GERIATRIC CARE MANAGEMENT:
IMPLICATIONS FOR SOCIAL WORK PROFESSIONALS

A Project

Presented to the faculty of the Division of Social Work
California State University, Sacramento

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

by

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SPRING
2013
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Division of Social Work
This primary purpose of this study is to investigate the private model of Geriatric Care Management, and explore how social workers use this model to meet the growing needs of the aging population. The secondary purpose of this study is to inform social work practitioners and educators about the field of Geriatric Care Management, as it may be a potential career for many future social workers. This exploratory study used in-depth interviews to collect data from nine social workers who serve older adults as Geriatric Care Managers in Northern California. The interviews identified and explored several topics, including professional qualifications, funding sources, client needs, obstacles, services, gaps in resources, and perspectives of Geriatric Care Managers. Many findings supported previous studies of Geriatric Care Managers, while other findings were unique to this study and provided additional insight to the private model of Geriatric Care Management. Because there is a growing need for services to the aging population, further research should evaluate whether the current model of private Geriatric Care Management is appropriate and effective, or if communities should pursue alternate...
models and funding. By gaining more knowledge and recognition of the profession of Geriatric Care Management, social workers can better understand its implications for serving a rapidly growing population.

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_____________________
Date
ACKNOWLEDGEMENTS

I first wish to thank Dr. Dale Russell for his invaluable advice and guidance through this whole process. It certainly would not have gone so smoothly without several brainstorming sessions in Professor Russell’s office. To my parents and my sister- thank you for pushing me through college these past seven years. I would not have gotten as far as I did without your continual support. To my wife and best friend- Laudanne, you know more than anyone how much encouragement it took to get me here, from our high school research paper all the way to this. Thank you so much. I am very blessed.
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Chapter 1

THE PROBLEM

In January 2011, the first “baby boomer” hit the retirement age of 65, beckoning a new and rising concern for the country: the U.S. population is aging. Currently, the population of older adults in the U.S. is growing at a much faster rate than the general population. In fact, the 2010 national census reported that more people were 65 years and older than ever recorded by any previous census, which means there are more older adults now than any other time in U.S. history (U.S. Census, 2011). This growth is not slowing either. Currently, over one in every eight, or 13.1%, of the population is an older American. By 2030 the older population is projected to grow at an accelerated rate and account for nearly 20% of the general population (Administration on Aging, 2012). Because of this trend, the care of older adults has also become a prominent concern.

Demands for aging services are expected to increase along with the aging population. The most needed services include increased medical care, appropriate and affordable housing, and caregiving support. Unfortunately, due to the recent recession, many state and county agencies have cut back on available resources (Walls, et al., 2011). Federally-funded services such as Medicare and Medicaid are the most encompassing and accessible for older persons; however, even these medical-based resources do not provide for housing or caregiving services most often needed by this population. Consequently, the burden of caring for older adults is most often placed upon other family members, who struggle to manage their time between jobs, family obligations and the care of their aging relatives. Developing a feasible and appropriate care plan for aging
adults can be very difficult for families. Accessing the fragmented resources for this population can become a full-time job of research, waitlists and endless phone calls.

Surprisingly, social workers are largely absent from the field of aging services, as compared to other social service fields. There is a great need for case management, education and advocacy for the population of older adults; however, social workers are largely limited to crisis situations such as abuse, neglect or declining health. One major problem, of course, is the lack of funding sources. In response to the current situation, more and more families of older clients are hiring professionals privately to help navigate the confusing maze of insurance policies, hospitals, home health agencies, caregivers, and residential care facilities. These new professionals are called Geriatric Care Managers, and they include gerontologists, social workers and nurses who use their knowledge, skills and interventions to manage the care of older adults. The purpose of the current study is to explore how social workers use this private model of Geriatric Care Management to meet the increasing needs of the aging population.

**Background of the Problem**

The rapid increase in the number of older adults is largely due to the increased longevity of the U.S. population. There are several factors that have led to increased longevity including advances in health care and medical interventions, increased public health awareness and interventions, and life-style changes (Administration on Aging, 2012; Hudson, 2009; Scharlach, et al., 2000). For example, because of recent medical advances, Americans are now living longer with complex chronic illnesses, which affect daily mental and physical functioning. In fact, the leading causes of death are almost all
related to chronic illnesses (Berkman, et al., 2006). In descending order, these include heart disease, cancer, chronic lower respiratory diseases, stroke, accidents (unintentional injuries), Alzheimer's disease, and diabetes (Hoyert & Xu, 2012). This means that although Americans are living longer, they are living longer with significant health problems.

However, this population shift is not only due to changes in health and longevity. It is also widely recognized that the burgeoning older population is also linked to the “baby boom” of the 1940s and 1950s (Administration on Aging, 2012; Burnette, Morrow-Howell, & Chen, 2003). Following the decreased birth rate of the Great Depression, birth rates jumped in the years following World War II. This created a sizeable generation that is just now entering retirement age.

The current shift in U.S. demographics is having an impact on today’s family structures. For example, due to increased longevity, there are currently 68.2 million grandparents in the U.S., which is more than ever. By 2020, grandparents are projected to account for 1 of 3 adults. However, this increase in grandparents has been accompanied by a decrease in the number of children per family and an increase in the incidence of divorce (U.S. Census, 2012). All of these factors combined means that families now may include four or five generations with fewer members in each generation than in the past. This “vertical” family structure differs from previous generations where families included multiple members of the same generation, a more “horizontal” family structure (Scharlach, et al., 2000). Therefore, the increasing need to care for aging parents is resting on the shoulders of fewer children and smaller families.
This increase in the number of older adults has several implications for the human service field, particularly for the social work profession. As the population ages, more and more services will be required to meet the needs of the aging (U.S. Census, 2006). According to the U.S. census, the older population requires much more assistance with activities of daily living (ADLs) than those who are younger. Almost 30% of people 80 years and older need caregiver assistance with ADLs, which includes dressing, bathing, eating, toileting and transferring (US Census, 2008). As recognized by Medicare and Medicaid, the growing aging population has increased the spending of long-term care such as nursing facilities and home health services; it has also increased the amount of acute medical services and expenses (Harrington, et al., 2000).

As the population ages, the incidence of mental and physical disabilities related to aging is also projected to grow. The annual incidence of Alzheimer’s disease, one of the most common forms of dementia, is projected to increase by 50% over the next 20 years (Hebert, 2001, p. 169). Dementia and Alzheimer’s disease lower the mental and physical functioning, which requires higher levels of care from caregivers (Alzheimer’s Association, 2011). However, this increased need for care is not limited to those with dementia. The increased incidence of chronic diseases such as heart disease, respiratory diseases, arthritis and diabetes has also led to a greater need for caregiving (Administration on Aging, 2012; Berkman, et al., 2006; Hoyert & Xu, 2012). This demand for competent caregivers will only increase as the “baby boomers” age and face further health difficulties.
Unfortunately, despite the increasing demand for services, many states have cut services for the aging population. In the face of a tenuous economy and reduced revenue, government-funded programs have tightened their belts. According to a research study by the AARP Public Policy Institute (Walls, et al., 2011), more than half of the states reported increased demands for information and referrals, home-delivered meals, respite, case management, personal care assistance, family caregiver support, transportation, and homemaker services. Despite this need, most states cut non-Medicaid spending on aging and disability services programs in 2010, and twenty-eight states expected to do so again in 2011. The study’s findings also indicated that the increased requests for services are likely correlated to the recent economic recession. As the population’s average income decreased, government taxes collected less revenue and yet more people qualified for government assistance programs (Walls, et al., 2011). Unfortunately, the available resources for older adults are too scarce to meet the demand.

Another study by the National Association of Area Agencies on Aging (2008) also examined the relationship between the recent economic downturn and community-based services for older adults. They estimated that eight million older adults helped by various Area Agencies on Aging (AAA) programs would potentially lose services if costs continued to increase while funding remained static. As a result of these cuts, other models of elder care have developed to meet the demand for services (Judd & Moore, 2011). These models will be examined in greater detail in the next chapter.

In addition to service and funding cuts, older adults face other barriers when searching for resources. These barriers include access to services and adequate care
coordination. An example of this is an older adult who requires higher levels of care, but whose income exceeds the eligibility limit for his or her state’s Medicaid waiver program. As a result, the older adult must either elicit informal care from family, pay for formal private care, or somehow become financially eligible for Medicaid. In fact, it is common practice for older adults to “spend down” their savings and assets in order to qualify for a skilled nursing home through Medicaid (Judd & Moore, 2011).

Another example of service barrier is when an older adult needs limited assistance with activities of daily living, but does not require the high level of care found at skilled nursing facilities. Unfortunately, most publicly funded programs do not provide funds for assisted living homes or private caregivers. If an older adult does not have the funds to move or obtain caregivers, he or she must enter a skilled nursing facility, a common fear for many older adults. According to the NCAL survey, about two-thirds (67 percent) of assisted living residents paid with their own funds, 8 percent of residents rely on family funding, 14 percent pay with SSI, and 9 percent pay with Medicaid (National Center for Assisted Living, 2001).

Besides the obstacles of access, many older adults face a dearth of case management and care coordination services (Judd & Moore, 2011; Firman, Nathan, & Alwin, 2009). Examples of where older adults receive case management services include hospital discharge, assisted living homes, skilled nursing facilities, hospice and home-health agencies, and adult protective services. However, these services are often short-lived, narrow in scope and do not coordinate between collateral service providers. In addition, many case managers are not educated or trained to adequately respond to the
holistic needs of the aging. The most appropriate care coordination for older adults is often informal, provided by family and friends (Judd & Moore, 2011).

Social workers have yet to make serious inroads into geriatric case management and advocacy. In a 2004 study by the National Association of Social Work (NASW), 9% of licensed social workers reported their primary area of practice as aging. The other top areas included mental health (37%), child welfare/family (13%) and health (13%). The study reported that MSW positions in aging had the lowest salaries compared to all other practice areas, possibly contributing to lower popularity among social workers (NASW, 2006).

Another study showed that “less than two-thirds of nursing home social service directors in one recent study had degrees in social work, most often a bachelors degree in social work, less than half were licensed or registered, and caseloads averaged 90 residents” (Simons, Shepherd, & Munn, 2008). Several reasons have been postulated why social workers are not adequately represented in the field of aging, where their knowledge and skills of case management, advocacy, education and referrals are sorely needed.

