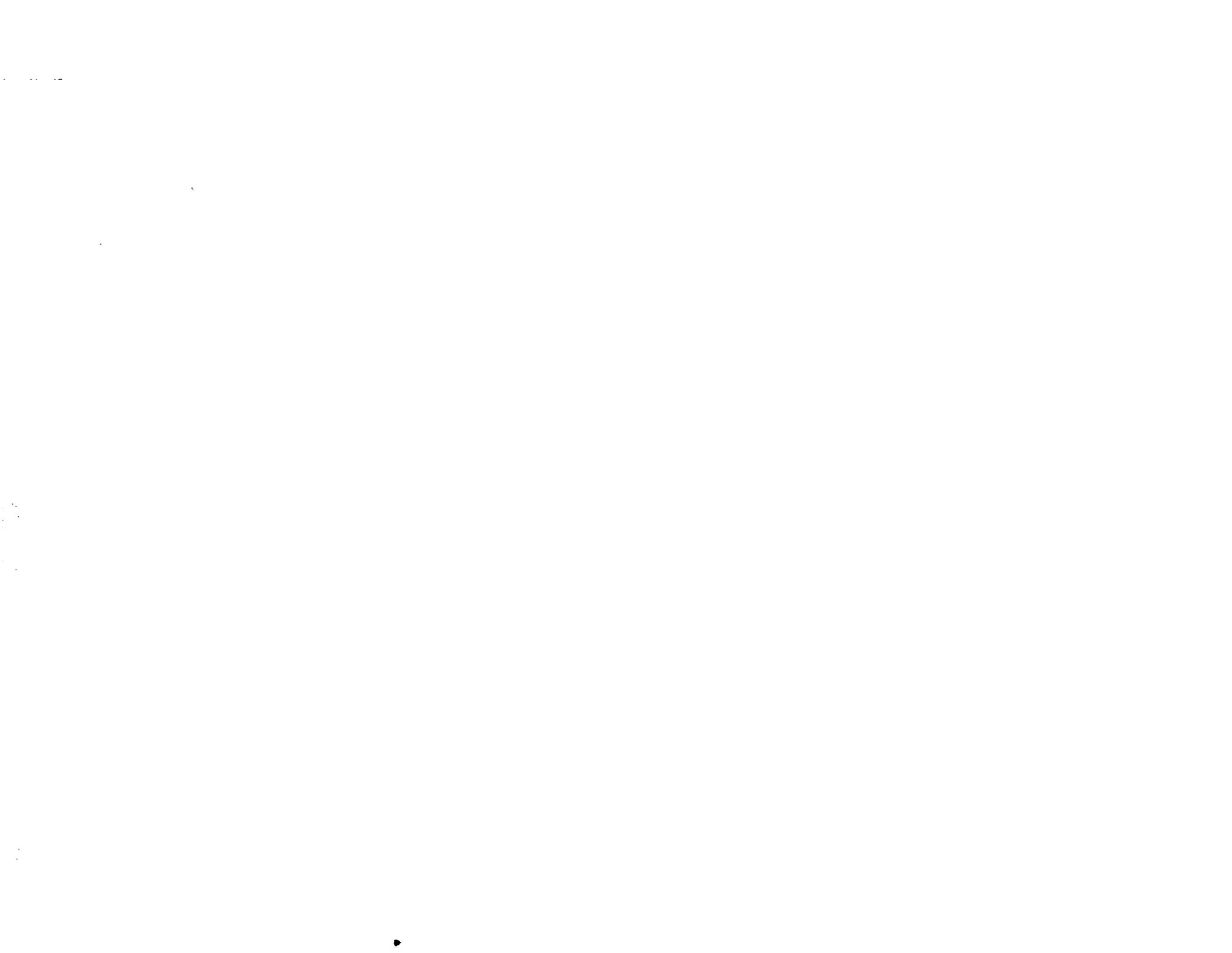
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