Seniors-at-Home: A Case Management Program for Frail Elders

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Abstract

- **Objective:** To describe a case management program to provide social services to frail elders living at home.
- **Setting:** The San Francisco Bay Area in northern California.
- **Program:** The Seniors-at-Home (SAH) program identifies at-risk seniors through a referral network that includes health maintenance organizations, hospitals, and physician offices. A geriatric care manager conducts a detailed health status assessment in the patient’s home, documenting any unmet activities of daily living and instrumental activities of daily living, social support needs, emotional status, any unaddressed health issues, and power of attorney status. A level of care is assigned, and an individualized care plan is developed. The care manager arranges for necessary resources to address the patient’s needs.
- **Results:** Frail elders receive services that improve their quality of life and reduce utilization of unnecessary medical services.
- **Conclusion:** This collaborative model provides for timely intervention to assist frail elderly at risk for increased utilization of medical resources as a result of social problems.

Within the next 2 decades, 55 million people in the United States will be older than 65 years and 13 million will be over 85 years. While a substantial portion of older adults remain independent in daily function throughout their lives, a significant number will have chronic illnesses that diminish their ability to carry out the activities of daily living (ADLs). The majority of those over age 85 will be frail and isolated and have social problems that compound their medical problems. Frail elders are at greater risk for falls, disability, hospitalization, and mortality.

Jewish Family and Children’s Services of San Francisco, the Peninsula, Marin and Sonoma Counties, a nonprofit social service agency, has developed an intervention model to address the needs of the frail elderly living in the community. Seniors-at-Home (SAH) is a social work-based case management program to improve health outcomes for at-risk seniors. The program, which received the American Society on Aging award for quality and innovation in managed care and aging in 1999 and 2001, helps elders to access in-home services that enable them to remain living safely in the community, thereby reducing the use of unnecessary medical services. This paper will describe the intervention model and our methods of tracking the delivery and impact of services.

Program Description

Setting

SAH serves the San Francisco Bay Area in northern California, a densely populated urban environment made up of 9 counties with over 6.2 million people. The area is ethnically and linguistically diverse, with 36% of households speaking a language other than English in the home. Eleven percent of the population is 65 years of age or older.

Screening and Referral

At-risk seniors are identified in several ways, including through physician offices, health plans, hospitals, and community members. To facilitate referrals from the physician’s office, front office staff in primary care offices are offered free training to recognize frail community-dwelling seniors who might be at risk for functional decline and/or loss of independence. We teach basic geriatric care concepts, provide information and resource manuals about community resources, and demonstrate how to refer patients to community-based agencies for help with nonmedical problems using illustrative cases. The 10-hour training program takes place at lunchtime, and to date 50 people have participated. The trained office staff member, called a geriatric resource person (GRP), uses a screening method developed by SAH that focuses on nonmedical reasons for referral. In addition, GRPs are alerted to certain chronic diseases that put seniors at risk for hospitalization. The GRPs also learn to pick up other cues, such as worsening forgetfulness, deteriorating personal hygiene, a pattern

From the Jewish Family and Children’s Services of San Francisco, the Peninsula, Marin and Sonoma Counties, San Francisco, CA.
of missed appointments, increasingly frequent contacts with the office, or simply “not doing as well as expected.” GRPs refer to SAH with the permission of the physician.

At health plans in our referral network, utilization management staff identify “frequent fliers”—those with frequent visits to the emergency room, high frequency of physician office visits, and/or 2 hospitalizations within a 6-month period. At hospitals, utilization review staff and discharge planners identify patients who are hospitalized repeatedly, are frequent users of the emergency room, are to be discharged to an empty house with no social support, or are confined to the hospital because there is no responsible party or no place to go. Community members and individual professionals also call SAH with referrals.

Assessment and Care Planning
Once identified and referred to SAH, patients receive a comprehensive assessment within 48 hours by a social work geriatric care manager. The assessment generally takes place in the home to determine the client’s nonmedical and psychosocial needs. The care manager completes a detailed assessment including risk factor identification and a mental status assessment. A health status assessment form is completed, documenting unmet ADLs and instrumental ADLs, adequacy of social supports, emotional and mental health status, unaddressed health issues, and whether a power of attorney has been completed (Figure). A weighted score for these elements is calculated.

Authorization forms to disclose confidential information are obtained at the initial visit in order to coordinate care with physicians, other involved professionals and the older adult’s personal support system. Care managers also consult with family members as appropriate to ensure that family members get the support needed to cope with the problems presented by their elderly relatives. A summary that describes the problems identified and interventions recommended is faxed to the referral source.

