

Editor's Message – Supervision in Care Management: Managing Quality

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This issue of the New Journal of Geriatric Care Management explores a topic that has not yet been addressed in much depth before – supervision in care management practices. Since there are no formal standards of supervision, we cannot make assumptions about the place of it in a care management practice/agency. Currently, the only references in the current NAPGCM Standards of Practice are to “consultation,” with no standard defining or requiring supervision:

- Standard 3: The Right to Privacy: “The GCM should not disclose identifying information when discussing clients for teaching or training or consultation purposes unless the client has consented to disclosure of confidential information.”
- Standard 4: Recognition of the GCM’s Personal Values and Beliefs: “The GCM should be cognizant of their personal and professional value system and beliefs through a continuous process of self–reflection and/or case consultation.”
- Standard 8: Definition of Role: “The GCM should accept only those roles and responsibilities for which he/she has the skills, knowledge and training. He/she should recommend consultations with other experts as needed.”

The National Academy of Certified Care Managers (NACCM) definition of professional consultation/supervision is:

“an ongoing process of consultation and performance appraisal for the purpose of maintaining and improving the quality of one’s care management practice. Professional consultation / supervision may be conducted by professional peers, mentors or supervisors in formal and/or informal arrangements. Activities may include face-to-face, individual, group or peer review of performance, record review or audit, case review, or client satisfaction survey/analysis. The content of professional consultation/supervision should include discussion of care management issues, ethical issues, care plan development and care management interventions, use of clinical skills and core care manager functions. The supervision may be provided onsite, electronically or via teleconference.” [1]

This definition of supervision may be useful in building the culture of quality based on “evidence–based practice strategies” which Robert Applebaum and Anthony Bardo challenge us to do in their comprehensive history of care management, Long Term Care Management Turns 40: what we know and what we don’t know.

Harriette Grooh begins this process by her review of multidisciplinary teams in care management practices and discussion of how these teams can improve practice. Phyllis Mensh Brostoff presents insights into how

professional care managers can use an evidence-based practice tool, The Predictive Index, to improve their supervision of the para-professional workers they are often called upon to supervise.

Building on NACCM's in-depth knowledge of what care managers actually do, the editors present An Accountability Rating Model: Using NACCM's Care Manager Tasks: Content Domains and Task Statements to Measure Your Practice and/or Supervisees. We hope that our members will try this out as a way to begin to build individual evidence-based practice strategies through evaluating their practices and/or their supervisees.

In addition, two sets of quality assurance measures are offered: one for client satisfaction surveys and the others to measure the benefit of supervision in a care management practice. A consistent approach to measuring client satisfaction and supervision is a goal NAPGCM may well be able to help members pursue in the near future, while acknowledging how supervision styles and frequency vary among geriatric care managers. Attaining and maintaining quality assurance is an ongoing process.

Explaining the importance of the place of supervision in the certification process, Monika White and Cheryl Whitman present an overview of Supervision and Certification, which emphasizes the importance of setting the bar for our professional standards.

Susan Birenbaum's article opens this dialogue by exploring the dilemma of the sole practitioner in evaluating their own performance and avenues to achieve this end. Furthering the discussion, Helene Bergman's case study lends insight from her own practice model of supervision, and includes both the supervisor's and supervisee's perspectives. Also from a sole practitioner standpoint, Debbie Drelich's article discusses the value of peer supervision, and what constitutes a good supervision group.

Steve Barlam discusses the core competencies of the LivHOME supervision model and how they are taught in his large agency. Vince Brim's article provides insight into the importance of managing one's own counter transference when working with clients as an element of the supervisory process.

Finally, Phyllis Mensh Brostoff's case study demonstrates one form of root cause analysis and shows how "Asking Why Five Times" can be an effective means of problem solving and learning from mistakes to improve the care of clients.

Throughout this entire issue, the authors discuss, from a variety of points of view, methods for care managers to manage the quality of our practices and, therefore, improve the services we give to our clients. While exploring this topic, we have come to realize the important place of supervision as a means to achieve this end. On behalf of the New Journal Editorial Committee, we hope you enjoy this edition!

References

[1] National Academy of Certified Care Managers CMC Renewal Instructions, page 3

Topics: Editor's and Guest Editor's Message, Supervision



Journal

Supervision in Care Management: Managing
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Long-Term Care Management Turns 40: What We Know and What We Don't

Robert Applebaum and Anthony Bardo

Background

In the introduction to our book on long-term care case management in 1990 we talked about its growing importance in the health and human services delivery system (Applebaum & Austin, 1990). Although some were calling it a fad at the time, today care/case management has become an integral component of many delivery systems including corrections, child welfare, substance abuse, mental health, acute health care, and long-term care services for the elderly and disabled. The litany of concerns identified as the rationale for long-term care management in the 1970s, including inadequate information for consumers, confusing eligibility criteria, a fragmented delivery system, a mismatch between individual needs and services provided, and poor quality of care, remain universal issues across an array of settings.

While there are many faces of case management, this article focuses on care management with older people experiencing chronic disability. Although the actual term “case management” dates back to the 1960s, care management in the long-term services arena was first tested in a series of demonstrations in the 1970s (Reiff & Riessman, 1965; Kemper et al., 1987). Long-term care management expanded dramatically in the 1980s and 1990s with the passage of the home and community-based Medicaid waiver program, now implemented in every state in the nation (Eiken, et al., 2011). Care management, including a systematic assessment, arrangement and coordination of services, and monitoring the quality of the consumer experiences, has become a core element of the home and community-based delivery system. In addition, private care management has developed for individuals and families who have the necessary income to purchase their own services, but who still need assistance in navigating the complex system of health and long-term services.

With its own journal, academic course work, training, and certification, and professional associations, care management has come of age. In our 1990 book we argued that long-term care/case management was not well defined and that there was limited evidence to demonstrate its effectiveness. So as long-term care management turns 40 it seems timely to ask, what do we now know about care management and what do we need to know to make it a more effective component of the future delivery system?

What we know about care managers and long-term services

Most people do not give much thought to the tasks of daily living, such as taking a shower, getting dressed, or preparing breakfast. Yet, it is the need for continual help because of physical or cognitive limitations that results in older people receiving long-term services and supports (LTSS). The initial expansion of HCBS was driven by a desire to control Medicaid expenditures and to help individuals to remain as independent as possible in the hopes of delaying or avoiding nursing home use (Kemper, et al., 1987). These goals were later

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enhanced by the U.S. Supreme Court's Olmstead decision, which emphasized consumer choice about living environment as a civil rights issue, not just a cost control mechanism (1999). Dramatic changes in the long-term services delivery system over the last two decades has resulted in over half of the Medicaid population receiving long-term services doing so at home – a proportion that would have been unimaginable two decades earlier (Eiken, Sredl, Burwell, & Gold, 2011).

With this expansion, the care manager role in the provision of services and supports in the community has become a core element of the HCBS system. The care manager is involved as a consultant, counselor, and gatekeeper in a set of complex decisions made by and with the care recipient and their family. There has also been tremendous growth in home care services in the private sector, reflecting both the continued increase in the number of older people and individual, family, and societal expectations that older people with disability can live at home with the right supports. A growth in private geriatric care managers has accompanied these developments.

Today's care management involves an array of services and providers, often including a variety of settings. For example, care managers are now assisting in hospital and nursing home transitions, working to assure that the individual is able to return to the community, but also to assure that a person can successfully remain at home. Care managers are also playing an increasingly important role in facilitating physician-patient communications, and as more and more states shift to integrated models of care, the care management role could become even more important (Ortiz & Horne, 2013; Sinha et al., 2011). Additionally, the economic downturn generated a greater need for care managers to provide assistance with financial issues, such as those surrounding eligibility and enrollment for public benefits, credit and debt counseling, foreclosure and housing options, and legal services related to lost pensions (Firman, Nathan, & Alwin, 2009). A final growing area of practice for care managers is advanced care planning (Black, 2010), which has become more critical as the disability and frailty levels of those receiving services at home continues to increase.

As long-term care management turns 40, we have learned some important lessons about the provision of managed home and community-based services. At the dawn of the home care era critics were concerned that managing and providing services to frail older people in their homes was a safety risk. Research findings consistently showed either no impact on mortality or increased longevity for individuals receiving home and community-based services (Kemper et al, 1987; Applebaum, 2012). Similarly, concerns about safety risks and declines in physical functioning did not prove to be correct, but a number of studies did report improvements in quality-of-life indicators (Applebaum, 2012).

There were also concerns that the presence of a care manager and the expansion of home and community-based services would supplant the extensive support provided by family members. Results of the National Long-Term Care Channeling Demonstration and other studies found that families remained actively involved in the care of their loved ones, but in some instances appropriately shifted some of the major tasks provided (Kemper et al., 1988; Applebaum, 2012). Thus, families remain a critical component of the system and care managers have learned how to support individuals and families in the provision of long-term services and supports.

At 40, the ability to assess the needs of the consumer has become much more refined, as has recognition of the importance of incorporating the consumer voice into the care planning and service delivery process. What began as human service professionals prescribing the needed services has become a much more consumer-driven process designed to maximize individual and family involvement. Providers have also had to adapt their approach, tailoring the services to the needs of the consumer rather than to simplify administrative tasks. Accompanying these advances have been technological improvements ranging from completing the assessment on a laptop to updating care plans and ordering services remotely and instantly.

At 40, the critical role of care managers in coordinating and communicating between systems and settings has been recognized. Whether it be the core care manager role in HCBS waivers, the major role in hospital and nursing home transition programs, or the emerging role in integrated care demonstrations, the care manager has become the glue of the long-term services system in the United States. There is now little discussion that care managers are a key component of any long-term services and supports program innovation.