Some of these reasons include a lack of social work education and research in gerontology (and therefore a lack of competency), negative stereotypes about older adults, a lack of interest and awareness, and a shortage of practice models for educators, researchers, and practitioners (Burnette, et al., 2003; Council on Social Work Education & SAGE-SW, 2001; Naito-Chan, Damron-Rodriguez & Simmons, 2005; Lee, et al., 2009; Marshall & Altpeter, 2005; Morrow-Howell & Burnette, 2002; Raveis, et al., 2010;
Rosen, Zlotnik & Singer, 2003; Scharlach, et al., 2000) Yet, others attribute the lack of social workers to funding shortages and structural lags in policy that support social work practice with older adults (Ferguson & Schriver, 2012). Whatever the cause to this absence, the future field of geriatric services is undoubtedly a good match for the skills and knowledge of social work professionals. In fact, this has been made clear by a new rising profession called Geriatric Care Management (GCM).

Almost three decades ago, several professionals predicted the increased need for care coordination among the aging population. They recognized that the services provided by the policies of the Older American Act were too complex and complicated to meet the needs of older adults (Judd & Moore, 2011; Morano & Morano, 2006). Consequently in 1985, a group of nurses and social workers formed the National Association of Private Geriatric Care Managers (NAPGCM) in order to help reach an emerging market of “Geriatric Care Management” (NAPGCM, 2012).

In 1993, the NAPGCM changed their name to the National Association of Professional Geriatric Care Managers with the intent of furthering the new profession. Eventually, the profession would develop a credentialing program as well as a Code of Ethics and Standards of Practice. Several variations of this private GCM model emerged, both for-profit and non-profit. Since 1985, the numbers of professional Geriatric Care Managers have grown steadily, with over 2000 NAPGCM members in 2012. The profession has recognized the potential growth in the aging population and has positioned itself to provide services that meet the growing needs (NAPGCM, 2012).
Statement of the Research Problem

The increasing age of the general population is linked to an increased demand of services for older adults, including healthcare services, caregiving services and caregiving facilities. Despite this need, the current system of funding and resources is convoluted and piecemeal; therefore, the ability to access services, coordinate care and educate clients remains an important piece of geriatric social services. Unfortunately, because of the lack of public funding, social workers have largely been absent from this field, with a few exceptions (e.g. hospice programs and adult protective services). Some private social workers have recognized this demand by founding the profession of Geriatric Care Management; however, there is limited research on how social workers use this model to provide case management services.

Purpose of the Study

This study aims to investigate the private model of Geriatric Care Management, and explore how social workers use this model to meet the growing needs of the aging population. The secondary purpose of this study is to inform social work practitioners and educators about the field of Geriatric Care Management, as it may be a potential career for many future social workers. Moreover, it is a subsequent aim of this study to spur additional research of this field. Because there is a growing need for services for the aging population, further research should evaluate whether the current model of private Geriatric Care Management is appropriate and effective, or if communities should pursue alternate models and funding. By gaining more knowledge and recognition of the
profession of Geriatric Care Management, social workers can better understand its implications for serving a rapidly growing population.

**Theoretical Framework**

Geriatric Care Management devotes much time and effort to understanding the client’s environment. Often the changes in a client’s situation, such as worsening dementia or health conditions, are out of the client’s control; therefore, the most appropriate theoretical frameworks for this study are the person-in-environment perspective and systems theory. Person-in-environment is a fundamental perspective that has guided most social work practice (Norlin, Chess, Dale & Smith, 2002). It seeks to understand both the client as well as the systems within which he or she interacts. It recognizes that a person’s behavior and coping responses are intimately related to the demands of the person’s environment (Greene, 2008). Likewise, systems theory is a framework that identifies interrelated members and components of a client’s environment. Emphasis is given to the interactions within systems and across larger systems, which affect the client. Therefore a modification in any one member of a social system will affect the system as a whole (Shriver, 2003; Greene, 2008).

The person-in-environment and systems theory provide a framework to assess geriatric care interventions from a social work perspective. This perspective may provide a healthy contrast to the dominant medical model that many older persons experience in the medical field. Usually, the medical model views the client from a deficit perspective and creates a strong power difference between the practitioner and the client. In fact, care models that combine Geriatric Care Management with managed health care have
demonstrated this common occurrence of power imbalances (Enguidanos, Davis, & Katz, 2005). Systems theory and person-in-environment perspective help social workers better understand how various systems such as families, nursing homes, hospitals, and social networks all interact with an older client. This then helps both the client and social worker envision the best way forward, and make the appropriate changes.

**Definition of Terms**

**ADLs**

“Activities of daily living” which include routine daily activities such as eating, bathing, dressing, toileting, and transferring.

**Assisted living homes/facilities**

A residential facility that combines housing, custodial care services and health-care services. Assisted living residents are too frail to live alone, but too healthy to live in a skilled nursing facility.

**Older adults**

Adults who are about age 65 years and older.

**Geriatric Care Management (GCM):**

A specialized field of professional care managers who provide assessment, planning, coordinating, and monitoring for older adults and their families. These services are often provided by professionals such as social workers, nurses, or gerontologists who help older adults maintain a highest possible quality of life as they age.
Gerontological social work

A specialty field of social work practice which focuses on older adults.

IADLs

Instrumental activities of daily living that are not as basic as ADLs, but allow persons to function independently in a community. IADLs may include managing money, housekeeping, managing medications, shopping or cooking.

Medicare

A national health insurance program which guarantees access for people with disabilities and adults over the age 65.

Medicaid

A federal and state-funded health program for low-income individuals.

NAPGCM

The National Association of Professional Geriatric Care Managers, which is a professional organization advancing the interests of Geriatric Care Management.

Skilled nursing homes/facilities

A residential facility that provides housing and health care services that are less acute than at a hospital, but more acute than an assisted living facility. Many skilled nursing facilities provide both long-term care (LTC) and short-term rehabilitation care such as physical and occupational therapies.

Assumptions

There are several key assumptions that guide this topic of Geriatric Care Management and social work. These include the following: 1) The increasing number of
older adults has lead to an increase in care needs and resources; 2) There is currently an increased need for care management and coordination among older adults; 3) Social work professionals have the appropriate skills and knowledge to meet these needs; 4) Publicly-funded programs for older adults are not adequately addressing the increased demand for services; 4) Geriatric Care Management as a profession developed in response to these lack of public social services.

**Justification**

The demand for aging services is a rising topic among researchers of many fields, and the implications of this demand are directly related to the future of the social work profession. Due to the aging “baby boomer” generation, health care social workers are predicted to be the fastest growing segment of social work with a growth of 34% between years 2010 and 2020 (Bureau of Labor Statistics, 2012). Social workers have already established themselves in a range of settings including hospitals, hospice programs, adult protective services, and various community-based organizations. However, despite the growing demand for assisted living facilities, skilled nursing facilities, and home-health care programs, social workers are largely absent from all three settings (Simons, et al., 2008; Benjamin & Naito-Chan, 2006). Indeed, considering the enormous number of older adults who can benefit from social work case management, advocacy, and knowledge, it is a wonder why social workers have not already created a stronger avenue for their services.

It appears that Geriatric Care Management has attempted to address this gap in services in way that public social services has not yet done. Since Geriatric Care
Management has recently established itself in the private field of geriatric social services, it is critical to examine its relationship to the social work profession. Already many social workers have become Geriatric Care Managers, and many more will likely follow. Unfortunately, because the profession is relatively new, there is little research on the structure, effectiveness, and ethical concerns of this private service model. Therefore, the findings of this study will be very useful in understanding Geriatric Care Management from a social work perspective.

**Limitations**

This study explored the practices and perspectives of a small number of Geriatric Care Managers in Northern California. Due to the exploratory nature of the research design, the findings cannot be generalized to the wider population of Geriatric Care Managers.
Chapter 2  
REVIEW OF THE LITERATURE  

In the review of literature, three broad subjects are discussed. These include (a) the scope of social work practice with older adults; (b) social work education and research; and (c) the profession of Geriatric Care Management (GCM). The gerontological social work section will cover the various settings and services of social work practice with older adults. The second section will address the future and present needs of social work in regards to aging. The third section will then explore Geriatric Care Management as a subset of gerontological social work. Specifically, it will address the GCM philosophy, services, professional requirements, types of agencies, research studies, intervention effectiveness and special ethical issues. In addition, literature regarding current public and private resources for the aging population will be discussed throughout. The purpose of the review is to better understand the emerging field of GCM and its relation to the social work profession.  

Gerontological Social Work  

Prior to the passage of the Social Security Act and the Older Americans Act, older adults were not a targeted population for social work services. However, since then, several federal programs have funded social work education in aging to meet the social service needs of those programs (Damron-Rodriguez, 2006). Today, the aging “baby boomers” have sparked further attention and research in the area of social work aging. Social workers are currently providing services in several settings that serve older adults.
Settings

Social work practice with older adults occurs in almost all fields of social services. Examples of these settings include hospitals, home-health agencies, hospice programs, mental health agencies, public welfare offices, adult-protective services, veterans’ services, long-term care facilities, senior centers and various community-based agencies (Berkman, 2006). Despite this broad range of social work practice, the limitations of each setting leave many older adults without adequate services.

For example, due to financial constraints and the emergence of managed care, hospitals have been shortening the length of stay for most patients. Older adults in particular often move in and out of hospitals more rapidly than in the past. This is largely due to the episodic nature of the chronic illnesses that older patients face. Consequently, social work services in hospitals are mostly limited to short-term crisis interventions that often cease upon hospital discharge (Volland & Keepnews, 2006).

Once discharged from the hospital, an older adult may need to stay at a skilled nursing home for rehabilitative therapies. Federal regulations only require large skilled nursing homes (120 beds or more) to employ a full-time social service provider with a bachelor’s degree in social work or “similar professional qualifications;” However, only 61% of these large nursing home social directors have degrees in social work, mostly bachelor level, and recent federal investigations have found these psychosocial services provided by these nursing homes to be inadequate (Simons, 2006). Little research has been conducted to demonstrate the social work contribution in long-term care facilities such as skilled nursing and assisted living facilities; therefore “there is little justification
for facilities to hire better qualified and more experienced social workers nor any incentive for the federal government to change the social service staffing regulations in order to enhance residents’ access to quality psychosocial care” (Simons, et al., 2008). More research and guidance is needed to better serve clients who live in these nursing homes and assisted living facilities.