Based on the assessment, the geriatric care manager develops an individualized care plan that identifies priorities, desired outcomes, and the strategies and resources to be used in attaining the outcomes. The responsibilities of the social worker, client, and others are clarified throughout the development of the plan and the client signs the care plan. The care manager then arranges necessary resources, such as home care, therapy, respite, and nutrition services. Frequently, bill paying, transportation, meal delivery, and volunteer services are also part of the care plan. Services are initiated through the use of the senior’s informal network as well as community resources, such as visiting nurses, home health aides, adult day health centers, durable medical equipment acquisitions, Meals on Wheels, paratransit, etc.—whatever is needed to address the patient’s needs.

A level of care is assigned. The level of care defines the time period and intensity of the activities that the care manager anticipates will be needed for an individual case. The Table describes the levels of care seniors may require.

To strengthen the support system of frail elderly, SAH also provides opportunities for families and friends to further their education on issues surrounding aging and offer them volunteer support, counseling services, respite help, and community resource information. The care manager engages with the senior and his support system, stays involved until reversible problems have been addressed, and then continues to monitor the situation to address changing needs.

Measurement and Tracking
SAH has developed a database using Microsoft Access that is designed to allow real-time tracking ability of the day-to-day operation of the program and the outcome of the social work intervention. All clients are registered in the database. Standard client demographics as well as physician, diagnosis, and results of the health status assessment (completed at opening and closing) are stored in the database. Comparisons are easily made, and the results of the interventions are noted. In addition, the database also functions as a “time and billing” program, tracking time spent by staff in carrying out the activities of the care plan.

The tracking system generates the following reports:

- Client care summary
- Active, pending, or closed clients
- Closed clients per physician
- Health status assessment totals per client
- Health status assessment statistics/change between open and closed/diagnosis
- Case manager time sheet, hours by client, by level, and by week
- Referrals by source
- Itemization of services provided

SAH reports outcome measures quarterly to health maintenance organizations (HMOs) and other referral sources in the form of health status assessment scores. We also code and report individual activities on an outcomes form that is completed at the initial visit and at closing.

Program Evaluation
With the support of foundation funding, studies of SAH have been undertaken to measure the effects of the program. A study funded in 1995 by the Robert Wood Johnson Foundation sought to measure the effects of the program on
## Health Status Assessment Form

<table>
<thead>
<tr>
<th>Client Name</th>
<th>DOB</th>
<th>Age</th>
<th>SSN#</th>
<th>MIS#</th>
<th>PCP</th>
<th>Auth Date</th>
<th>Case Mgr.</th>
<th>CM Phone #</th>
<th>Date of Home Visit</th>
</tr>
</thead>
</table>

### 1. ADLs
Rate from 1–4: 1 = independent; 2 = minimal assistance; 3 = moderate assistance; or 4 = total dependent (because of health problems)

- a. Walking across the room
- b. Getting out of chair/bed
- c. Dressing
- d. Bathing or showering
- e. Using the bathroom
- f. Feeding

### 2. IADLs

- a. Using telephone
- b. Light housework
- c. Taking medications
- d. Using transportation
- e. Running errands
- f. Preparing meals
- g. Grocery shopping
- h. Paying bills or doing paperwork

### 3. Unmet ADLs
Unmet needs for formal or informal care and/or equipment (Yes = 1; No = 0)

- a. Walking across the room
- b. Getting out of chair/bed
- c. Dressing
- d. Bathing or showering
- e. Using the bathroom
- f. Feeding

### 4. Unmet IADLs

- a. Using telephone
- b. Light housework
- c. Taking medications
- d. Using transportation
- e. Running errands
- f. Preparing meals
- g. Grocery shopping
- h. Paying bills or doing paperwork

### 5. Living Arrangement

1. Spouse/partner Suffered losses in past year?
2. Others (Yes = 1; No = 0)
3. Alone (Inadequate = 1; Adequate = 0)

### 6. Losses

- a. Death
- b. Move
- c. Separation
- d. Divorce
- e. Retirement
- f. Physical

### 7. Social Supports (Inadequate = 1; Adequate = 0)

### 8. Caregiver to Another (Yes = 1; No = 0)

### 9. Emotional Status

- Feels downhearted or blue (Rate 1–4)
  - a. Never
  - b. Some of the time
  - c. Most of the time
  - d. A lot

- Anxiety in last month (Rate 1–4)
  - a. None
  - b. A little
  - c. Some
  - d. A lot

- Sleep problems (Yes = 1; No = 0)

### 10. Cognitive Status

- Lacks cognitive orientation (Yes = 1; No = 0)
  - a. Date
  - b. Place
  - c. Person

- Impaired judgement (Yes = 1; No = 0)

- Memory problems in past month (Yes = 1; No = 0)
  - a. Short term
  - b. Long term

- Mental illness (Yes = 1; No = 0)
  - a. Acute
  - b. Chronic

### 11. Health Status

- Health condition (Self-Report) (Rate 1–4)
  - 1. Excellent
  - 2. Good
  - 3. Fair
  - 4. Poor