What We Don't Know

Despite reaching middle age and achieving widespread expansion and popularity, there is much we don't know about the effectiveness of care management. Areas of uncertainty include both the work of care management and the expected outcomes of their efforts. For example, we still have unanswered questions about such basics as the optimum disciplinary training of care managers, caseload size, supervisory approaches, modes and frequency of assessment and monitoring, the most effective way to develop and implement a plan of services, how self-direction can work with and compliment the work of care managers, and how care managers will balance their roles in the new models of integrated care that accentuate the somewhat competing advocacy and gatekeeping roles of care management. There are also a series of unanswered questions about the impact of care management. Are consumers getting the right configuration of services? Has the care manager worked with the consumer to maximize independence? How has the care managed service package impacted participant quality of life, physical and mental functioning, hospital admission/readmission, mortality, and nursing home utilization? How can a care managed long-term services intervention achieve the best outcomes for consumers, their families, and the system? As the number of HCBS participants in both the public and private sectors continues to increase, the importance of assessing the effectiveness of care managed long-term services will multiply.

Why at age 40 is there still so much we don't know about care management? We have identified two challenges that impact the ability to assess care management effectiveness. First, extensive research in this area has tested care management combined with an expansion of an array of home and community-based services. Because the studies used care managers to develop and implement a plan of services the research tested the combination of care management and services. The studies did not attempt to isolate the care manager or service effect, such that we do not have good evidence about the effectiveness of the care management intervention.

The second factor, and perhaps the more challenging one, is that we do not have consensus on the goals and outcomes of care management. For example, what are the expected outcomes of the care management functions? Ensure that consumers feel included in the development of their services plan? Ensure that family members are satisfied with the plan of services? Ensure that family members will remain involved? Ensure that the participant has the needed services and supports to remain independent in the community? Ensure that participants achieve a better quality of life? Ensure that public or private resources are spent in an efficient and effective manner? Lower the use of nursing homes? Improve longevity and decrease health care costs? Ensure that the services delivered are the correct match for the consumer? Ensure that the services are provided in a high quality manner and that the services achieve the intended effect? Compounding the complexity of responding to these questions is that it is difficult to know which of these outcomes can be examined separately for the care management functions and the home and community-based services received.

To illustrate the challenges associated with assessing outcomes we choose an example from the quality area. Quality of care is often measured in terms of participant outcomes, but there are no set standards for what is a "good outcome" (Enguidanos et al., 2003). Indeed, quality can be measured by health status, hospital readmission rates, length of residence in the community, or consumer and family satisfaction. In a qualitative study of professional care managers Kelsey and Laditka (2009) found that care managers view their role in maintaining quality of life as vital, and dependent on their ability to assist individuals in their efforts to live

independently at home, arrange appropriate levels of care, and helping older people die peacefully and with dignity. The role of care managers in their contribution to consumer quality of life is also supported in a recent survey of care recipients (Ortiz & Horne, 2013). In light of the lack of sufficient quality measures, how are care managers to know whether or not they are doing “a good job?” Bowers and Jacobson (2002) identified six processes that characterized excellence. Some of the key processes included; developing and maintaining close relationships with consumers and their families, co-workers and supervisors, and service providers; respecting and facilitating participant autonomy; and the need for supervisor support. However, a lack of consensus on which of these factors are most critical means that it is difficult to develop clear and measurable outcomes of the care management intervention.

These challenges highlight why even though long-term care management is entering into its fifth decade many of the basic questions remain. Two very basic components of practice, caseload size and supervision, provide good examples of the difficulties. Every organization has to make decisions about the organizational structure of their care management program. Deciding how many consumers each care manager will work with and determining supervisory staffing patterns and approaches have substantial cost implications for both public and private agencies. A review of both of these areas shows tremendous variation in strategies across care managed programs. Caseload in the public sector can range from a low of 40 per care manager to over 200, while private care management practices typically have caseloads that average 15–20 clients. Supervisory ratios and function also vary widely. Efforts to systematically study even these basic management issues are limited by the lack of consensus about the intended outcomes of care management. If maximizing individual autonomy, enhancing communication with family members, and extensive monitoring of services are high priority outcomes then smaller caseload sizes may be necessary. If a program's most important goal is to serve a large number of moderately impaired older persons, then low administrative costs, higher caseloads and a lower expectation about the interactions between consumer and care manager would be expected. The lack of agreement about consumer and program outcomes means that systematic studies of questions like optimum caseload size or supervisory ratios and tasks have simply not been addressed. As individual programs have developed their own priorities and procedures they have developed their own practice patterns. But common outcomes and approaches to practice have not been established.

A Path Forward

Given this context, how can we generate better data about the effectiveness of care management?

What are the expected outcomes of care management?

It is clear that until there is agreement about the expected outcomes of care management our success in assessing the effectiveness of the intervention will be limited. But given the diversity of long-term care management programs is it possible to identify a core set of outcomes? While difficult, it is our contention that such a goal is achievable. The approach that we recommend has its roots in the early days of home care, when the motivation for expanding home and community-based services was consumer choice. In more recent years through such efforts as the expansion of self-directed care and the growth of private geriatric care management, the principles of consumer choice have become the bedrock of home care. Of course for consumers receiving services paid for by the public sector there will always be tension between public resource expenditures and individual choice, but those difficult choices can be mitigated by a clear sense of program/individual principles. For example, if a driving principle of care managed long-term services and supports is to help the individual live in the setting of their choice whenever possible, measures to assess this outcome can be implemented. Use of nursing homes could be one outcome, but so could a measure that focuses on residential choice. Similarly, since involving the consumer in the development of the service plan is consistent with the principle of choice, this outcome could be a common one across programs. It is certainly expected that programs that focus on special populations or on a more extensive array of services, such as

those integrating acute and long-term services, could have add-on outcomes, but it does seem possible to develop a core set of expected outcomes for care management.

Knowing what works

Once we have agreement about the outcomes of care management, then we can develop evidence-based practice standards. As we discussed earlier currently we do not have evaluative data on basic questions, such as optimum caseload sizes, disciplinary training, or supervisory ratios. We are even further from answering more nuanced questions, such as what is the right amount and configuration of services, what is the best approach for empowering consumers and their families, and how can care managers most effectively monitor the quality of in-home services provided?

To address these and other questions it will be necessary to use the same evidence-based practice strategies now being used in health and aging services. Practice areas such as caseload sizes, supervisory practices, assessment approaches, care plan development, or monitoring techniques can be incorporated into ongoing agency evaluation and improvement activities. Although we don't want to minimize the cost and complexity of these types of studies, they can be accomplished in the same way that evidence-based practices have advanced the state of knowledge in other areas. If care management is to remain a critical component of long-term services it will be critical to improve our understanding of what works and what does not. Seems like a good goal for a 50th birthday celebration.

References

Article References

Topics: Supervision

One thought on “Long-Term Care Management Turns 40: What We Know and What We Don't”



1. John M. Miller says:

November 4, 2018 at 1:10 pm

How do I find a management practice for myself, if I can no longer manage for myself and have not to turn to?

[Reply](#)



Journal

Supervision in Care Management: Managing
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Providing Care Management with a Multidisciplinary Team: Managing Quality

Harriette Grooh, PHD, CMC

Summary

The complex needs of some older clients demand the attention of an array of professionals in order to formulate and execute comprehensive care plans. Geriatric care managers employ a variety of methods in solving complex problems of the elderly. One modality is the team approach to assessment, care planning, and on-going care coordination. Some teams comprised of representatives from different disciplines can address both client needs and potentially harmful changes in the client's status. This article makes the distinction between work groups and team units. It describes the evolution, makeup, and processes of a high-performance team, leadership duties, and suggestions for supervisors embedded in multidisciplinary teams of geriatric care managers. Several variations of multidisciplinary teams are described.

Providing Care Management with a Multidisciplinary Team: A Holistic Approach

As a mental health professional (an inveterate problem-solver), I believe that older adult clients represent the most intriguing of all client populations. The challenging problems this population presents are many: fragmented health care and social services systems; complicated, sometimes distant, or dwindling families who are un-informed, in conflict, or exhausted; the fundamental questions about life, death, obligations, and choice; profound spiritual and ethical dilemmas; complex legal options; and the sheer cost of funding a life that is longer than may have been expected.

Geriatric care managers take a holistic approach to solving these problems because they understand the interdependence of the bio-psycho-social-environmental-financial-legal variables and the impact they have on the safety and autonomy of each client. Care plans are devised to take all of these factors into account and to recommend feasible resources to address a myriad of needs. When a care manager pulls together all needed resources on a case-by-case basis, it may result in an ad hoc group of providers representing various disciplines; but this is not the same thing as leading a multidisciplinary team of care managers.

A comprehensive approach to geriatric assessment is designed to screen basic medical, psycho-social, environmental, and safety concerns. These

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Harriette Grooh is a Clinical Psychologist and a certified care manager who has worked in geriatric and mental health care all her professional life. In the late 1970's as Geriatric Coordinator in the Transitional Services unit of Marin County Community Mental Health Services she created the county's first inter-disciplinary Marin Mobile Geriatric Evaluation Team, comprised of a geropsychiatrist, physician, geriatric nurse specialist and mental health counselor.

In 1983, she entered the private sector by establishing HGA Personal Care Consultants, a unique private, for-profit multidisciplinary consultation and care management firm, specializing in serving the behavioral, bio-psycho-social needs of elderly and disabled beneficiaries of individual trusts and family offices in San Francisco and the Greater Bay Area. Dr. Grooh has a private psychotherapy practice in San Francisco and Kentfield, California. Her specialization is in geropsychology.

She served on the Board of Directors for the National Association of Professional Geriatric Care Managers, was a founding director of the Western Regional Chapter of

screenings should be performed by clinically trained care managers, because geriatric clients can present with atypical symptoms. Care manager teams comprised of licensed clinical professionals (nurses, social workers, psychologists, and others) have the education, training, and instruments necessary for making assessments within their scope of practice that will indicate the need for further evaluation and possible treatment interventions. A classic example of the need for these teams is the referral of the older person who presents with cognitive / behavioral changes: confusion, agitation, dizziness, falling, or hallucinations; but with no fever, no pain, or other typical symptoms of a treatable urinary tract infection (UTI). Another example is the client who has significant weight loss, sleep disturbance, and has difficulty planning or remembering things. If no medical causes are found, it may be these changes are due to a major depressive episode. It would be a mistake to treat only the symptoms, overlooking the underlying problem, which may be treatable.