Staffing regulations play a large role in the presence of social workers in aging services. For example, the Veterans Health Administration (VHA) requires every VHA facility to include a palliative care team where 25% of the personnel must include physicians, social workers, nurses or chaplains (Howe, & Daratsos, 2006). Similar Medicare guidelines require that social workers provide medical social services in hospice programs (Centers for Medicare and Medicaid Services, 2012). Consequently, the VHA and hospice programs are consistent employers of social workers.

Unfortunately, home health agency staffing regulations are less friendly to social work practice. Unlike hospice regulations, Medicare does not consider home health social work to be a “core” service; therefore, it does not require all home health patients to be seen by a social worker, nor are social workers needed to develop the patient’s plan of care. The only requirement is that social work services need to be made available to patients (Benjamin & Naito-Chan, 2006; Lee & Rock, 2005).

Services

Despite some of the setting limitations, gerontological social work skills and interventions are ideally suited to working with older adults. The roles of the social workers vary across the different aging settings; however, several of the same services
are commonly provided. Some of the relevant social work skills include case management (or care management), geriatric assessments, interdisciplinary care planning, and family interventions.

Case management or care management is also widely recognized as a key social work intervention for older adults (Firman, Nathan, & Alwin, 2009; Naito-Chan, Damron-Rodriguez & Simmons, 2005; Wodarski, & Williams-Hayes, 2003). According to the NASW, “the primary goal of case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs” (2012a). In other words, case management is often used by organizations to improve the quality of care for a client while at the same time containing the costs of that care. Social work case managers may use assessments, coordination, monitoring, evaluation and advocacy in the process of managing services for a client. Currently, two common perspectives guide social work case management: strengths perspective and person-in-environment, both of which are conducive to working with older adults (Naleppa, 2006).

Geriatric assessments, as identified by the Council on Social Work Education (CSWE), are also a core intervention for a social work practice with older adults (Geron, 2006). Many social workers use comprehensive biopsychosocial assessments in order to understand the client’s needs, resources and strengths. Most standard assessment tools measure several areas of functioning of older clients. These include measurements of physical functioning such as activities of daily living (ADLs), cognitive functioning such as levels of dementia, and social functioning such as the strength of social support
networks. The assessments also investigate areas such as emotional wellbeing, financial resources, spiritual beliefs, and living situations. All the information is then used to develop care plans and appropriate interventions for older clients (Kane, 2006).

The development and implementation of care plans is a critical task of gerontological social workers. As noted before, many older adults face the prospect of higher care needs, ranging from minor assistance with grocery shopping to 24-hour caregiving and supervision. The best care plans balance the preferences of older clients with their need for safety and care. Helping older adults plan for their own care needs is consistent with the social work value of self-determination, and it has been found to improve older adult’s psychological wellbeing and reduce the burden of family members (Pinquart, Sörensen, & Peak, 2005). Almost two-thirds of older adults rely on family and friends to provide caregiving needs, making caregiver stress a real concern in any care plan (Greenberg, Seltzer, & Brewer, 2006). The impact of caregiving also often leads to family problems, and consequently, the need for family interventions.

Family interventions are common in any field of social work; however, they are especially useful in social work practice with older adults. As mentioned before, caregivers are often family members of the client, and they may experience several difficulties while providing care. These may include social isolation, stress, depression, and a reduction in paid employment. Family disputes often arise around caregiving plans or the wishes of the older adult. Social workers may employ care conferences with the family to resolve disagreements in a therapeutic group structure and environment. Other times, social workers working with older adults may use family case management in
order to identify family strengths, locate resources and improve interpersonal functioning (Greene & Riley, 2006).

**Social Work Education and Research**

In the past two decades, increased attention has been given to aging in social work education and research. In particular, several researchers have noted a shortage of social work education in aging (Rosen, et al., 2003; Scharlach, et al., 2000). In 1998, the John A. Hartford Foundation created an initiative for improving gerontological education for the social work profession. The funding from this initiative sparked several projects, including a project by the Council of Social Work Education (CSWE), which sought to identify competencies for gerontological social work (Rosen, et al., 2003; Damron-Rodriguez, 2007). These competencies divided into three domains: knowledge about older adults and their families, professional skills, and professional practice.

As a result of several surveys and research, a Geriatric Social Work Competency Scale was developed to measure educational learning objectives and outcomes. In addition, another CSWE project created the Gero-Ed Center Competency Goals, which are used to guide curriculum development of aging education in BSW and 1st-year MSW coursework (Damron-Rodriguez, et al., 2007; Naito-Chan, et al., 2005). In 2006, in response to these developments, the NASW created three specialty credentials for social work gerontology (one credential each for BSW, MSW and LCSW social workers). These credentials represent specialty expertise and knowledge for social workers working with older adults (NASW, 2012b).
In addition to the demand for gerontology education and credentialing, the need for additional research in gerontological social work has also been recognized. Several research areas in aging have been identified, including intervention tools and effectiveness, psychosocial assessments, living arrangements and care settings, service delivery of health, mental health and social services, family caregivers, and the recruitment and education of the workforce (Burnette, et al., 2003; Morrow-Howell & Burnette, 2002; Simons, et al., 2008). Additional social work research is needed to ensure the both the quality and accessibility of social work services to older adults.

**Geriatric Care Management**

Today, many social workers are turning to a specialized field of gerontological social work called Geriatric Care Management (GCM). Because of the recent arrival of the GCM profession, social work literature is just now beginning to discuss the implications of Geriatric Care Management. Consequently, the National Association of Social Work (NASW) has not yet recognized GCM or provided a definition for it. Nonetheless, Geriatric Care Management can be described as a field of social services which “provides assessment, planning, coordinating, and monitoring for older adults, their families, and/or significant others in regard to all issues that affect day-to-day living” (Goldberg, 2008, p. 245). Similarly, Geriatric Care Managers are professionals such as social workers, nurses, or gerontologists who help older adults maintain a highest possible quality of life as they age (NAPGCM, 2012). Their experience and credentials vary widely; however, their services are often very similar. The problems faced by clients of GCM may include decreased mental health, decreased levels of physical functioning,
financial or physical abuse, neglect, the loss of family member or spouse, and the need to move to a higher level of care (Cress, 2010). As noted previously, the increasing care needs of this population along with limited public resources has led to the recent growth of GCM.

**Philosophy**

The philosophy of GCM is client-centered and consumer-driven, meaning that Geriatric Care Managers, who are often paid privately, provide services that are sensitive to the needs and desires of the client and family. The goal of GCM is to provide older adults with the maximum possible independence and dignity, while addressing the issues of care with both the family and client. Principles such as self-determination of the client, involvement of formal and informal support networks, and a good working relationship with the care manager are all important to the success of GCM services (Morano & Morano, 2006). GCM services are often very flexible and responsive to the clients’ needs because most private care managers are not subject to funding regulations of medical insurance companies, large social service agencies or public grants.

**Roles and Services**

The roles of Geriatric Care Managers are very similar to those described previously under gerontological social workers. Care management services may also include consultations, psychosocial assessments, functional assessments, counseling, financial management, access to entitlements, crisis intervention, information and referrals, placement services (such as assisted living facilities), discharge planning, and coordination of home services (Goldberg, 2008). According to a survey of 712 members
of the NAPGCM, Geriatric Care Managers are fairly uniform in the types of care management services that they provide. Some of these include locating appropriate services for clients (95%), arranging for services (94%), conducting an assessment of family/social support (94%), developing a care plan (93%), conducting an assessment of clients’ functional abilities (90%), and providing ongoing management of client care plans (Stone, Reinhard, Machemer, & Rudin, 2002). Despite the number of similar services, Geriatric Care Managers are not uniform in how they provide their services. This depends largely on the caseload size, funding sources and types of referrals.

Placement services include assessing the client’s care needs, locating appropriate long-term care housing, and coordinating the client’s move into the new facility or home. Placement services are similar to those provided by hospital discharge planners; however, Geriatric Care Managers have the ability to be much more thorough and client-centered in their recommendations for housing. For example, the hospitals save a great deal of money by discharging a patient immediately after providing the insurance-covered services; therefore, discharge planners are often under a lot of pressure to locate housing for patients as soon as possible (Volland & Keepnews, 2006). Alternatively, Geriatric Care Managers have the flexibility and time to be much more responsive the client’s wishes, the location of support networks, the level of caregiving needs, and financial concerns. Some Geriatric Care Managers may even have the ability to tour potential facilities alongside the client before assisting in the decision-making process.
Professional Requirements

The National Association of Professional Geriatric Care Managers (NAPGCM) have set its own requirements for all GCM members and certified care managers: “(1) They must hold a Baccalaureate, Master’s or Ph.D. degree with at least one degree held in a field related to care management, i.e. counseling, nursing, mental health, social work, psychology or gerontology; (2) They must be primarily engaged in the direct practice, administration or supervision of client-centered services to the elderly and their families; and (3) they must have two years of supervised experience in the field of care management following the completion of the degree” (NAPGCM, 2012).

In 2006, the members of the NAPGCM voted to approve a fourth requirement for certification for the association. By 2010, all voting members were required to hold credentials in one of four approved certifications. These included Care Manager Certified (CMC), Certified Case Manager (CCM), Certified Advanced Social Work Case Manager (C-ASWCM), and Certified Social Work Case Manager (C-SWCM). These credentials are provided by the NASW. The purpose of these requirements is to elevate the profession in the knowledge and expertise of its practitioners (NAPGCM, 2012). The NAPGCM also provides oversight for client or collegial grievances, with the threat of sanctioning or loss of membership (Morano & Morano, 2006).

While the NAPGCM oversees the members of the association, there is no state or federal regulatory body for Geriatric Care Managers outside of the association. In fact many choose to remain outside of the NAPGCM and develop a private business without any certifications (Cress, 2010). Since, GCM is still relatively unknown, many Geriatric
Care Managers market themselves as private nurse case managers or private medical social workers; therefore, their respective nursing or social work degrees and licenses are more important than NAPGCM certifications.

**Types of GCM Businesses**

Twenty years ago, the most common type of GCM business was a private practice, where an individual social worker or nurse provided the care management services. A partnership between a nurse and a social worker is a common variation of this. However, other types of GCM businesses have also developed in the past two decades. For example in San Diego, one social worker combined GCM with in-home care services within a single private business, which she grew into a multi-million dollar company (Frates, 2008). In this business model, the care managers supervised the in-home caregivers as well as provided traditional care management services. Other large GCM businesses followed this model by combining social work assessments with in-home care staffing. Other practices have combined private Geriatric Care Managers with assisted living facilities, family law groups and even physicians. These pairings often act as a referral base for each other by offering additional resources to clients (Cress, 2010).