- Drinks 2 or more drinks per day
- Smokes cigarettes
- At risk for abuse or neglect

### 12. Unaddressed Health Issues (Yes = 1; No = 0)

- Nutrition problems
- Fell 1 or more times within the past month
- Physical environment unsafe
- Needs DME equipment
- Vision problem unaddressed
- Hearing problem unaddressed
- Abnormal weight gain or loss (≥ 10 lb)
- Dental problem unaddressed
- Podiatry services unaddressed
- Urine problems unaddressed
- Bowel problems unaddressed

### 13. Needs Power of Attorney for Health Care (Yes = 1; No = 0)

### 14. Medications

- Total number of prescriptions taken regularly
- Total number of nonprescription medications taken regularly

### 15. Housing (Inadequate = 1; Adequate = 0)

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**Figure.** Health status assessment form used in the Seniors-at-Home program.
costs [1]. The study was a randomized controlled trial conducted within a San Francisco independent practice association composed mostly of small practices, including 200 primary care physicians under capitated contracts with 6 HMOs providing care for 14,000 older Medicare beneficiaries. Financial risk for care was shared by the medical group and its affiliated hospital, California Pacific Medical Center. Fifty primary care practices were invited to participate and 35 accepted. Of these, 16 practices (3480 patients) were randomly assigned to case management program and 19 practices (2929 patients) to usual care. The cost of hospital, physician, case management, and other health-related services were measured. The study found that the program was cost-neutral; including the cost of case management, it neither reduced nor increased the use of health care.

In a second study funded by the California HealthCare Foundation, the Retirement Research Foundation, and the Evelyn and Walter Haas Jr. Fund, 24 primary care internal medicine practices were randomized to receive either the SAH intervention or usual care. A total of 1098 older patients with histories of high medical care utilization were evaluated at baseline and at 1 year with self-reports of health; cost and utilization information was obtained from automated databases. The study found that the program was cost-neutral; including the cost of case management, it neither reduced or increased the use of health care.

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### Replicability and Applicability to Other Settings

This model of care management can be replicated by other organizations. The implementation manual and standardized forms developed by SAH are available on the agency’s website (www.jfcs.org). Programs more likely to succeed will be associated with the following factors: strong, reliable referral partners; well-trained care managers, preferably with master-level degrees in social work; software tools to identify and track activities; and an infrastructure to manage and ensure quality outcomes.

### Next Steps

More research is needed to refine our understanding of care management in general and in particular the unique areas of care management overseen by a social worker. This understanding might permit more focused clinical trials of the aspects of social work care management that are most likely to improve health outcomes and lower costs. This research, if favorable results are demonstrated, should ultimately lead to federal policies that allow Medicare to pay for care management.

### Table. Levels of Care Assigned in the Seniors-at-Home Program

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Activities</th>
<th>Time Frame</th>
<th># of ADLs/IADLs Identified</th>
<th>Support System</th>
<th>Cognitive Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk care management</td>
<td>Up to 3 home visits and calls to the client, physician, and referral source; written report to the physician</td>
<td>60 days</td>
<td>Up to 4 ADLs/IADLs</td>
<td>Patient is capable of being responsible or responsible party fully available</td>
<td>Able to follow directions</td>
</tr>
<tr>
<td>Moderate risk care management</td>
<td>Up to 5 home visits and calls to the client, physician, and referral source; written report to the physician</td>
<td>90 days</td>
<td>More than 4 ADLs/IADLs</td>
<td>Inadequate social supports due to caregiver stress or lack of responsible party</td>
<td>Moderate cognitive impairment</td>
</tr>
<tr>
<td>High risk care management</td>
<td>Up to 10 home visits and calls to the client, physician, and referral source; written report to the physician</td>
<td>120 days</td>
<td>More than 4 ADLs/IADLs</td>
<td>Inadequate social supports due to caregiver stress or lack of responsible party</td>
<td>Severe cognitive or emotional impairment</td>
</tr>
<tr>
<td>Monitoring for chronic high risk clients</td>
<td>Monthly home visits; weekly calls to client; calls to the physician and referral source; written report to the physician</td>
<td>180 days</td>
<td>More than 6 ADLs/IADLs</td>
<td>Inadequate social supports due to caregiver stress or lack of responsible party</td>
<td>Unstable home situation</td>
</tr>
</tbody>
</table>

ADL = activities of daily living; IADL = instrumental activities of daily living.
HMOs and medical groups in northern California with Medicare risk contracts have undergone substantial changes. Blue Shield, Aetna, and CIGNA no longer offer a senior HMO product; other insurers have added a monthly premium, increased co-pays, and decreased some benefits. Many California independent practice associations have gone out of business. Because of the declining number of seniors enrolled in Medicare managed care, it will be important to study the effects of this model on a Medicare fee-for-service population. A research project to address this question, for which SAH will be a demonstration site, is in its initial planning phases.

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References