A comprehensive assessment deserves a comprehensive care plan

To implement and manage holistic care plans that address resolution of maladies, rehabilitation from injuries, and prevention of further complications, the professional care manager may be coordinating an array of treatment plans representing the efforts of medical and psychiatric providers; ancillary professionals (speech therapists, physical therapists, occupational therapists, nutritionists, and dietitians); and adjunctive providers (music therapists, art therapists, massage therapist, and oral history recorders). Additionally, the geriatric care manager may involve social, community, and spiritual services to maintain successful plan implementation and to create or sustain quality of life. The geriatric care manager may be called upon to design and implement a team of non- or para-professional providers (including family members) for home care duties consistent with the care plan. In addition to the bio-psycho-social assessment and development of the care plan, the care manager may be the on-going implementer of the plan to ensure it continues to be within reasonable financial and legal limits and congruent with the client's on-going preferences.

How to deliver the package – care management teams

Clearly, for the professional geriatric care manager this is a whole lot of coordination! While some geriatric care managers operate as solo providers, it is a great benefit to have the ability to use a multidisciplinary team model for assessments and care management. However, it can be very challenging to supervise people who come from different professional perspectives so that efforts are maximized and the outcomes are successful.

It is important to distinguish between managing personnel and supervising the individual team members' work. Managing entails human resource duties: recruiting, hiring, firing personnel. Supervising involves leadership and oversight that aims to direct and support team members to accomplish work duties in accordance with certain parameters.

The evolution of high performance teams as an organizational unit

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Before discussing the team model as it might be applied to geriatric care management, some background might be helpful. Highlights from Leonard and Freedman's (2000) succinct review of the development and study of work groups yields a sweeping perspective and demonstrates how recently the concept of teams appears in the workplace. Before the 20th century, work teams that were not primarily families, were rare and not highly valued with the exception of governmental and military units, orchestras, and theaters. The advantages of teamwork became apparent as nation states evolved and the Industrial Revolution emerged; although the integration of work, interpersonal communication, cooperation, and problem-solving was still limited. Because cheap labor was abundant, efficiency and integration of effort was less important.

Psychologists engaged in the study of human behavior, including the behavior of humans in groups. In the late 19th to early 20th century the focus was on the psychology of collective behavior, e.g. the regressive nature of groups or crowds. In the 1930s, 40s, and 50s, Social Psychology emerged, studying the effect of people on other people and the interactions between people, generating exciting new observations of how groups worked, including feedback loops, sensitivity training, participatory leadership, and an interest in group dynamics and applied social change. Beginning in the 1960s social psychology turned its focus from social growth toward personal growth. "In business and corporations, organizational leaders were willing to allow behavioral scientists to work with their subordinate teams but not with their organization's larger subsystems or governance process. As a result, early organizational development (OD) practitioners often focused change efforts on smaller units. Team building seemed more achievable and realistic than efforts to enrich jobs or democratize the workplace." (Leonard and Freedman, 2000)

By the mid-60s, researchers recognized "the impact of the characteristics of the work itself had on the way work was organized...One could not effectively institute significant changes in the technical aspects of work without involving the people who had to work in this new environment in planning for the changes." (Leonard and Freedman, 2000) The best way to do a job was not determined by top-down scientific management. Rather, teams that could self-organize and regulate, that exhibited "responsible autonomy," could determine the best way to do a job and lead to greater creativity, personal motivation, and work commitment. By the 1970s team-based techniques and strategies were developed and refined. Tuckman's (Tuckman 1965) stages of group development (forming-storming-norming-performing) became a widely known model of group development.

In the 1980s the economy was mired in recession. With downsizing and the death of the economic contract, i.e. loyalty of workers and managers in exchange for life-time employment, and re-engineering that leveled the managerial pyramid; business needed new ways to achieve efficiency and motivate workers. Teams seemed to be the answer. By the end of the 20th century team-based structures, in particular high-performance and cross-functional teams, were relied upon to improve productivity and quality. (Leonard and Freedman, 2000)

This was the time when the pioneers of geriatric care management started their entrepreneurial practices, and began to develop multi-disciplinary teams to serve their clients. After 30 years of development of the team approach, some geriatric care managers now use an emergent model in teams: the trans-disciplinary team. In the trans-disciplinary team, members of different disciplines are not only proficient in their own specialties, but through cross-training and working on the team, become knowledgeable in other specialties as well, resulting in overlapping competencies among team members. Trans-disciplinary training and teamwork permits the care manager to see a more complete picture of each client, and to a certain extent allows for assessment and care planning with skills and knowledge from a discipline other than one's own. (Hobbs, M.D., 2005)

Building a better team

Not all high performance professionals are equipped to work well in a team setting. Ideally, individuals with a proven track record of teamwork are recruited to the team. Key characteristics to look for and to develop in an

effective team member include respect for the team leader and for other team members, regular attendance at meetings, honesty, and patience to listen. It is desirable that the member knows one's personal abilities and limitations, understands each member's respective roles and responsibilities, and embraces the client-centered mission of the organization. A resilient team member is open to constructive criticism and has the ability to empathize and to see another person's point of view. Ideally, the professional can manage personal stress by recognizing the early signs of burn-out and has a willingness to seek assistance or to delegate tasks to ease the strain. Closely related to stress reduction is having a sense of humor, which helps maintain perspective during challenging times. Intellectual generosity is the willingness to share one's knowledge and resources and to communicate information in non-technical language with other members of the team. It is an essential component of the multi-disciplinary team model. In some teams, members operate with a kind of emotional reciprocity or camaraderie which the whole team experiences as professionally supportive.

As the team supervisor, one may act as a teacher, counselor (but not therapist), consultant, monitor, and gatekeeper. The supervisor is responsible for developing the organization's program, policies and procedures; managing referrals, assigning cases, and monitoring the size of caseloads; and overseeing the quality of service. If the supervisor is not the owner/manager, he or she serves as liaison to the management/owner of the organization. In addition, the supervisor is responsible for ensuring that performance targets are met; for example, achieving expected response times for setting up an initial client interview, writing documentation in a timely manner and meeting project objectives within the expected and reasonable number of hours billable. (Munn, G. and Forsythe, D., 2013)

A good supervisor is an excellent team member who models the team process well by exemplifying all the key characteristics of the individual team members. The supervisor motivates and supports the team, providing opportunities for staff development and training, ensuring that team members have current knowledge and refreshed skills. Sometimes individual supervision is needed to augment group supervision, especially for new members of the team.

The supervisor needs to build and sustain a trusting team culture, which includes practicing transparency, for example, enforcing a policy prohibiting the use of blind copies. Team leaders devise and participate in bonding activities, provisioning and managing resources effectively, criticizing constructively, praising in public, and reprimanding or correcting in private. A good supervisor is approachable, a good listener, takes initiative in improving the team's methods, is friendly, pleasant, reassuring, and celebrates team successes. As a contributor to team discussions, it is important for the leader to possess relevant knowledge, skills, and resources to share. The responsible supervisor will train a relief supervisor, possibly another member of the team, to cover in his or her absence.

Most importantly for successful group dynamics, the leader creates an atmosphere of mutual trust and safety through purposeful and goal-directed communication, clear expectations, and genuine respect. The supervisor nurtures a safe environment by establishing clear, well-defined, consistent boundaries and by developing a sound structure that focuses on the client. The supervisor needs to understand the different scopes of work, standards of practice, professional ethics, and legal regulations by which each discipline on the team is bound.

Good supervision includes accepting individual differences, discouraging groupthink^[1], encouraging introverts to speak, respectfully restraining extroverts to make space for others, embracing positive conflict through facilitating open and honest differences of opinion or style. The effective supervisor acknowledges the team members' differences in cultures and backgrounds, theoretical constructs, opinions, expectations and needs, personalities, egos, interests, communication styles, and competencies.

Challenges of managing a team

Because collaboration is not a widely held norm in work settings, team members may need guidance to develop a collaborative approach. Collaboration includes listening to everyone's views, developing trust in each member's expertise, methods, and judgment.

The supervisor must also take responsibility for mediating conflicts, which can be caused by a team member's difficult personality or stressful life challenges. Conflict is normal, and it can be managed. Conflict can lead to positive results and to negative results, to win/win solutions, or to needed change in the makeup of the team. Signs of team conflict can include name calling, gossiping, sarcasm, increased absenteeism, verbal complaints or critical emails, overt anger or clique formation, refusal to share information, lack of results, and missed deadlines.

The first rule of managing conflict is to acknowledge the conflict – it is not self-healing. The supervisor can make resolving the conflict a team effort. This would begin by having the team define the conflict, focusing on the situation, identifying the causes, and not taking the conflict personally. The team can brainstorm solutions, establish common ground, agree on a plan to resolve the conflict and execute the plan.

A strong leader knows he or she is fallible, and does not expect perfection from the team members. How a leader admits to making mistakes and actively goes about rectifying errors serves as a powerful model for team members. A demonstration of how to learn from one's mistakes, can give courage to a team member who may have erred and is too embarrassed or afraid to seek help. An experienced supervisor discretely guides a valued team member toward solutions to performance problems, thereby overcoming the inevitable trauma of making mistakes.

Finally, a well supervised, high performance multidisciplinary team eventually becomes a cohesive, successful entity and a source of pride and job satisfaction for the leader and the team members. Team members trust their supervisor to see the big picture and “to have their backs” when a case becomes impossibly challenging. Because they believe the supervisor knows their work and worth, they feel more valued and appreciated, which in turn makes the worker want to step back and find ways to improve their own performance. Solid productivity and exceptional quality may ensue. Understandably, when a teammate leaves a tightly knit group, the supervisor should be prepared for a significant shift in the group, because members are likely to experience a profound sense of loss. At these times it is best to recall Tuckman's phases of group development which predicts a regression to earlier phases of forming and storming when a person leaves or is added to the team.