Historically, the social and medical models have been kept separate because of different funding sources and standards (Cress, 2010); however, in the Los Angeles area, Kaiser Permanente, a large managed care organization, developed a Geriatric Care Management division within their health care system. According to Enguidanos et al. (2003), this model was based on the premise that “access to home and community-based services will prevent physical decline, promote optimal health status and quality of life,
and minimize use of more-expensive acute care services by frail elderly” (p. 710). This premise was based upon findings from studies of the Medicaid Waiver Program that sought to provide community-based alternatives to older adults in place of nursing homes (Harrington et al., 2000). It is also similar to the justification for home health agencies to prevent hospitalizations by providing support in the home. In this case, the prevention is focused more on social services than typical home health agencies.

Kaiser’s model is different from the other private businesses because the GCM services are funded in-house through Kaiser’s managed health care insurance. Therefore, the fundamental purpose is to reduce the acute health care costs of aging Kaiser members through specific functions of nurses and social workers. These four key functions include assessments, developing care plans, implementing interventions and monitoring the clients with follow-up. While Kaiser’s Geriatric Care Managers provide much of the same services as other private GCM businesses, the caseloads are much higher, averaging around 80 clients per care manager (Enguidanos et al., 2003). While Kaiser’s program is largely based on the medical model, the continued research has been attempting to shift towards a patient-centered and evidence-based model (Hackstaff et al., 2004 & Enguidanos et al., 2005).

Despite the emergence of different models of GCM, the vast majority of Geriatric Care Managers are private practitioners with a fee-for-service reimbursement model. Because the typical fees of GCM can range from $75 to $150 per hour, the target population is only a small segment of the older adults who could actually benefit from GCM services. Consequently, the clients or the client’s adult children are typically
middle-class to upper-middle-class. Interestingly, the clients rarely refer themselves to GCM services; rather, it is usually the children who seek services on behalf of the older adult because of a significant physical or cognitive impairment (Morano & Morano, 2006).

Social work educators, Judd and Moore (2011), recently proposed an alternative public model of Geriatric Care Management, which would provide services for those who do not have the financial resources to pay privately. In this model, the care manager would practice in the same way that many existing private care managers: “a care manager would be autonomous in the sense that he or she would not be employed by any one specific agency providing services to the care recipient. With the care manager acting independent of any service agency, he or she becomes an agent of the care recipient” (Judd & Moore, p. 654, 2011). However, the proposed model diverges from the current private-pay model because it would cover low-income older adults by reimbursing the care managers with Medicare and/or state funds. Of course, along with public funding, the care managers would likely have more regulations such as certifications, credentialing and restrictions; however, by remaining an independent provider, the care managers would have the ability to follow clients across all the various systems of medical and social services, coordinating resources and care plans in such a way that the current systems are unable to do separately. In this way, Geriatric Care Managers would be able to provide the same client-centered care for low-income older adults as they do for higher-income older adults (Judd & Moore, 2011). Currently, this model only exists on paper, as there are no public reimbursement funds for GCM services.
Other Related Studies

As of today, very few studies have interviewed or surveyed private Geriatric Care Managers about their practice, and none of the studies have specifically targeted private GCM social workers. In 1987 one study surveyed 117 private Geriatric Care Managers about staffing, services provided, sources of referral, fees-for-services, characteristics of clients and regulation (Parker & Secord, 1987). Another qualitative study was conducted the same year through telephone interviews of 10 professional Geriatric Care Managers. This study by Dobrish (1988) asked about professional background, services provided, fees, frequency of contact, health and economic status of clients, and job satisfaction of Geriatric Care Managers.

More recently, another study was sponsored by AARP, which surveyed 712 Geriatric Care Managers registered with NAPGCM. This survey asked about the background and employment of Geriatric Care Managers, length of time in the profession, description of clients, services provided, costs of services, and views on certification. This study found that about two-thirds of Geriatric Care Managers were licensed professionals; 19% had a bachelor’s degree as the highest degree obtained; 68% has a master’s degree; 7% had a doctoral degree; 37% had a social work license and 30% had a nursing license. The average caseload was 17 clients per month. Geriatric Care Managers (45%) usually worked with clients and families for one year or less (45%) or between one and two years (21%). The findings on services provided are described above (Stone, et al., 2002).

In 2006 Kelsey and Laditka (2009) conducted another important study of private
Geriatric Care Managers. The purpose of the study was to examine how GCM services benefit older adults and how Geriatric Care Managers “perceive their role to enhance the quality of life of older adults” (Kelsey & Laditka, 2009). This study utilized in-depth telephone interviews to examine several topics of GCM: (a) why respondents became Geriatric Care Managers; (b) aspects about GCM that they enjoy the most; (c) reasons why clients seek GCM services; (d) what respondents have learned from working with clients; (e) the most important services provided; (f) challenges encountered by GCM; and (g) recommendations for changes in the GCM profession. 58% responded that adult children, who were often providing care from a distance, were the primary referral source for clients. 37% reported that their clients are often referred during a crisis situation when families do not know where to turn. The most common challenge mentioned by respondents was family conflict (50%). Almost 60% recommended implementing a certification process so that the profession would become more legitimate (Kelsey & Laditka, 2009).

**Effectiveness**

Because GCM businesses are very diverse in their structure, interventions and goals, it is difficult to measure effectiveness and generalize the findings across the field. In addition, the recent arrival of the profession, the smaller average size of geriatric care businesses, and financial resources have limited the number of studies done on GCM (Cress, 2010). However, some studies have been done by the medical field to determine if geriatric care interventions are effective in their proposed goals, and they have found
mixed results (Counsell et al, 2007; Hackstaff, Davis, & Katz, 2004; Enguidanos, Davis, & Katz, 2005; Enguidanos & Jamison, 2006).

Kaiser Permanente has produced studies of the effectiveness of their GCM program in the managed care setting. The study found that the more costly addition of GCM in the managed health care system did not measurably improve the clients functioning, service use, depression, caregiver burden or cognition (Enguidanos & Jamison, 2006). Another medical study was done for a program of GCM combined with primary care physicians. This study did find improved quality of care and a reduction in the use of acute care services among low-income seniors (Counsell et al., 2007). Another GCM company collected their own data to see if their interventions reduced hospital readmission among their clients. They reported that both emergency department visits and hospital readmissions were reduced after receiving services (Bartelstone, 2011). Much more research and standardization is needed to study the effectiveness across the different models of care management.

**Ethical Issues**

In 1985 the National Association of Private Geriatric Care Managers held their first conference and discussed several ethical issues including confidentiality, client loyalty and conservatorships (Elder, 1985). Today many of the same ethical dilemmas remain, including issues of self-determination, fiduciary responsibilities and fees for service. In 1990 the NAPGCM published Standards of Practice to address these specific issues as well as supplement the NAPGCM Code of Ethics. These standards include identifying the client, promoting self-determination, right to privacy, recognition of the
Geriatric Care Manager’s personal values and beliefs, professionalism of the relationship, definition of role, plan of care, knowledge of employment laws, undertaking fiduciary responsibilities, continuing education, certification, fees-for-service, advertising and marketing, and disclosure of business relationships (NAPGCM, 2012).

In addition to these potential conflicts of interest, professional social workers follow their own Code of Ethics published by the National Association of Social Workers (NASW). The NASW Code of Ethics indicates social justice as a primary value, particularly in the areas of poverty and equality of opportunity (NASW, 2008). This has historically created ethical dilemmas for private social work practitioners as they determine how to serve those without financial resources (Wolfson, 1999). With the exception of Kaiser’s managed care model, most Geriatric Care Management is fee-for-service and privately paid. Therefore, only those with financial resources can access most geriatric care services (Goldberg, 2008). Early on in the formation of the geriatric care profession, there was fear that the private model would create a two-tiered system of social services for the aging population: publicly funded services for low-income seniors and privately paid services for higher income seniors (Elder, 1985). There may be an element of truth to this reality, especially if GCM services become more available to low-income families through public funds.

According to the NASW (2008), “When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients’ ability to pay.” While not unique to social work or Geriatric Care Management, there is an unclear balance between promoting the
interests of the profession and the clients. As noted by Wolfson (1999), “a clinical-ethical tension surfaces when a private practitioner must weigh the client’s priority for a reduced or partial fee against his or her own priority for a reasonable and consistent income.” Social work values of equality and social justice may conflict with the financial reality of providing GCM services to adults.

Placement fees are another ethical concern related to GCM. Some businesses charge long-term care facilities a fee for each client they refer to the facility. However, when Geriatric Care Managers are paid by clients and families to find the most appropriate home for a client, it seems unethical for the Geriatric Care Manager to also charge a placement fee to a long-term care facility when making a referral. This produces a conflict of interest for GCM and does not promote client-centered care. While this practice is common among placement agencies, no studies have investigated the prevalence among Geriatric Care Managers.

Another ethical issue arises from the fact that the majority of geriatric care clients are referred by a third party, not by the clients themselves (Cress, 2010; Hackstaff et al., 2004). Often the adult child will hire the care manager for their parent, which leaves the care manager in between the wishes of the client and their family. Often it is difficult to respect the self-determination of a client when they are under adult guardianship or conservatorship (Wilber, Reiser, & Harter, 2001). Many of these issues are addressed in the NAPGCM Standards of Practice; however, it remains to be seen if these are interchangeable with the NASW Code of Ethics for social workers.
Conclusion

The settings of social work practice with older adults are varied, depending on funding, accessibility and demand. For example, more research regarding social services in long-term care facilities could increase the availability of social work services as well as help improve the quality of life for the residents. The knowledge, skills and interventions provided by gerontological social workers are particularly useful for practice with older adults; however, the absence of social workers from some areas of aging has caused concern. Advances in education and research are attempting to ameliorate the situation and better prepare the profession for the increased needs of the aging population.

Geriatric Care Management is a specialized profession in an emerging field. It is not yet regulated or licensed by a public authority; however, due to its professional developments of NAPGCM, this will likely change soon. While the NASW does not specifically include Geriatric Care Management as a separate credential, the NAPGCM requires its members to hold social work case management credentials from NASW. There are currently several types of GCM businesses, but the most common type includes owner-run, private-pay companies. This model limits most services to clients with financial resources. The GCM services are targeted for older adults who are experiencing problems related to aging, such as cognitive or physical declines in functioning. Only a few studies have surveyed or interviewed Geriatric Care Managers about how they serve their clients. Some research has been done on the effectiveness of these services and interventions, particularly within the managed health care model; however, the research
that is available shows mixed results. There are also several ethical dilemmas faced by this profession related to the complexity of the client issues as well as the private funding source.