Current models for multidisciplinary care management teams – variations on a theme

There are at least four models of multidisciplinary teams currently in use in various care management organizations at this time: the Focused Care Manager Team; the Interdisciplinary Team; the Multidisciplinary Care Management Team, and the Multidisciplinary Consultation Team.

The Focused Care Manager Team – In this team all care managers are of the same discipline, which may not be a clinical discipline. Each care manager carries a caseload, assessments are generally functional with more depth from the perspective of the care manager's discipline. This group may operate as a single unit of separate service providers, but it may operate as a collaborative team. Examples of Focused Care Manager Teams are (1) a nurse-owned care management group, staffed with nurse care managers who provide functional assessments and care plans with an emphasis on medical issues; or (2) a care management team led by a gerontologist, staffed by non-clinical certified care managers who provide only functional assessments and recommendations.

The Interdisciplinary (Inter-professional) Team – In this team each team member has a different discipline. All members may be assigned the same client, but the primary care manager is the team leader determined by

which discipline is seen as top priority based on the client's needs at any given time. The lead care manager role can rotate over time depending on case priorities. Assessments are generally comprehensive. The group may operate more as a unit of rotating professionals. The Interdisciplinary Team is more likely found in an integrated primary care or rehabilitation care setting, than community-based geriatric care manager setting.

The Multidisciplinary Care Manager Team – In this team members are of different disciplines. The care manager may take the primary care manager role for a caseload and / or serve as the back-up care manager for a teammate. Usually, these dyads, or nested teams, of primary and back-up care managers are comprised of different disciplines.^[2] Assessments are both comprehensive and clinically oriented. They may include functional, medical, psycho-social, behavioral, and environmental assessments and screenings. These teams are the most cohesive model for clinical assessments and care planning. These multidisciplinary teams may evolve into trans-disciplinary teams; if not by design, then by intra-team teaching and learning.

The Multidisciplinary Consultation and Care Management Team – This team includes a multidisciplinary team of care managers and a nested multidisciplinary team of clinical consultants and other specialists. The consultants do not see the clients or carry a caseload. They may discuss clients with the decision makers or the client's treatment team. Mainly the consultants counsel the care managers on formulating case specific assessments and care plans. An example of the composition of this team may include: consultants – pharmacist, geriatric nurse practitioner, disabilities specialist, public benefits specialist, gero-psychiatrist; and care managers: clinical psychologist, clinical social worker (mental health and substance abuse focus), clinical social worker (medical and disabilities focus), geriatric nurse specialist, palliative care nurse, general nurse care manager. In this case the psychologist is the team supervisor.

The multidisciplinary team model for geriatric assessments and care management offers one of the most comprehensive approaches to problem-solving and quality care planning for one of the most challenging client populations. While there is a growing acceptance of this modality among professionals and the clients they serve, it is not well studied and it is expensive. More investigation into the home and community-based multidisciplinary team is warranted particularly as this segment of the population expands exponentially. Supervising a multidisciplinary team is also a challenge, but if run well, this team model can give the team leader and care managers alike an enriching and satisfying environment in which to do very hard, but rewarding work.

References

Article References

[1] “Groupthink” is a psychological phenomenon that occurs with a group of people, in which the desire for harmony or conformity in the group results in an irrational or dysfunctional decision-making outcome. Group members try to minimize conflict and reach a consensus decision without critical evaluation of alternative viewpoints, by actively suppressing dissenting viewpoints, and by isolating themselves from outside influences.” <<https://en.wikipedia.org/wiki/Groupthink>>

[2] De Stampa, Matthieu, et al (2014) found in their qualitative study of multidisciplinary case manager teams for the elderly in France that most of the case managers “had organized themselves within the multidisciplinary teams so that case management would continue even if a case manager was absent.” P.5

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Journal

Supervision in Care Management: Managing
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Care Managers Supervising Caregivers: A Power Team

Phyllis Mensh Brostoff, CISW, CMC

Summary

Care managers are often called upon to supervise paid caregivers working with their clients but may not have been specifically trained in how to do so. This article provides a theoretical framework for care managers to understand how their own preferences and motivations differ from those of the paid caregivers with whom they interact, and direct application of an approach to supervision through an integrative coaching model. The goal of this model is to foster a team approach to enhance the quality of care and life for their mutual client.

Introduction

The great majority of care managers work with clients living in their own homes, and these clients often receive assistance, or need assistance, from a paid caregiver who is not a family member. Care managers provide oversight and support, if not direct supervision to these paid caregivers. Some care managers have a group of privately paid caregivers with whom they share cases, which may continue over many years. Other care managers employ their own paid caregivers which gives them the direct responsibility to hire, train, supervise, and discipline, up to and including firing the caregivers. The majority of care managers may direct caregivers through a home care or licensed home health agency. This poses the challenge of supervising a caregiver who is actually the employee of another agency.

How many care managers have been formally trained to provide any supervision to paid caregivers, (formal or informal, direct or indirect) and does this relationship require a different type of supervision than the one the care manager has experienced? Since there are many different types of supervisory models, starting with a basic definition of supervision may be useful in understanding this role: Supervision is considered to entail “a critical watching and directing” (<https://www.merriam-webster.com/dictionary/supervision>), whereas in social work literature, supervision is defined as “the relationship between the supervisor and supervisee, in which the responsibility and accountability for the development of competence, demeanor, and ethical practice takes place” (NASW Standards).

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Phyllis Mensh Brostoff is the CEO and co-founder of Stowell Associates in Milwaukee, Wisconsin, providing geriatric care management and care managed home care services to the elderly, disabled adults, and their families since 1983. She received her master’s degree in social work from the University of Maryland in 1970, and immediately began working with the elderly. Phyllis is certified by the state of Wisconsin as a Certified Independent Social Worker (CISW), the National Association of Social Workers Academy of Certified Social Workers (ACSW) and the National Academy of Certified Care Managers (CMC). She taught at the University of Wisconsin–Milwaukee School of Social Welfare from 1971–1977. She was a founding member of the NAPGCM and was the President of the National Board in 2009 and President of the Midwest Chapter Board 2006–2008. She has given numerous speeches, workshops, and presentations throughout the country on care management, assessment, ethical issues, the care of the chronically ill, and how to grow a business to social workers, nurses, attorneys, trust officers, financial planners, and the general public.

The nursing profession refers to “clinical” supervision primarily between similarly educated professionals, and not necessarily between a highly educated professional care manager and a caregiver who may have only the most rudimentary education beyond high school. While many caregivers do have formal training as certified nursing aides or assistants, many have not received specific training in working in the home setting, and many have never worked with a care manager or understand the supervisory role involved.

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The nursing profession also uses the word “delegation” to define the relationship between the professional nurse and nursing assistants who perform specific care tasks delegated by the nurse. Although each state defines “nursing delegation” in detail within its licensing rules and through the Board of Nursing, there is a consistent use of the definition of delegation: “the transfer, at the discretion of the nurse, of authority for the performance of a task of client care from the licensed nurse with authority to perform the task to someone who does not otherwise have such authority”

<https://www.nh.gov/nursing/nursing-assistant/documents/delegation-cc.pdf> (Delegation: Know Your Responsibility) <https://www.nh.gov/nursing/nurse-practice-act/> (Nurse Practice Act)

<https://www.ncsbn.org/1625.htm> (National Council State Board of Nursing: Regulations and Delegation).

Furthermore, The “Five Rights of Delegation” (National Council of State Boards of Nursing, (1997) The Five Rights of Delegation <https://www.ncsbn.org/fiverights.pdf>) concisely captures the specific expectations of delegation/supervision and the flavor of the relationship between the professional RN and the nursing assistant:

1. The Right Task: “right for the client and for the nursing assistant’s knowledge and experience.”
2. The Right Circumstances: “type of setting, supervision offered, available resources, and the condition of the client.”
3. The Right Person: “the nursing assistant should have been taught to perform the task and competency should be assessed.”
4. The Right Direction and Communication: “clear, concise information [about]...what task is to be performed and for whom, when the task is expected to be performed and ...conditions to report to the nurse...during...[and] once the task is completed.”
5. The Right Supervision: “Supervision should include ensuring that the nursing assistant is competent to perform the task and understands the request of the task. Supervision also includes assisting with problems/concerns during the task and follow-up after to ensure the desired result and documentation occur.”

The many disparities between the care manager and a caregiver of education, background, and power (to mention a few) can pose a significant challenge – providing many opportunities for misunderstanding, confusion, possibly anger, and despair, but also for a wonderful, fun, and fruitful collaboration as well as great service to our mutual clients. Good communication between the care manager and the caregiver should lead to the fulfillment of mutually agreed upon goals based upon the needs of the client as well as an enhanced quality of life for the client. This collaboration may lend itself to a sense of satisfaction for both the caregiver and the care manager in a job well done.

Facing the Challenges

How do you forge a respectful working relationship with someone whom you see only periodically? The caregiver knows the client in the most intimate way, spends far more time with him or her than you do, may

have a very different cultural background, and may believe she/he does not necessarily need your “critical watching and directing.” In fact, your delegation of doing things the “right” way may be perceived as merely bossy. The situation is further compounded by the caregiver’s need to find the “right” balance between two (or more) bosses: you, the client, and possibly the employing agency. Communication of roles and expectations in the nascent stages of this relationship is key and must be tailored towards a working relationship.

To this end, supervision may take a different tack from “critical” and “bossy”: it can use a coaching approach, focusing on ongoing mentorship and guidance, identifying specific targets of skill and knowledge required for the job, and identifying the practice that leads to improvement and excellence. Coaching necessarily requires observation, listening, reflecting, revising, refocusing, and of course, the presence of explicit rules –that need to be followed. These rules are often written in a formal caregiver care plan by the care manager, identifying details of what the caregiver is supposed to do regarding the client’s personal hygiene, food preparation, housekeeping and oversight, and companionship of the client.

Home care agencies may require caregivers to keep some type of documentation, using forms or notebooks, which care managers can read during their visits to the client’s home. If no formal, written notes are required, the care manager may request that notes be written to document patient changes on a daily basis, otherwise the care manager has to rely on observation of the condition of the client, the home, and the caregiver’s report of the client (mood, sleep, appetite, ambulation, continence, etc.) during the care manager’s routine monitoring visit.

Utilization of Predictive Index

In 2008, my agency utilized The Predictive Index Management Information System (PI) to improve our understanding of how to provide the best supervision to our care managers and caregivers (including home care as well as care management services). Steve Barlam of LivHome had initially introduced the PI at an NAPGCM Advanced Practice Retreat. He reviewed the PIs for both care managers and caregivers with our organization based on the adjectives that best describe the jobs of the care manager and caregiver. An explanation of The Predictive Index from the PI training program Reference Manual is referenced below:

The Predictive Index (PI) was developed and administered experimentally by Arnold S. Daniels during the period 1953 and 1954. It is one of a class of objective assessment techniques based on certain fundamental assumptions of behavioral psychology, the first being that work/social behavior is primarily an expression in activity of a variety of responses to environmental stimuli, recognizable as consistently expressed personality traits.

The Predictive Index adjective checklist is essentially a symbolic environment, the individual will respond to them in a manner consistent with the ways in which s/he responds to the actual environmental stimuli that the words in the checklist symbolize. The measurements made by the Predictive Index establish for each individual the location or magnitude on the continuums of the six drives, which when integrated, provide a specific description and prediction of the individual’s work-related behavior. The present norms are based on a total N of over 8000 persons in the industrial/commercial population.

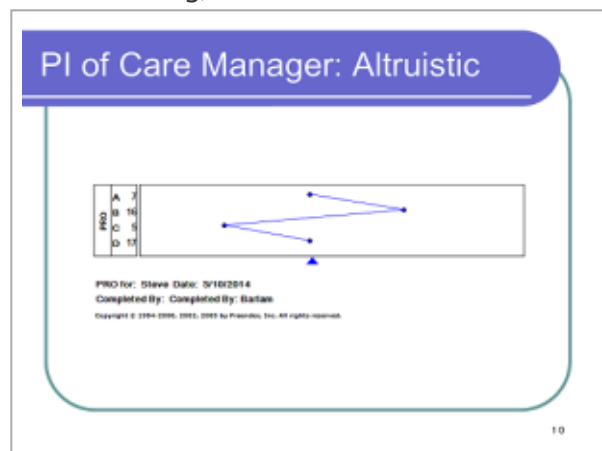
A Normative Reliability Investigation of the Predictive Index Organization Survey Checklist” (N=2546), reporting the results of a statistical analysis completed in April, 1996, again confirms the soundness of the measurements of individual behavior and potential provided by the Predictive Index. Numerous studies of the criterion-related validity of the Predictive Index have consistently confirmed its work-relatedness and accuracy...it is thus possible to use the Predictive Index to objectively assess and describe individual behavior and job demands in the same terms,...[of course] managers must recognize, understand, and deal with all of their people as individuals.

In summary, the PI is based on the concept that human behavior is an individual's response to stimulus, a response that we are either born with or have learned. Since most people behave in a consistent, predictable way, their motivations can be understood, and therefore influenced in a positive direction, when the person doing the influencing (i.e. the supervisor) understands their motivation. The PI identifies four major personality traits, which each individual has on a continuum from high to low:

1. Dominance: desire for control (from unassuming to assertive);
2. Extroversion: desire to be liked (from reserved to sociable);
3. Patience: interest in stability (from driving/intense to relaxed); and
4. Formality: interest in getting things right (from independent to conforming).

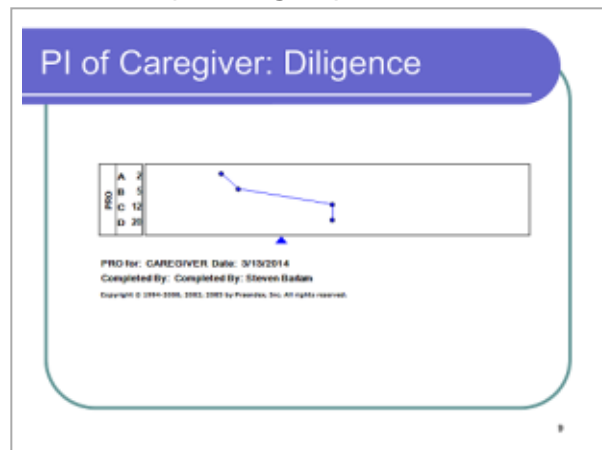
The PI of the care manager job fits the pattern that is defined as “Altruistic Service,” and the list of the statements about that pattern of behavior does describe a “typical” care manager. The care manager PI has a high B, representing extroversion; a middle A, identifying cooperativeness; a low C, identifying the need for variety and a change of pace at work; and a middle D, a focus on knowledge and rules.

The Altruist is a specialist who needs structure, is cooperative, collaborative, congenial, open and receptive to ideas, input, suggestions, and has a positive response to pressure. They are empathetic, extroverted, enthusiastic, fast, intense, efficient, and precise and detailed in follow-up. The Altruist asks, “What can I do to help you?”



The PI of a caregiver is different: it is “Diligence.” The caregiver job requires a high D and C — a stabilizing pattern identifying a person who is patient and exact; and a low A and B for a person who is agreeable and matter of fact. This job requires an individual who is skillful at detail work, precise, wants to do the right thing, needs strong structure and rules to go by, respects and seeks direction, and a plan to go by from a professional they trust as an expert. The Diligent person works harmoniously with the group, helps others, is unselfish and approachable but at the same time shy with strangers, opening up in familiar circumstances. The Diligent person is patient, steady, and has a high tolerance for repetitive work.

In considering how best to influence the Diligent caregiver, the Altruistic care manager can focus on the caregiver's desire to have certainty and understand what the rules are and what specific knowledge is needed to do the job. For example, if the care manager is introducing the caregiver to a new client, the focus may be on specific details of the client (i.e. she likes her shower in the mornings, not the evenings), details of the home (the knick knacks must be dusted on a Monday), scheduling or preference of the meals (she wants her meals at exactly 8am, noon, and 5:30pm), and other details that may help the caregiver achieve success as soon as possible (bring slippers to the home to walk in and take your shoes off as soon as you enter the door, turn the TV on only at 4pm to listen to Jeopardy, and on and on). This is why having a written care plan can be very useful – however, the Diligent caregiver prefers to receive information initially by hearing it, (not reading it), so that a precise, detailed review is necessary in the form of a phone call, an initial meeting at the client's home or in the care manager's office.



Direct observation of on-going care by a caregiver with the client can provide the supervising care manager with the information that is pertinent to crafting a recommendation when improvement is needed. The caregiver may best be coached by the care manager listening carefully to concerns about the client, the home, the family, or the facility. The care manager can then develop approaches with specific direction and guidance which can be observed in subsequent visits. The Diligent caregiver needs encouragement and recognition, and may respond best to “modeling” changes needed in behavior by the care manager demonstrating the new behavior that is desired. For example, the care manager may show the caregiver that the client with dementia responds better to her if the caregiver is not “in her face” but a short distance away in a space that may appear less threatening to the client. In addition, the care manager’s use of body language and tone/volume of voice can also be helpful to model the desired behavior for the caregiver.

Through the use of the PI tool, the care manager who is supervising a caregiver can consider the “typical” behaviors and needs of the job and the specific individual they are supervising who is doing that particular job. Of course, this is based on the belief that the caregiver is actually suited by her own individual needs and typical behaviors to this job (not an assumption that can always be made). However, if the caregiver does like his/her job, and the care manager believes in his/her ability to take the approach of a “coach” who observes and suggests, maintains a consistent, clear, respectful, and responsive style, supervision of caregivers by care managers can be managed very well. If you are able to forge a positive working relationship with the caregiver, the client will understand that you are working together to provide the best care and hopefully not sabotage your plan. This truly makes the care manager and caregiver a powerful team!

Note: The author wishes to thank Steve Barlam, LivHome, for introducing her to the PI and preparing a PI “Pro” report with her recently for the jobs of care manager and caregiver.

References

Graphs and Charts

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Journal

Supervision in Care Management: Managing Quality

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An Accountability Rating Model: Using NACCM's "Care Manager Tasks: Content Domains and Task Statements" to Measure Your Practice and/or Supervisees

National Academy of Certified Care Managers and Phyllis Mensh Brostoff

Introduction

In their article "Long-Term Care Management Turns 40: What We Know and What We Don't," Robert Applebaum and Anthony Bardo challenge us to develop "evidence-based practice strategies."

In its "Renewal Instructions" for its credential holders, the National Academy of Certified Care Managers (NACCM) explains its requirement for its credential holders to actually be practicing care management. 1 Credential holders are asked to use "NACCM Care Manager Tasks: Content Domains and Task Statements" as a measure of what that practice needs to include. NACCM's definition of supervision is: "as an ongoing process of consultation and performance appraisal for the purpose of maintaining and improving the quality of one's care management practice."

These Domains/Tasks were developed by experts in the field, many of whom are members of NAPGCM. We propose using the NACCM Domains and Tasks as a tool which individual care managers, or care management agencies, can use to rate either their own practice, or that of care managers they are supervising, as the next step in building those "evidence-based practice strategies" Applebaum and Bardo suggest.

Using the charts below, rate your agency, yourself as a care manager, or the care managers who work in your agency, in how they achieve these tasks using the following scale:

- 0 - does not perform this task at all
- 1 - performs this task but not consistently.
- 2 - performs this task consistently but needs to improve
- 3 - always performs this task and at a high level

Scores could range from 0-66.