The relationship between gerontological social work and Geriatric Care Management is still unclear. In regards to professional requirements, services and client population, there are both divergence and overlap between the two professions. However, the critical pieces to the puzzle are still the service models and funding sources. They govern how social workers serve older adults in our society. The current study will examine the perspective of professionals who are both social workers and Geriatric Care Managers. This will help illuminate the relationship and the implications for both professions.
Chapter 3

METHODOLOGY

The purpose of this chapter is to address the methods used to investigate the practices of Geriatric Care Managers with social work degrees in Northern California. The study explores the professional background, services, clients and perspectives of Geriatric Care Managers in an effort to draw out implications for social work practice with older adults. This chapter covers the study design, sampling procedures, data collection procedures, instruments, data analysis and the protocol for protection of human subjects.

Study Design

The current study adopted an exploratory, cross-sectional research design to study the field of Geriatric Care Management and its implications for social work practice. According to Yegidis and Weinbach (2006), “exploratory research is appropriate when problems have been identified but our understanding of them is quite limited” (p. 115). An exploratory design is appropriate for this study because the profession is very new and few studies have examined the social work perspective of Geriatric Care Management. This study design is also qualitative in order to allow a wider range of perspectives and generate new insights regarding the topic. Qualitative research tends to focus on the depth and relevance of the data rather than a large sample size (Marlow, 2005). A small sample size was used in this study (n = 9 participants).

In order to study the proposed research question, in-depth telephone interviews were conducted to elicit the knowledge and perspectives of professional Geriatric Care
Managers. Due to the exploratory nature of the study, the purpose is not to generalize the findings to the larger population of Geriatric Care Managers; therefore, non-random sampling strategies were used. These strategies include convenient, purposive sampling and snowball sampling.

**Sampling Procedures**

The sample population for this study included professional Geriatric Care Managers in Northern California. Most of the participants were identified through the national membership directory of the National Association of Professional Geriatric Care Managers (NAPGCM) found online at the following internet address: http://memberfinder.caremanager.org. Snowball sampling was also utilized by asking interviewed participants if they knew of other Geriatric Care Managers in their area. The search of potential participants was limited to Geriatric Care Managers in Northern California, located within a 200-mile radius of Sacramento, California. The study also limited the participants to those who had bachelor’s level or master’s level social work degrees (including Licensed Clinical Social Workers). This limitation was included in order to explore the perspective of social workers and possible implications for the social work profession.

The interviewer initially contacted every potential participant by email and/or phone to determine if he or she were willing to participate in the study. No inducements were used; however, each participant was offered the opportunity to receive the results of the overall study if he or she was interested. If the response was positive, a date and time was scheduled for the phone interview. The participant was also offered to immediately
proceed with the interview at the initial phone contact if they so desired. Fifteen (15) Geriatric Care Managers were identified and contacted by telephone to participate in the study. The interviewer successfully made contact with and interviewed a total of nine (9) participants. Before each interview, the informed consent form was discussed and then emailed to the participant for review. After the interview, each participant was asked for names and contact information of other Geriatric Care Managers who may be interested in participating in the study.

Data Collection Procedures

The data for the study was collected during the phone interviews with a tape recorder and notepad. Every participant was notified of the recording procedures of the interview, both verbally and in writing (informed consent form). The tape recorder microphone that attached to the phone audiotaped both sides of the conversation. In addition, the interviewer took written notes on a notepad to assist in the interview. After the interviews, each recording was transcribed into an electronic text document (or transcript) and then stored on the interviewer’s computer. Only one interviewer (the author of this paper) conducted all the interviews. The length of the interviews ranged from 20-30 minutes depending on the length of responses from the participants.

Instruments

The instruments used in this study include the 13-question interview guide (Appendix A) and participant consent form (Appendix B). The interview guide is composed of a range of questions about the professional background, services, clients and perspectives of Geriatric Care Managers. It includes several open-ended questions in
order to give the participants freedom to answer the questions with their own words. Examples include: “What services does your business/agency provide to clients?” and “How are you funded?” Clarification or elaboration questions were also included, such as “What do you mean by…?” or “Tell me more about…?” The interview is also semi-structured, meaning that the interviewer followed the specific list of questions on the interview guide, but was willing to allow the conversation to go to unanticipated directions if it might further the study (Gaskell, 2000).

**Data Analysis**

Several known strategies were used to analyze the qualitative data from the interviews (Gaskell, 200; Yegidis & Weinbach, 2006). First, each recorded interview was assigned an identification numbers and then transcribed into an electronic text document, or transcript. The researcher then read through each transcript at least twice, highlighting the relevant ideas, concepts and information. Each transcript was then condensed through the use of data reduction. This process of data reduction included simplifying some data and eliminating other data that only tangentially addressed the research question. Themes and patterns were identified, labeled and organized into coherent categories and subcategories. These categories were sorted by participant and by interview question, and they were then placed inside a data matrix for further analysis.

The next step in the process includes the interpretation of the data. Patterns and connections within or between categories were identified. Key ideas and important findings that emerged were listed in a separate table. Relevant quotes were also presented. The implications of these findings are discussed further in Chapter 5.
Protection of Human Subjects

The research study received approval from the Division of Social Work Committee for the Protection of Human Subjects, at California State University, Sacramento. This study was determined to be “exempt” under federal regulations because the interview participants are social service professionals being interviewed about the model and services of their professional practice; therefore, there is little to no risk of psychological, social or economic harm.

The participants’ rights to privacy and safety were protected in several ways. First, an informed consent form notified the participant about the nature of the interview questions in advance of the interview. All participants had the right to refuse to be interviewed as noted on the informed consent. They also had the opportunity to refuse to be recorded. Second, the recorded audio files were destroyed soon after they were transcribed, and in any case, no later than one year after they are recorded. Until the collected data was destroyed, both the audio and text data were stored in a secure and password-encrypted location on the researcher’s personal computer. No one but the researcher had access to the data (both audio and written). Third, the researcher was the only person to interview the participants, and the only person to analyze the data. Personal identifiers such as name, contact information, or business/agency name were not recorded in any way, as they were unnecessary to the study. Instead, identification numbers were assigned to each interview for the data analysis.
Chapter 4

FINDINGS

The purpose of this study was to explore how social workers use the private model of Geriatric Care Management (GCM) to meet the growing needs of the aging population. Information was collected about professional education and credentials, goals of GCM services, types of clients, client’s needs, common obstacles, types of services, funding sources, common resources, gaps in resources and the perceived future of GCM. The in-depth interviews included 13 open-ended questions in addition to clarification questions, which allowed the participants to expand on specific topics of interest (see Appendix A for interview guide).

Overall Findings

As reflected in the structure of the interview questions, the purpose was not to measure the similarities of Geriatric Care Managers in order to generalize to the wider population. Rather, the interviews allowed the participants to respond in very diverse ways so as to inductively explore ideas previously known or unknown to the researcher. Nonetheless, the following section describes the participant’s answers to each question, with similarities and percentages noted where appropriate.

Characteristics of Geriatric Care Managers

Table 1 displays the gender, education/credentials, and type of practice of the 9 interview participants. Seven (78%) of the participants were female and two (22%) were male; this distribution is comparable to the general membership of the NAPGCM, from where the sample was taken (Kelsey & Laditka, 2009). Only Geriatric Care Managers
who obtained a social work degree were selected for the interview sample; Only two (22%) of the participants had a Bachelor of Social Work (BSW) without a Master of Social Work (MSW) degree; the other seven (78%) participants held MSW degrees, and one of the MSW participants was also a licensed clinical social worker (LCSW). Four (44%) were Care Manager Certified (CMC), which is a certification of the NAPGCM. Two (22%) other participants were certified case managers (C-SWCM) by the NASW. One participant was a licensed fiduciary.

Two-thirds (six) of the participants were owners or partners of for-profit GCM agencies. Only one of these owners ran a solo practice, which is divergent from the distributions of previous studies (Kelsey & Laditka, 2009). Only one of the participants worked for a non-profit organization. Every participant (9) was working in the private sector.

Four of the nine participants owned a business that only provides GCM services. Of these four participants, one primarily served adults with mental illness; another served predominantly wealthy clients and families; and another focused on clients conserved by the courts. The other five participants were involved different types of non-GCM services, which expanded their funding sources. One participant primarily provided fiduciary services; one participant was an employee of a Continuing Care Retirement Community; another participant was an employee of a large non-profit senior services organization; one participant was an employee of a national caregiving company; and another participant owned a GCM agency that also provided caregiving services.
Table 1

*Characteristics of Geriatric Care Managers*

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**The Purpose of GCM**

Every participant described the purpose of Geriatric Care Management (GCM) differently; however, there were some common responses. One-third of participants described GCM as services that help clients remain independent, which sometimes means helping clients stay out of a nursing home. One participant stated, “The premise of Geriatric Care Management is to help our clients stay as independent as possible for as
long as possible.” About 44% mentioned accessing and coordinating resources as a central part of GCM. Representative comments include, “I help advocate for vulnerable adults to access appropriate needed resources and assist them in their care plan.” “It is assisting families and clients with navigating the complex healthcare system and to helping them find resources that meet their needs.”

Some of the unique responses may have been a result of the type of practice of the respondent. For example, a care manager who provided fiduciary services mentioned the responsibility “to oversee their well-being financially, and make decisions to extend their assets as long as possible.” Another care manager is an employee of a caregiving agency, where all of the clients have hired caregivers to come into their home. This respondent primarily emphasized the need to understand the client’s preferences when developing their care plan. Notably, five of the nine participants used the imagery of family relationships to describe the relationship between the client and the care manager. For example, two participants described themselves as being “surrogate children” or “professional daughters,” indicating the type of roles they play as Geriatric Care Managers.

**Types of Clients**

All of the participants worked with seniors; however, most participants (78%) also served adults of any age who had care needs. Five (56%) mentioned working with adults with mental or physical disabilities. One participant reported also working with children with developmental disabilities. One participant primarily served adults and seniors who were conserved by the courts. Another participant worked only with wealthy
seniors (primarily 80 years and older) who lived within a Continuing Care Retirement Community (CCRC). Several care managers mentioned serving clients and their families at a distance (56%). This usually refers to clients whose family members live in a different town or state but are still very involved in managing the care of the client. As noted by one participant, “It is not uncommon to have family members in different states or countries.” One respondent even reported coordinating care with a client’s adult child who lived overseas. Most respondents also reported working with clients whose family members are the primary caregivers as well as decision-makers for the clients; “The reality is that the majority of that [senior] population is staying at home and family members are providing the care.”