Domain 1: Assess and identify client strengths, needs, concerns and preferences

Domain I: Assess and identify client strengths, needs, concerns and preferences		
Task	Care Manager or Agency	Notes
Screen client to determine appropriateness, eligibility for service and assist in making informed choice		
Explain, discuss role, program parameters, client rights, responsibilities prior to assessment		
Perform assessment by interviewing, observing, administering instruments, collecting data on: health, function, behavior, mental health, cognition, environment, finances, support system		
Verify assessment data using other relevant sources to validate and expand information obtained		
Synthesize, interpret assessment data to identify areas of concern		
Document all information in client record for baseline data, statistical analysis, and quality improvement		

Domain 2: Establish goals and a plan of care

Domain II: Establish goals and a plan of care		
Tasks	Care Manager or Agency	Notes
Prioritize areas of concern with client and support system to identify potential areas for intervention		
Identify options and resources that address interventions, discuss advantages, disadvantages, costs with client to establish mutually agreed upon goals		
Develop action steps to achieve the agreed upon care plan goals		
Document care plan, all providers, frequency, intensity, duration, cost, source of payment, tracking accountability, quality measurement		

Domain 3: Implement Care Plan

Domain III: Implement Care Plan		
Task	Care Manager or Agency	Notes
Coordinate services, interventions by referring, education, negotiating, mediating with client, formal and informal providers to meet goals of care plan		
Counsel, educate, negotiate, mediate with client and support system to strengthen, sustain support system, identify health promotion behaviors, meet goals of care plan.		
Document referrals, coordination of services, action steps taken related to provision of services, progress to meeting goals.		

Domain 4: Manage and monitor the ongoing provision of and need for care

Domain IV: Manage and monitor the ongoing provision of and need for care		
Task	Care Manager or Agency	Notes
Monitor deliver, quality of services, interventions provided to assure agreed upon care plan is implemented		
Perform ongoing monitoring, reassessment of client status and satisfaction with service, evaluate progress toward achieving goals, determine need for and make adjustments to care plan		
Document monitoring activities, client status to record actions taken and progress to achieve goals		
Discontinue services when client no longer needs, desires services, becomes ineligible for services, document discharge plan in client record		

Domain 5: Ensure professional practice

Domain V: Ensure professional practice		
Tasks	Care Manager or Agency	Notes
Advocate for client autonomy by mediating between values and needs of consumer and society to preserve client's right to self-determination		
Recognize and respect diversity including culture, religion, ethnicity, gender, sexual orientation, socioeconomic status, to uphold client's value system, preferences, choices		
Adhere to standards of practice, applicable ethical guidelines to maintain professional accountability and protect client rights		
Work through ethical dilemmas by identifying the issues(s), consulting with an interdisciplinary team, identifying strategies in order to preserve client rights and resolve the dilemma		
Evaluate, document care management services using tools such as peer review, record auditing, client satisfaction surveys, grievance procedures and take corrective action to promote the quality of care management practice		

Charts

Accountability Rating Charts

References

1 National Academy of Certified Care Managers CMC Renewal Instructions pages 12, 13

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Measuring Quality



Supervision in Care Management: Managing Quality

Jennifer Voorlas, Helene Bergman & Phyllis Mensh Brostoff, 2014

Measuring Quality	
Measuring Client Satisfaction	Measuring Supervision
1. Services and costs were clearly explained before service began.	1. Quality and timeliness of documentation
2. The care manager accurately assessed the needs of the person who receives our services and made appropriate recommendations.	2. TEAM approach to care: ability to cultivate and maintain relationships within the agency
3. The individual care plan met the needs of the person who received our services.	3. Increased problem solving ability
4. The services of the agency met my expectations.	4. Case stability
5. The agency's services decreased the level of personal stress in my life.	5. Thoroughness and timeliness of task achievement
6. I would recommend the agency's services to others.	6. Timeliness and responsiveness to client system and supervisor
7. The billing system was easy to understand.	7. Enhanced desire to learn
8. I did not have to miss work because of caregiving responsibility	8. Flexibility and ability to multi-task and to prioritize
	9. Reduction in GCM burnout
	10. Client retention (as a result of all the above)

Charts

Measuring Quality Side Bar

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Supervision Requirements for Certification

Monika White, MSW, PHD and Cheryl Whitman, BSN, MSN, CMC

Supervision is one of many tools professionals have to assure the quality of service delivery. It is particularly important in case/care management because of the complex nature of consumer and service delivery systems and the independent nature of the case/care manager role. Supervision is an important aspect of case/care management credentialing, both to qualify to take an exam and to renew certification. To qualify for membership at the “Certified Care Manager” category, certification is mandatory. NAPGCM recognizes certifications from three bodies and each of them requires some form of supervision:

- Commission for Case Manager Certification (CCMC). Certified Case Manager (CCM). A license or other certification is required to take the exam and 12 months of acceptable, full-time case management employment supervised by a CCM. The CCMC defines supervision as “the systematic and periodic evaluation of the quality of the delivery of the applicant’s case/care management services.” Working as a case/care management supervisor for 12 months is another acceptable criteria for certification. A third employment category is 24 months of acceptable case/care management experience that requires supervision but not necessary by a CCM.
- National Association of Social Workers (NASW). Certified Social Work Case Manager (C-SWCM). NASW offers 2 certifications. Eligibility for the C-SWCM includes one year (1,500 hours) post-BSW paid, supervised work experience as a case manager. More specifically, supervision must be one hour for every 15 hours direct client-level case management tasks and the supervisor must be by a BSW with five years’ experience or an MSW with two years’ experience. The C-ASWCM is an advanced credential for MSW case/care managers and requires documentation of at least two years (equivalent of 3,000 hours) of paid, supervised, post-MSW case management experience.
- National Academy of Certified Care Managers (NACCM). Care Manager Certified (CMC). NACCM defines supervision as “individual, group or peer evaluation of the applicant’s performance of the core care management tasks including the quality and efficacy.” For new applicants, each year of required care management experience must include 50 hours of supervision. Supervision is a requirement to maintain the CMC’s certification.

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Ms. Whitman earned a bachelors of science in nursing from D’Youville College in Buffalo, NY and a master’s of science degree from the University of CT, School of Nursing. She has 40+ years of experience in a variety of nursing settings including hospitals and home care; has worked as a clinical care manager, supervisor and manager at a non-profit care management organization; and has 15 years experience as a private geriatric care manager.

She is a founding member of the National Academy of Certified Care Managers (NACCM). She was a leader in the development of the certification process, has participated in item writing, exam construction and was the very first person to sit for the CMC examination. She has served on the board of directors since 1995 and was the Executive Director until October 31, 2014.

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Monika White, PhD, MSW
An experienced practitioner, educator, researcher, author, lecturer and administrator, she has worked in both public and private sectors. For nearly 40 years, her career has focused on coordinating health, mental

Although NACCM accepts a broad range of who can serve as consultant or supervisor, a CMC is preferred. Documentation of the methods utilized and the content evaluated is required. Supervision can be obtained with professional colleagues (as in the case of solo practitioners); supervisors/managers; mentors; or other certified case/care managers.

Based on NACCM experience, supervision usually includes evaluation of clinical skills and core case/care management functions; evaluation of clinical documentation by case/care manager; case presentations with other care managers; discussion of current practice issues, ethical dilemmas, and case/care management interventions. Measures of quality are also useful.

Methods of supervision range from: one-on-one meetings; observation of case/care manager interactions with clients in the field and on the phone; record reviews; agency or company specific performance appraisals; and client satisfaction surveys.

Clearly each certification has its own eligibility criteria and should be looked at carefully to assure a fit. Additional information and applications for each certification are available on-line: CCMC (www.ccmcertification.org); NASW (www.socialworkers.org); and NACCM (www.naccm.net). Supervision is an essential component of the case/care management certification process for a new or renewing applicant, and it is important in achieving and maintaining quality practice.

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health and community-based service delivery systems for older adults and their families. A leading authority on care management, eldercare services, caregiving, volunteer programs and healthy aging, she speaks and consults nationally and internationally. Retired President/CEO of Center for Healthy Aging in Santa Monica, CA, she is currently an Adjunct Associate Professor, USC Graduate School of Social Work and the Leonard Davis School of Gerontology. She is a past NAPGCM President, an Adele Elkind Award recipient and serves on the New Journal of Geriatric Care Management Editorial Board.

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How Geriatric Care Managers in Sole Practice Approach their own Supervision

Susan Birenbaum

The discussion of supervision in this article addresses the issue of professional geriatric care managers in a solo practice and how they approach their own supervision. When the topic of supervision comes up, it is generally with GCMs who have either GCMs working for them or with other employees working with or for them. A colleague will speak of the need for consultation on a case, but rarely does anyone speak of an on-going need for supervision.

When one begins to look at the important issue of supervision, it is necessary to examine two distinct situations. One is the GCM who is part of a larger organization, and those who are sole practitioners with independent practices. The Care Management Benchmarking Study, 2014 reports that the percentage of GCMs who are part of Independent Practices (82.7%) is disproportionate to the remaining survey (17.3%) who are part of non-independent practices (corporate, large hospital groups, home health care agencies, non-profit agencies). Unfortunately, the percentage of sole practitioners in the independent practice statistic is not available. However, if we consider the nature of the GCM profession and anecdotal evidence, we can estimate that at least 40 – 50% of Geriatric Care Managers in independent practice are sole practitioners.

While these statistical results may define a need, they may also be suggestive of a differential gap, which may lend itself to seeking out different types of available supervision available. Further, a variable which must be considered for the sole practitioner is the geographic location of their practice.

A question may be posed about whether supervision exists in the location where the GCM practices, and if he/she would be motivated to travel to seek supervision. While the exact geographic distribution is unavailable, it is known that the majority of sole practitioners work in urban locations. This indicates that those GCMs practicing in a rural area tend to be more isolated than those in urban areas. In addition, they may struggle with how they can qualify for credentialing if they don't have formal or proper supervision.

Group Practice

The size of group practice can range from two people to multi-state/multi-locations within states. The key benefit of a group practice case is that even if it is composed of two people, a supervision group can be

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created. Within this dyad, the GCMs can exchange ideas, work on ongoing resolutions for clinical, ethical, or practice issues. They can also develop measurement tools for evaluating their clients' satisfaction.

Sole Practice

In this model, the practitioner has to be more creative in how they satisfy supervision needs. This will largely depend upon the motivation and willingness of the GCM to identify the need for assistance in order to maintain objectivity. Often times this necessitates the need for GCMs to extend beyond the GCM community to other professionals such as: psychologists, psychiatrists, RNs, social workers, etc. They may also rely on professional networking associations, former colleagues, or ongoing informal peer supervision groups. Within these avenues, it is not uncommon for the supervisory relationship to involve monetary exchange for supervision provided.

Sole practitioners are entrepreneurs juggling all aspects of their business. In general, they are at a disadvantage in the area of supervision. They work alone and it is very difficult to find ways to:

- Evaluate their performance
- Find people and time to discuss ethical & clinical issues of cases
- Help with areas in which they need to grow
- Resolve business issues
- Incorporate practice administration, marketing, computer software, and other responsibilities.

In 2008, NAPGCM recognized this need and developed the National Peer Consultation Model which includes:

- Monthly telephonic meetings open to all chapter members
- Leader to facilitate meetings
- Case/Problem/Issue submitted to facilitator prior to the meeting
- Discussion of ethics of the case
- Response methodology as needed

The benefits of telephonic sessions allow GCMs from all over the region to participate. This is exceptionally beneficial to sole practitioners who are often isolated. Another key reason that these sessions are valuable is that this format allows GCMs to participate in a safe “non-competitive” environment where people can speak openly about an issue.

Different regions have modified their peer consultation to suit the needs of their members while other regions do not have it. Julie Wagner, of NAPGCM, surveyed the presidents of the different chapters to learn about how they handle the peer consultation or if in fact, they use the model.

A sampling from that survey follows:

South Central Chapter

Geri Sams, LCSW, CMC and Myra Johnson, LCSW, CMC are joint facilitators.

Peer Consultations via teleconferencing occur on a quarterly basis and during the South Central Chapter Meetings and National Meetings:

- Two cases are presented each time

- Requests for cases, peer reviewers and moderators are sent out to GCMs and general chapter members. Cases are selected by the facilitators. No more than two cases are presented
- Generally, six to ten people participate, primarily sole practitioners

Western Chapter

Rebecca Montano in the San Diego Unit Group offers peer supervision. They meet on a monthly basis. Every third Tuesday from 9 to 10:30 am at a place for coffee/breakfast. Out of this meeting process, individuals have become free to reach out to colleagues between meetings.

New York Chapter

Ellen Polivy, LCSW, C-ASWCM, Founder, Peer Supervision in New York Chapter.

The New York Chapter has two supervision groups both facilitated by Ellen:

1. General Cases
2. Cases related to Medicare and Medicaid issues

The General Case Group meets on the third Wednesday of the month from 8 to 9:30 am. The special case study group meets on the fourth Wednesday of the month on an ad hoc basis. Cases are solicited by the leader for discussion with no more than two cases in session. These peer consultations take place on a conference call. Reminders are sent out prior to the meetings. Participants total six to ten, primarily sole practitioners.

Midwest Chapter

Annicc Davis White, MS, CMC, LACHA is the facilitator in the Midwest Region.

Peer consultation teleconferences meet on the third Wednesday of the month from 4 to 5 pm. The schedule is sent out at the beginning of every year. These sessions meet the NACCM requirements for consultation/supervision.

Although some regions offer peer consultation on a regular basis, it appears that there is only a cohort of six to ten GCMs who participate in the calls and it is generally, the same people.

Private Peer Group Supervision

Response from Listserv– issue of forming self-supervision groups (NAPGCM, 6/5/14).

In the social work tradition, individual groups formed to discuss cases, ethical, and practice issues. This has been a historical tool and many times the groups have met for many years. I am aware of several groups in the NYC area. I was interested in finding out if this type of supervision group existed elsewhere in the country.

I specifically sought out answers to my question about how many GCMs felt the need to participate in individual support groups — either in person or telephonically to fill this void.

Based on the question that I posted on the NAPGCM listserv, there were 20 people who responded. Primarily GCMs with sole practices <5 years. Three of the respondents said that they had hired supervisors for either for on-going supervision or qualifying for certification. The remainder said that they had either tried to put together a group or they would be interested.

I followed up with emails to all the respondents to find out if they participate in peer consultation, and the entirety of them said they did not. The reason for the lack of participation is not evident and it does not seem to be due to inconvenience or expense. The calls are all 800 numbers and generally convene at non-busy times.

Conclusion

I believe that there is a definite need within the sole practitioner segment of the GCM community to find a way to build a user-friendly “peer consultation” focus. It might simply be a reimagining of the existing model, or perhaps breaking it down into smaller unit groups. Nevertheless, creative problem solving is necessary to address the deficiencies that exist.

A remedy within the regions might be to place more emphasis on the need and discussion of the importance of supervision for GCMs whether they are just starting out in practice or have been practicing for many years. It appears that this need is not recognized as a significant part of a GCM practice. This might be because many GCMs do not come from professional backgrounds where supervision is a requirement. However, in all three professional certification requirements, the amount of supervision is clearly stated.

Another factor in the low participation in supervision is that people do not understand that it is more than simply a review of cases. Supervision is an important part of personal and professional development and an acknowledgement of the need for quality assurance. This is more than client satisfaction, but how we measure our own performance is still in question.

Supervision should become an essential part of every geriatric care manager’s practice just as the use of research tools should be built into measuring practice performance.

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Journal

Supervision in Care Management: Managing
Quality

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Managing Quality in a Small Agency: Supervision Model

Helen Bergman, LMSW, C-ASWCM

As a small care management business, I offer a supervision model that is dynamic and has evolved over the years from my experience as a supervisor for social work interns from the Hunter College School of Social Work in New York City, as well as professional collaboration and practice. I have a two phase model: Phase One, training for new hire, and Phase Two on-going care management.

Phase One is much more time intensive and instructional. It begins with shadowing whereby the new hire accompanies a care manager to some complex cases and/or those to be assigned. This ‘on-the-job-training’ demonstrates the comprehensive home visit and introduces all the facets of on-going care management. The 1:1 twice weekly sessions in month one, then focus on care management tasks, specific client needs in assigned cases, record keeping and most importantly job satisfaction. Gaining familiarity with the local area and its comprehensive resources (i.e. medical, social) is incorporated in the training. The new care manager’s caseload is gradually increased and overall mastery usually follows a learning curve of three months.

Throughout this phase and the next, the following Core Competencies are stressed:

Collaborative

Attentive

Responsive

Expressive

Multi-tasker

Adaptable

Non-judgmental

Available

Co-getter

Ethical

Responsible

Phase Two expands the educational content but is more tailored to individual need. Throughout this phase, there is close attention to the

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supervisee's well-being and job satisfaction:

- Weekly 1:1 session with agenda from supervisee and supervisor (group supervision if more than one employee),
- Reading and approval of all emails to families/collateral following home visits,
- Daily review of JewelCode (Professional Care Management Software) notes with feedback to supervisee [i]
- Availability for ad-hoc support for problem solving (24 x 7), and
- Periodic informal review of performance.

How does a Care Manager supervisee feel about the supervision model?

I asked two of my employees what strategies were most helpful and their recommendations for improvement. Here are their responses:

Most helpful according to the supervisees:

1. The Agenda– there is consensus that this is beneficial. Keeping my own lists of “concerns” throughout the week to review when we meet is helpful to ensure nothing “slips through the cracks.” When the agenda of the supervisee was similar to that of the supervisor, it affirmed supervisee's skill in assessment and self-evaluation.
2. Use of software: JewelCode– To stay current on every client, utilizing the case list in JewelCode as the context to review each case one by one. Supervisees remarked that becoming familiar with all clients– even those they were not managing–increased their knowledge and skills and enabled them to cover when needed.
3. Focus In on 1:1 sessions includes:
 1. Clear communication about expectations from care manager, caregiver, and family
 2. Guidance with prioritizing issues and cases/visits
 3. Giving both positive and negative feedback
 4. Focus on how to respect “boundaries” when CM is working with caregivers and clients
 5. Analyzing steps in problem solving; modeling for conflict resolution
 6. On-going education–always learning something new and full guidance in new situations
 7. Full support when having to deal with unpleasant caregiver issues
4. Supervisor review of emails before sending (or responding to those from families/collateral) helped supervisee to write more concise summaries that are objective and do not cause alarm. This technique was seen to increase the writer's empathy with the reader and to avoid any confidential or liability issues.
5. Ad-hoc availability to help problem solve and brainstorm, whether by email/phone/text, almost immediately.

Recommendations from supervisees:

1. Supervise without interruption– Weekly sessions were usually interrupted by a client phone call, text, or email. While this became fodder for multi-task learning, it disturbed the continuity and focus.

2. Moderate the education component–“too much to learn too soon” leaves one feeling overwhelmed and insecure.
3. Provide additional help in resolving ethical conflicts over charging for services. This is especially important for social workers transitioning to a non–profit.
4. Provide more focus on care manager self–care and boundary issues with clients, families, and caregivers.
5. Include care managers more in business development; adding this component to supervision.

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[i] “CareComplete Plus.” – JewelCode Corporation. Software. 01 Nov. 2014.