Related to this situation is the ethical question addressed by three of the participants: Who is my client? As noted by other researchers, family members are often the ones who seek care management services and pay for them (Cress, 2010; Hackstaff et al., 2004; Morano & Morano, 2006). Older adults are sometimes more hesitant to accept GCM services. This dilemma is reflected by statements of the participants, “The client’s concerns are often different from the families’ concerns.” “Really, the families have become my clients because they are often so burnt out and tired of trying to figure out what to do with their disabled family member.” The care coordination becomes even more complicated when the client is conserved by a third party such as a fiduciary. As noted by two of the participants, the goals of the conservator is to extend the client’s assets as long as possible, but the goals of the family and the client are often different from the conservator’s goals.
Client Needs

The most common needs of clients varied by each respondent; however, some of the frequently mentioned needs included in-home caregiving resources, long-term care, medical monitoring, remaining independent or in the home, help with crisis situations, quality of life, safety, caregiver support, and medication management. As one participant reported, the most common needs of clients are directly related to limited resources: “Normally most of my clients…come to me because they’re either in crisis or they’ve run out of resources and they are stressed and they are not able to cope with the resources that they do have.” As noted by this participant and others, client referrals often occur in the context of medical or caregiving crises.

Obstacles

When asked about the most common obstacles faced by the participants in GCM, almost everyone gave a different answer; however, the lack of similarity in these answers is likely due to the nature of the interview questions, which were all open-ended. It is probable that several participants would answer similarly if presented with a survey of common obstacles; however, the purpose of the interview questions are to elicit new ideas and explore them in an inductive fashion. Communication issues and family dynamics were mentioned by a third of the participants (33%); other obstacles mentioned by participants include HIPAA regulations, Medicare limitations, mental health issues, a lack of public knowledge about GCM services, and finances. One participant presented the idea that finances underlie most other obstacles: “It is always about finance. Even though it looks like it is family conflict, the bottom line is always finance. Finance kind
of dictates your resources and your access to resources and your options to appropriate care.” Another participant noted the obstacle that most people do not know what Geriatric Care Managers have to offer: “I think the challenge that we find within our profession is getting the word out there that we absolutely are a resource.”

**Services**

When asked about the services provided by the participants, several of the responses paralleled the findings of an AARP survey conducted on Geriatric Care Managers (Stone, et al., 2002). The majority of participants reported that they coordinate resources (100%), develop care plans (89%), conduct assessments (78%), monitor clients’ care (56%) and find appropriate long-term care placements (56%). Other services mentioned by the participants include consulting, advocacy, crisis intervention, counseling, fiduciary services, and managing in-home caregivers. See Table 2 for further details.
Table 2

**GCM Services**

<table>
<thead>
<tr>
<th>Services</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate resources</td>
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<td>100</td>
</tr>
<tr>
<td>Care plans</td>
<td>8</td>
<td>89</td>
</tr>
<tr>
<td>Assessments</td>
<td>7</td>
<td>78</td>
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<tr>
<td>Monitoring</td>
<td>5</td>
<td>56</td>
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<tr>
<td>Placement</td>
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<td>56</td>
</tr>
<tr>
<td>Consulting</td>
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<td>22</td>
</tr>
<tr>
<td>Advocacy</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Counseling</td>
<td>2</td>
<td>22</td>
</tr>
</tbody>
</table>

**Funding**

Without exception, every participant reported that the majority of their clients or families pay for their GCM services privately. Often the services are paid for directly from the clients to the GCM agency or business. Other times, the GCM services are contracted through outside agencies such as caregiving agencies, case management staffing agencies, elder law attorneys, fiduciaries, financial planners and Employee Assistance Programs (EAP). For example, one participant is often contracted by a local caregiving agency to conduct assessments and develop care plans for caregiving clients who have particularly challenging situations. Another participant works closely with fiduciaries to coordinate and monitor the care of a conserved client. In this scenario, the geriatric care manager is paid by a court-appointed fiduciary who manages the client’s finances.
However, the majority of the participants’ agencies provide more than Geriatric Care Management services; five (56%) out of nine of the participants either own or are employed by agencies that provide other paid services in addition to GCM; one participant is a fiduciary and receives funds from the conservatorships; one participant is employed by a Continuing Care Retirement Community, which provides independent living apartments, assisted living services and skilled nursing services all on the same property; another participant is employed by a large organization that provides a variety of services to older adults, including CCRCs, low-income housing, home health care, and a social membership program of classes and social activities for seniors who live at home. In this funding model, anyone in the community can pay directly for GCM services; however, members of the social activities program can receive up to 30 minutes of GCM services per month as a benefit to their membership.

Another participant is employed by an agency that receives most of its funding by providing in-home caregivers, and the GCM services are included with the caregiving services. Therefore, the funding sources are more diverse. For example, some clients can receive in-home caregiving services as a benefit of their long-term care insurance policy or the Veterans Administration’s (VA) Aid and Attendance program, which is federal funding. Another participant owns a GCM agency where employed caregivers are ancillary services to the Geriatric Care Management services. This participant uses the most diverse funding sources for in-home caregivers, including the Medi-Cal waiver project, which uses Medicaid funds for skilled nursing facilities to provide alternative forms of long-term care. This participant also receives funding from long-term care
insurance policies, an organization that serves clients with developmental disabilities, a county program that supports family caregivers by providing respite care, Multiple Sclerosis Society, and the VA’s Aid and Attendance program. While some county, state and federal funds are available for in-home caregiving services, no participant reported public funding for Geriatric Care Management services.

Two participants reported that there have been previous attempts to publicly fund GCM services; however, it did not succeed because there was not enough evidence that GCM services improved the care for older people. Nonetheless, several of the participants reported that they prefer to remain privately funded. One of the reasons for this included the belief that social services are historically one of the first things cut out of a budget when a government is low on funds. Two participants also mentioned their desire to avoid all the frustrating rules and regulations that often accompany government funding.

In addition to receiving private funds for GCM services, eight out of nine (89%) participants provide GCM services pro bono on a case-by-case basis. One participant receives funding from the organization’s non-profit foundation to provide services to clients who cannot pay the full rate. Two of the participants who provide pro bono work also have the option to use a sliding scale to determine the rates. Most of pro bono work included consulting services and education about community resources.

**Resources**

All of the participants work with other disciplines and resources in the field of aging. Some of the common resources that the participants use include geriatric
physicians (78%), home care agencies (56%), attorneys (56%), transportation services (44%), and Medi-Cal services (44%). The resources and referrals reported by the participants can be sorted into four categories. 1) The largest category of resources encompasses health and medical resources. This includes physicians, psychiatrists, pharmacists, physical therapists, nutritionists, podiatrists, dentists, discharge planners, home health agencies, medical supply companies, community nutrition programs, Medicare, Medi-Cal, and other health insurance policies.

2) The next category of resources includes long-term care resources such as assisted living facilities, skilled nursing facilities, board and care homes, placement agencies, home care agencies, private caregivers, and In-Home Supportive Services (IHSS). 3) The third category of resources includes legal and financial resources such as elder law attorneys, fiduciaries, conservators, probate courts, trust officers, financial planners, CPAs, Adult Protective Services (APS) and ombudsmen. 4) The final category includes resources in the community help support older adults in important ways. These include transportation services, the California Telephone Access Program, day activity programs, friendly visitor programs, caregiver resource centers and peer counseling programs.

**Gaps in Resources**

Every participant was asked to identify resources that they wish existed or were more readily available. In response, every participant gave a different answer, but most related to case management services, long-term care funding, or other community resources for older adults. One respondent presented the idea of a community case
management program that was once considered by the California Department of Aging. This program would have provided case management to clients for a period after being discharged from the hospital, in order to monitor the patient’s care and prevent re-hospitalization. Another participant believed that GCM services should be universally available and free-of-charge to both disabled persons and seniors. In this respondent’s perspective, care management should be similar to other public entitlements.

Government-funded long-term care was another sorely needed resource identified by a participant. Currently, assisted living facilities and board and care homes do not receive government funding, except through a limited Medicaid pilot project. Another participant wishes that Medi-Cal funding would provide more in-home caregiving. As reported by one participant, Adult Day Health Centers and Social Adult Day Centers have recently experienced massive cuts in California, even though the respite services were widely used. This participant would like to see Adult Day Health Centers funded again and expanded to be open 24 hours a day and 7 days a week. This participant also admires the model of Programs of All-inclusive Care for the Elderly (PACE), which uses Medicare and Medicaid funds to help clients remain in the community rather than living in nursing homes. In fact, the recently passed Affordable Healthcare Act has a similar component to the PACE model.

The participants identified other gaps in resources, including reliable community transportation, geriatric physicians, community info-lines for seniors, respite care funding and friendly-visitor programs. Regarding the info-line, the participant stated,
“So often I hear families who are calling me and just trying to get advice, but they may not hire me. I give a lot of people 45 minutes to an hour, and I can give them a roadmap in just an hour. But why is not someone else doing that?”

Several participants also noted the need for greater accessibility to existing resources: “Of course, I would love to have more resources. But besides more resources, I think what I would rather have is that people know what is out there and have an easier time accessing it.” Many of the participants noted the frustration and complexity of accessing public resources for clients and their families.

**The Future of GCM**

When asked about the future of the Geriatric Care Management profession, every participant reported that the aging population and their needs are going to increase. 56% of the participants mentioned the baby boomer population as evidence of this increase. Two-thirds of the participants also believe that the GCM profession will grow because of the aging population’s increasing care needs. One representative statement includes, “I think the future is wonderful for geriatric care managers. There is more and more of a need. Especially because of the baby boomers are now being more and more involved in their parents’ care and they themselves are getting older.”

Several other reasons for the professions future growth were also mentioned. This included the idea that baby boomers are service-oriented customers who want options and immediate access. Therefore, as more of the baby boomers and their parents need care, more clients will seek GCM services. Two participants mentioned that the current aging networks are too confusing for families to navigate in a crisis, leading those families to
seek professional GCM services. Other reasons for the profession’s future growth include the belief that there is more public awareness of GCM services, aging resources are fragmented and constantly changing, GCM services can prevent re-hospitalization, and Geriatric Care Managers can act as a neutral entity in the courts. One participant stated that there is currently a shortage of Geriatric Care Managers.

Despite the general optimism, three of the participants had some reservations about the future growth of Geriatric Care Management. One participant felt that the profession should not assume that more seniors equal more business; rather, care managers should be creative and they will find “a wide open field” of aging services. Another participant believes that there will always be a role for Geriatric Care Managers, but the profession will not necessarily grow. In contrast to most other responses, one participant was very hesitant about the future of GCM and other senior services:

I think part of the question is going to be funding. How do you find it? Back in the day when the baby boomers were just coming of age, there was this perceived need for childcare. And there was a huge need for it. The problem was the funding issue and so they were turning out a lot of childcare workers. And the universities were saying we need more childcare workers because there are jobs. And there were. But the funding was not there so it just was not sustainable. So with geriatric care managers and those services serving the aging community – in order for them to work effectively, you are going to have to pay these people a living wage. And so I think that is going to be one of the biggest barriers that lies
ahead for us. It’s value. It’s value for the dollar and what that perception is. And so I think funding is going to be one of the biggest issues.

This participant also believed that the country is running a decade behind the needs for aging services, and several things need to change in order to meet these needs. This includes the idea that many will need to delay retirement and stay in the workforce; communities will need to pool resources and focus on intergenerational activities so that the older population is not isolated from the younger generations. His perspective is similar to that of Ferguson and Schriver (2012), who believe that funding shortages and structural lags in policy will produce services that are at least a decade behind the growing needs of older adults.

**Additional Findings**

The purpose of the in-depth interviews was to explore Geriatric Care Management from the perspective of the social workers in the field of GCM. Due to the nature of these interviews, participants were allowed to speak about other topics not specifically addressed by the interview questions. Several of these topics were relevant to the current study of GCM and are further explored below.

**Lack of Knowledge of GCM**

The researcher did not foresee the following obstacle when constructing the interview tool, but four of the nine participants discussed the lack of knowledge about Geriatric Care Management services. The respondents frequently explain their services to clients and families who have never heard of Geriatric Care Managers, which indicates a general lack of public knowledge about the profession. This was listed as an obstacle for
several respondents because potential clients are unaware of their resources, and current clients are confused about their role as care managers. Nonetheless, two participants mentioned that GCM is becoming more noticed on national television and newspaper outlets.

**Client Resistance**

Four of the participants also discussed the topic of client resistance. As one participant stated, “In my work it is very rare that a client will say that they need help with care management.” The participants explained that other family members usually seek GCM services on behalf of the older clients. Baby boomers were specifically mentioned as a generation who is seeking care for their aging parents. When care managers initiate services at the request of the family, clients who have capacity often question the necessity of the services and may resist the care manager. The family members are often overwhelmed with the care needs, but the older adult may deny the severity of the situation. According to the respondents, this resistance may be due to the older generation’s desire to preserve resources as long as possible. Other times, it is due to cognitive or mental health issues. According to one participant, “Often we have to wait for things to happen or for a crisis situation to evolve if there is non-compliance with that older individual.” Crisis situations usually are hospitalizations or a rapid decline in functioning.

**Caregiver Support**

Several participants reported that their services focus on the caregiver as well as the older adult. Caregiver burnout is reported as a common phenomenon in the field of
GCM. This happens more often when family members are the primary caregivers. As one participant noted,

“It is overwhelming when you think about it. It’s overwhelming for professionals but it is even more overwhelming for a wife to take on that. She may have been taking care of them cooking and cleaning, but when it gets down to taking care of someone 24/7, it is a whole different story.”

Another participant mentioned the guilt that family members feel when they can no longer take care of their older relative. It is common for family members to promise not to place their loved one in a nursing home. Therefore, caregiver support was noted as an important focus for care managers. A representative statement noted that it is the care manager’s responsibility “to validate and support the people surrounding the disabled person so that the disabled person really wins.”

Technology

Three of the participants discussed the current and future uses of technology in GCM. Communication through email or Skype is helpful for the participants when the families of clients live at a distance. Laptops, tablets and smartphones were also mentioned as useful tools to record client information, especially during assessments. Another technological tool used by one participant is a tablet monitor that stays in the client’s home to help with medication management and health measurements. For example, a scale, pressure cuff, glucose monitor and pulse oxygen monitor are attached via Bluetooth to the tablet, which records the clients’ health data, and then emails the data to the care manager. The tablet also uses audio and video reminders for medications and
health measurements. All three of the participants discussed the positive aspects of technology and the importance of staying abreast of the improvements in the GCM field.

**Interdisciplinary Teamwork**

Several of the participants also addressed the topic of working with different disciplines within the GCM agencies. These disciplines included nurses, psychologists and social workers. All of the respondents of this topic reported positive outcomes when working with different types of care managers. Representative statements include, “It is nice that we can all trouble shoot together if we have something that we think is a better fit for another care manager;” or, “[the nurse and the social worker] butt heads set times but it always ends up being better for the client in the end.” It was common for the participants to mention the balance between medical concerns and social or emotional concerns when working with other disciplines.

**Staying in the Home**

During the interviews it was a common sentiment that clients should remain in their own homes for as long as possible. Different reasons were listed for this goal: 1) It is very expensive to live at an assisted living facility or a skilled nursing home; 2) Older adults tend to thrive more at home than a nursing home; and 3) Most older adults want to remain in their homes. The following is a representative statement, “People want to be able to stay at home. Nobody wants to have to be institutionalized. Every family that we talk to want to be as supportive as possible so that this individual can remain at home.” The geriatric care managers try to respect the client’s preferences as much as possible; however, it is sometimes unsafe for older adults to remain in their own home if they do
not have the proper care. Finances, social support and the level of functioning all
determine how long a client can stay at home.

Social isolation

Two of the participants also mentioned the occurrence of social isolation for older
adult clients. Although this topic was not widely addressed by the participants, it was
noteworthy to mention as a topic relevant to the research study. The respondents
explained that older adults sometimes become isolated because their family does not visit
often, their spouse may have died, they can no longer drive, and they live alone in their
home. One participant stated, “I think some seniors then end up signing up for meals-on-
wheels because someone comes out every day. So they don’t necessarily want the food,
but they just want to see someone every day… it is really hard emotionally to be older.”

Friendly visitor programs and transportation services were listed as an important resource
for socially isolated older adults.

Licensing and Titles

Several of the participants reflected on the importance of licensing, certifications,
and titles within GCM. Two of the participants specifically mentioned the occurrence of
care managers who display the title of a social worker or care manager but do not have a
social work degree, nursing degree or other relevant education. The respondents felt that
it was important that the NAPGCM require certification of the care managers in order to
make the profession credible to the public. Interestingly, one participant presented the
idea that Licensed Clinical Social Workers (LCSW) are less likely to do the same work
as geriatric care managers because their education and license would lead them to higher paying jobs elsewhere.

Value of GCM

Another important reason for licensing is that it increases the perceived value of the services. Such as the following statement, “I am noticing that people these days want value. They want you to show them value, for their money. So if that is the case, they want people to be certified, they want people to be licensed.” Several participants believed that the future of GCM relies on the perceived value of Geriatric Care Management services. As one participant stated in relation to funding, “And so I think that this is going to be one of the biggest barriers that lies ahead for us. It’s value. It’s value for the dollar and what that perception is. And so I think funding is going to be one of the biggest issues.”

Comments on the Private GCM Model

Two of the participants discussed the benefits and risks of other variations of the private GCM model. For example, one participant is a partner of a GCM company that only provides care management services, and the participant expressed a preference for the company’s current model; however, this participant also mentioned admiration for another GCM company in California that provides caregivers in addition to care management services. The participant also mentioned some of the risks of the caregiving model including potential conflicts of interests and increased liability from the caregivers. In particular, the participant was concerned that a care manager would not be able to adequately advocate for the client’s care if the care manager was also managing and
representing the client’s caregivers. This participant also expressed admiration for a GCM practice where an occupational therapist and a psychotherapist partnered together to provide GCM services. The second participant also expressed concerns about the practice of fiduciaries who are also care managers. This will be discussed in the next section about ethics.

**Ethics**

Ethical questions around care management were a common topic among the participants. One of these topics included the ethical responsibilities of conservatorship and fiduciaries. In particular, one participant expressed concerned about fiduciaries who are also care managers. This participant stated,

“I have met only a few who understand the defining line that can happen between care management and fiduciary responsibilities. For example, if they are making healthcare decisions to keep someone alive and the quality of life is low, then this is questionable.”

Fiduciaries are responsible for managing the finances of conserved individuals so that the client’s assets are extended as long as possible. However, fiduciaries may also have the power of attorney for healthcare, which means that they can make healthcare decisions for the individual. Combined with the responsibility of the managing the client’s care, the participant was concerned about the conflicts of interest that must arise in such a situation.

This participant quoted above was not a fiduciary; however, even the participant who was a fiduciary mentioned the ethical concerns in the area of conservatorship. When
discussing the future of the profession of GCM, the participant reported the need to have professional organizations with clear ethical procedures and guidelines that hold care managers responsible. This participant stated,

“I think that seniors and disabled folks who are needed in these services are very vulnerable. And the people that provide services are also at risk because the longer they are in the field, the temptation is there to do things inappropriately or to self-serve or self deal is huge.”

In this specialty of conservatorship, the participant witnessed caregivers, family members, attorneys, accountants and even judges take advantage of seniors.

Another ethical issue discussed by participants was the issue of low-income clients and their access to resources, including GCM services. One participant was particularly clear about this issue:

“Finance dictates your resources and your access to resources and your options to appropriate care. So it is like those who have, have and those who don’t, don’t. It can increase your life expectancy or reduce it based on your access to appropriate resources in a timely manner… the fairness, the equality, that everyone should have access to appropriate resources in a timely manner, and that is not always the case.”

Most of the participants acknowledged this reality during the interviews, but besides pro bono work, none of the participants further discussed the ability of low-income people to find care management services in the community.
Chapter 5

CONCLUSION AND RECOMMENDATIONS

This study provides a recent perspective of social workers who are Geriatric Care Managers in Northern California. From the types of services to funding sources, the study explored the creative ways in which these social workers are navigating the private model of Geriatric Care Management. Some of the study’s results were comparable to previous research studies; however, much of the current data explored topics of GCM that had not previously been studied, including the unique perspective of social workers. These new topics provide insight into the field of Geriatric Care Management and the consequent implications for social work professionals.

Summary of Study

Many of the current study’s findings confirmed the results of other recent studies of Geriatric Care Managers. For example, the AARP survey in 2000 studied the members of the National Association of Professional Geriatric Care Managers (NAPGCM) and found results similar to the current study: the majority of care managers coordinate resources, conduct assessments, develop care plans, and monitor clients’ care; the majority of care managers also work frequently with physicians, attorneys and other health professionals; more than two-thirds of care managers are self-employed and less than one-third are employees of an organization. They also found that it is often family members who seek GCM services for the older adult client; proper certifications and education are perceived as important qualifications for professional care managers; and the lack of public awareness of GCM services is an obstacle to care managers. Ethically,
two of the same concerns were raised in both the AARP survey and the current study, including: 1) a conflict of roles when providing both care management as well as caregivers; 2) a conflict of interest when acting both as a Geriatric Care Manager and as the fiduciary or power of attorney for a client (Stone, et al., 2002).

The recent study by Kelsey and Laditka (2009) used similar methods as the current study to collect data from Geriatric Care Managers. The study used semi-structured telephone interviews of NAPGCM members to examine the perceptions of professional Geriatric Care Managers. Some of the findings are similar to the current study. These findings includes the following: 1) clients are often referred to care managers during crisis situations; 2) adult children often seek services for an older adult, sometimes from a distance; 3) initial and ongoing assessments, caregiver support, advocacy, education, and coordinating resources are important services of Geriatric Care Managers; 4) family conflicts are a common challenge for care managers; 5) the profession of GCM would benefit from the implementation of licensing and certifications as well as an increase in the public awareness of GCM services (Kelsey & Laditka, 2009).

While many of the current study’s findings were consistent with those detailed in the literature review, several findings were unique and provide additional insight into the perspective of social workers who are Geriatric Care Managers. Major findings include the following:
The majority of care managers reported that their overall purpose is to keep older adults as independent as possible. This is accomplished by identifying the client’s wishes and coordinating resources around their care plan.

Several care managers described their role as a type of surrogate family member for the client because their role is similar to what families provide to older adults.

The majority of participants coordinate with clients’ families at a distance. Almost 80% of the participants also work with adults younger than 65, most of whom have physical or cognitive disabilities.

The goals of the family or conservator are sometimes different from the goals of the client, creating a dilemma for care managers who may be paid by the family or conservator.

According to the participants, the most common needs of the clients include in-home caregiving resources, long-term care housing, medical monitoring, and help with crisis situations.

The funding sources for GCM services are always private and usually fee-for-service. Sometimes, the care managers are contracted through outside sources such as caregiving agencies, case management staffing agencies, elder law attorneys, fiduciaries, financial planners, and Employee Assistance Programs.

More than 50% of the participants either own or are employed by agencies that provide additional services outside of care management. Examples of
these include in-home caregivers, fiduciary services, low-income housing, assisted living housing, skilled nursing facilities, and home health care.

- When GCM agencies provide and manage in-home caregivers, the funding sources are more diverse and may include public funding sources.
- In addition to receiving private funds for GCM services, eight out of nine (89%) participants provide GCM services pro bono on a case-by-case basis.
- Several of the participants reported that they prefer to remain privately funded due to sporadic government funding and frustrating funding regulations.
- Participants reported several gaps in resources for older adults, including better discharge planning, community case management, government-funded long-term care, adult day health centers, better respite care resources, senior info-lines, friendly visitor programs, and reliable transportation services.
- Technology is becoming increasingly popular for Geriatric Care Managers to manage the client’s care and coordinate with families.
- Interdisciplinary teamwork may increase positive outcomes with GCM clients.
- Seven out of nine participants believe that the GCM profession will grow due to the growing aging population and their care needs.

Overall, the results of the study provide helpful insight into the variations of the private GCM model. Most of the participants reported similar practices in regards to GCM services, resources, types of clients, and pro bono work. However, the nine GCM businesses varied greatly in their partnerships, non-GCM services, funding sources and
referral sources. These variations of the private GCM model indicate the creativity of the social workers in the field of aging services.

**Implications for Social Work**

As noted in the literature review, the U.S. aging population is growing quickly, leading to an increase in care needs. However, as noted by one participant, the increased demand for care management services does not necessarily lead to increase in services. Adequate funding and public value are crucial components to the success of GCM services. It is likely that the future of privately funded GCM services and the future of publicly funded GCM services are inversely related. If GCM services become publicly funded, the use of private GCM services will likely decrease (as well as the education level of the care managers). If GCM services do not become publicly funded, the use of private GCM services will likely increase along the increasing demand. In either scenario, the challenge for social workers will be to discover how to use both existing and new funding models to meet these needs of clients regardless of financial status.

Consequently, the topics and findings of this study are highly relevant to the social work profession. Geriatric Care Management is a relatively new profession that has the potential to grow. It is also particularly well suited to the knowledge and skills of social workers. GCM services such as case management, psychosocial assessments, and coordinating resources are certainly germane to the social worker’s toolbox.

The benefit of this study is obvious for social workers who are already in the GCM field or plan on becoming Geriatric Care Managers. This study explored the private model of GCM in order to better understand how GCM services are meeting the needs of
older adults. In addition, this study specifically examined Geriatric Care Management from the perspective of professional social workers who were currently providing GCM services. The education, credentials, clients, services, needs, obstacles, resources, gaps in resources, funding sources, models, and future of the profession are crucial topics for any Geriatric Care Manager. However, these findings are not only useful to other GCM social workers. These results will also benefit social work educators who teach about aging services and interventions. Whether social workers join the profession of GCM or work in other fields, knowledge of care management and aging services are universal to almost any social service career.

**Recommendations**

Because the profession is relatively new, very few research studies have examined Geriatric Care Management. Consequently, there is a need for further studies in several areas of GCM. This includes the goals and effectiveness of the GCM services. For example, if the goal is to keep older adults in their own homes as long as possible, do GCM services help older adults meet this goal? Alternatively, research can examine if GCM services reduce the incidence of re-hospitalization or increase the client’s quality-of-life. Further research on goals and effectiveness may increase the perceived value of GCM services and help secure future funding. It will also help social workers determine whether to pursue GCM models in the field of aging.

Research that focuses on the consumers of GCM services would be particularly beneficial to understanding the scope and magnitude of older adult needs. In particular, what needs of older adults are currently being unmet? Another important question is the
use of GCM services by minorities. Are minorities disproportionately absent from the field? If so, researchers should examine whether this contributes to lower use of other aging resources.

In addition to further research, it is recommended that social work education focus more attention on the aging population’s needs and services. As noted in the literature review, the current social work education regarding older adults is an inadequate response to the dramatic population shift in the U.S. In addition to individual interventions, social workers should be at the forefront of public policy and program planning of geriatric services. Without proper education and experiences, the social work profession will be unable to make a significant impact in the resources and services of older adults.

**Limitations**

While the results of this study are likely beneficial to social workers and Geriatric Care Managers, the findings cannot be generalized to all Geriatric Care Managers. The sample size is relatively small and limited to the NAPGCM social workers listed in Northern California. The structure of the study also presented limitations when comparing responses between participants. Several of the participants were interviewed during the first contact and were therefore unable to review and reflect on the interview questions ahead of time. In addition, busy work schedules and the use of telephone interviews also likely affected the quality of the responses. Despite these challenges, the in-depth interviews were able to contribute informative qualitative data about the field of Geriatric Care Management.
Conclusion

The field of aging is witnessing a large population shift, resulting in rising care needs and services. Because of the relevant skills, knowledge and values of the social work profession, social workers have a unique responsibility to address the needs of this vulnerable population. Using in-depth interviews, nine social workers were able to provide rich insight into how they provide GCM services to older adults. Using the private model of Geriatric Care Management, several of these social workers developed creative ways to secure funding and add value to their profession. Additional studies about Geriatric Care Management will help social workers determine the best way forward for serving older adults and their families.
APPENDIX A

Research Interview Questions

1. How would you define Geriatric Care Management?

2. What education or credentialing helped you become a Geriatric Care Manager?

3. What types of clients do you serve?

4. What are your clients’ most common needs or concerns?

5. What services does your business/agency provide to clients?

6. What is your overall purpose when serving clients?

7. How are you funded? (or who pays for the services?)

8. Does your agency/business ever serve clients who are unable to pay?

9. What other professionals, businesses or organizations do you partner with to make your business/agency possible?

10. What outside resources do you often make referrals for, or recommend to clients? These may include both public and private resources.

11. What other resources do you wish existed or were more readily available to your client population?

12. What are the most common issues or obstacles that you encounter while working with your client population?

13. Looking forward, what do you see as the future of the profession of Geriatric Care Management?

Clarification or elaboration questions may also be used, such as:

“What do you mean by …?” or “Tell me more about …?”
APPENDIX B

Consent to Participate in Research

Geriatric Care Management: Implications for Social Work Professionals

**Purpose:** You are being asked to participate in a research study, which will be conducted by Zachary Woodard, a student in Social Work at California State University, Sacramento. The study will explore the services and models of Geriatric Care Management in northern California.

**Research Procedures:** You will be asked several questions by the researcher about your professional background, the services you provide to clients, and other aspects of your agency or business. The interview may require up to thirty minutes of your time.

**Risks:** There are no known risks to the questions in the interview. You are free, however, to decline to answer any questions you do not wish to answer or to stop the discussion at any time.

**Benefits:** You may gain additional insight about geriatric care management and elderly services, or you may not personally benefit from participating in this research. It is hoped that the results of the study will be beneficial for both students and practitioners who work with the elderly population.

**Confidentiality:** Your responses on the questions will be anonymous to everyone except the researcher who will conduct the interview. Personal identifiers such as name, contact information, or business/agency name will not be recorded. With your permission, the interview will be audio taped. Those recordings will be permanently deleted as soon as the discussions have been transcribed, and in any event no later than one year after they were made. Until that time, they will be stored in a secure location.

You will not receive any compensation for participating in this study.

If you have any questions about this research, you may contact Zachary Woodard at (916) 792-2610 or by e-mail at zw43@saclink.csus.edu. You may also contact the faculty advisor, Dale Russell at (916) 278-7170 or by email at drussell@saclink.csus.edu.

Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page and agree to participate in the research.

__________________________________________  ______________________
Signature of Participant                        Date
REFERENCES