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Peer Supervision in the GCM practice: a model of support and resource sharing

Debbie Drelich, LMSW, ACSW, CMC, GCM Fellow

A geriatric care manager working as a solo practitioner or in a small private practice needs professional support for both simple and more challenging cases. This is true for beginners, as well as well more seasoned care managers. Unarguably, the life of a GCM involves the probability that conflicts arise daily — at all hours — and ethical dilemmas abound. Where can the GCM turn for refuge of an “objective” voice offering knowledge, resources, and most of all supervision? Our NAPGCM listserv reflects the fact that many GCMs experience a sense of loneliness and are seeking the need for direction and affirmation. While it may offer opinions, thoughts, and resources especially for the newer GCMs, advanced practitioners need something more tangible to measure quality assurance and accountability. One alternative is that an advanced GCM can secure paid 1:1 supervision from their professional discipline (i.e. nursing, social work) or they can seek a group of like-minded professionals. Peer supervision is an excellent support model especially for problem-solving, reducing isolation, and stress reduction. This model of reciprocal learning that comes from the mutual sharing of resources and direct clinical evaluation and feedback can provide exactly what GCMs need without the formal supervision of an “expert” paid supervisor. The forum of the group potentially provides the collective wisdom of a number of peer professionals rather than one expert, which can enhance problem-solving.

An effective peer supervision group must be formed with a clear structure. The group can either be composed of members who are of similar level of expertise or mixed, although a homogeneous composition might be more valuable to a more seasoned member. This factor, among others, is important to consider when inviting a new member to join the group. Frequency and meeting mode (in-person or telephone) needs consensus and consistency. An agenda for each session should be collaboratively created and a facilitator appointed; the latter can be either fixed, rotated, or one or two group members may naturally evolve into this role. The agenda should have time for a clinical case presentation and the sharing of resources. Each member would be scheduled for a Case Presentation, and a skilled facilitator would need to be mindful during a case presentation that all members have the opportunity to speak and that no particular group member monopolizes the entire meeting. Roles would need to be defined as relates to scheduling, record keeping, and communication. Most important would be confidentiality and trust; the group must be a “safe place” where members can openly speak about their businesses and cases without fear of competition or judgment. If the group is to become a true peer supervision group, there must be commitment on the part of

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the members to regularly attend the group, to bring cases to the group for feedback, as well as to facilitate when appropriate.

My own personal need for a peer supervision group came at a time when I was transitioning to a full-time private practice six years ago from being a staff member, supervisor, and department head in a large geriatric institution. I immediately felt a need for support when faced with a large number of clinically complex cases. The New York chapter's regular educational meetings and listserv offered excellent opportunities to interact and call upon many wonderful experienced colleagues, but I felt that I needed something more. I learned that there was one peer supervision group existing but that had closed its membership. It was during an "if only there was" conversation with a colleague, that I heard there was a recently formed peer supervision group that would be happy to welcome a new member. Upon attending the first meeting, it became immediately obvious that this group was composed of a mixture of experienced practitioners, all with different strengths, length of practice (though all have been in practice for over 5 years minimum) serving clients in different geographic locations, and all potential competitors. However, there was an underlying mutual respect. In time, additional members were invited to join, and a structure that encouraged more equal participation / responsibility was developed. The hosting of the meetings is now rotated amongst more of the members, and all who participate bring items so that the host is not overburdened with food preparation.

Two years later, the meetings have evolved into a safe and supportive environment, meeting every four to six weeks, with calls and emails circulating ad hoc when members need additional support or information on resources. The group now utilizes a "doodle" poll to survey everyone's availability, as a time saver in scheduling meetings. The meetings themselves have fostered camaraderie, warm relationships, and cross-referring of cases when appropriate. While many chapters have a long-standing telephonic peer supervision group, there is something uniquely special about this more intimate group mode that ultimately helps to ameliorate the loneliness of being a solo practitioner.

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Supervision: Managing Quality in a Large Care Management Practice

Steve Barlam, MSW, LCSW, CMC

In a large geriatric care management organization with multiple locations, consistency in the delivery of quality services is essential. To this end, the organization must commit and invest in safeguards to maintain the integrity of the brand, and to assure clients' needs will be most appropriately met.

Supervision is the cornerstone to this process. It starts immediately when the new geriatric care manager begins his/her work at LivHOME. No one is hired to work as a GCM without a minimum of 2 years experience working with older adults and their families.

Supervision is broken into:

1. Initial Training
2. Observation / Application of learning
3. On-going Training
4. On-going Supervision / Coaching

Initial training is just one component of how we invest in our staff. Initial training on the core functions, tasks, policies and procedures, and the roles expected of our team members is provided in a classroom environment.

Post initial orientation training, our staff spend time in the field with seasoned care managers. They observe, and practice skills in the presence of those who are experienced. This allows for them to apply what was learned in the classroom to the field, and get "real time" feedback. We know that training is not effective if there is not on-going reinforcement of the learning. Studies have shown that 90% of what is learned is lost within 21 days if not practiced or reinforced (Thalheimer, W., 2010, April, How Much Do People Forget?).

LivHOME trainers make a commitment to partner with new care managers to help them become better care managers and to help them provide care management services in the LivHOME way. We expect our care managers to have an attitude that embraces learning, professional development, and enhancing one's skill sets.

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Steve Barlam
LivHOME Chief Professional
Officer and Co-Founder

Steve Barlam, along with Mike Nicholson, founded LivHOME in 1999. Since 1984, Steve has worked exclusively in the field of geriatric care management. His experience draws from work in both the non-profit family service arena as well as from his own private for-profit care management firm.

Steve is a Certified Care Manager (CMC) and a Licensed Clinical Social Worker (LCSW). Steve earned his Master's Degree from the University of California at Berkeley.

Steve is a recognized leader in the field of geriatric care management and is professionally active as a speaker and writer at both the local and national levels. He is actively involved in the professional credentialing process for care managers through his involvement with the National Academy of Certified Care Managers.

Steve additionally serves the interests of the geriatric community through the following associations:

National Association of Professional Geriatric Care Managers, past board member

Ongoing training is provided through regularly scheduled webinars. Topics for training are selected through feedback from the field. LivHOME identifies experts, nationally acclaimed professionals, to address our care managers on chosen topics. Training is additionally provided through regional onsite trainings (as needed), as well as staff are encouraged to attend local training venues.

and past president.
Stroke Association of Southern California, board member and past president.
National Academy of Certified Care Managers, board member.

Coaching begins post training, with the new care manager filling out a “self-assessment survey.” The survey is comprised of approximately 80 tasks/skills that are expected of a care manager. The care manager is asked to self-evaluate their proficiency level for each of the tasks at hand, using the following scale:

- 4 “I am a master at this skill/task, and can train others”
- 3 “I consistently practice the skill/task at a high level”
- 2 “I get it, but don’t practice it consistently”
- 1 “I don’t quite get the concept as yet”

The importance of this self-assessment survey is to ensure that the supervisors know those areas in which an individual needs customized coaching.

How is Supervision handled in the individual offices?

Most offices have a Care Manager Team Leader who is responsible for the 1:1 oversight of the care managers in that office. If there is not a team leader, supervision is the responsibility of the Executive Director with corporate support.

Depending on the size of the location, the supervision is either provided on 1:1 basis or in the case of a smaller office it may be provided in a group setting. Supervision consists of a case review and discussion of what the individual is working on. Specific challenges and issues are raised, discussing what else can be done to enhance the skills of the care manager to achieve the results we are looking for.

Coaching brings training to life. It is an on-going process. It communicates that we value you as an employee and are willing to invest in you. To succeed the care manager must be committed to learn and grow, and there needs to be a skilled coach to help the care manager with the needed growth. The three critical components to good coaching are:

1. Specific and Focused
2. Time Bound
3. Measurable

Coaching should be a positive experience between those involved. Every coaching intervention should result in incremental improvement of the care manager’s skills. Great coaching takes a commitment between those involved to become the very best at what they do and to create a positive experience for our clientele.

Coaching takes commitment from the supervisor or “coach” to consistently follow up on the issues raised and to work with the care manager through regular communication, providing customized training, brainstorming, problem-solving, observation, demonstration, role playing, and exploration of creative alternative ways of handling situations.

By investing in our care managers through the offering of initial training; observation / application of learning; on-going training; and on-going supervision/coaching, we can achieve a high level of certainty that as a

company with multiple locations we can deliver a quality service in the most consistent manner.

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Using the Concepts of Transference and Counter-transference in Care Management Supervision

Vince Brim, PsyD, CMC

Care manager supervisors can utilize the concepts of transference and counter-transference as a tool in helping care managers handle the many challenging situations they experience in working with clients and families. The concepts of transference and counter-transference were initially developed in clinical psychology to explain the phenomenon that happens between patient and therapist when the patient “transfers” feelings and a pattern of relating onto the therapist, and the therapist uses his/her understanding of his/her own feelings in response. To be clear, I am not talking about using this concept between supervisor and supervisee because this relationship is not that of a patient-therapist.

Transference as a tool in psychotherapy is defined as the feelings and wishes often rooted in unconscious childhood experiences redirected toward a new person. For example, a patient might relate to a therapist as if the therapist was his mother. Therefore, any old feelings such as love, hate, resentment, etc., the patient continues to harbor for his mother will be transferred to the therapeutic relationship. He will relate to the therapist accordingly, patterning his interactions and responses to the therapist as he has done with his mother. This dynamic typically occurs unconsciously. While a therapist might do little to nothing to create such feelings in the patient, the patient will still relate to the therapist in ways similar to how he related to his mother. It is the job of the therapist to identify these feelings in the patient through the therapist’s use of counter-transference. By identifying unresolved feelings in the patient, the therapist can help him become more aware of some of the unresolved feelings harbored that may be getting in the way of healthier and more productive relationships. The therapist helps the patient become more aware of how he relates to others in destructive ways, and models new and healthier interpersonal engagement.

The phenomenon of transference is not limited to the realm of psychotherapy. We all engage in transference without recognizing it, since it happens so unconsciously. However, outside of therapy, we do not have the benefit of having the recipient of our transference help to enlighten us. Transference left unchecked can wreak havoc interpersonally, and restrict the development of healthy and positive relationships. For example, your boss reminds you of your critical father, so you cower accordingly and feel some pressure to please him and fear you never will. Meanwhile, your co-worker has a more positive transference to him and is reminded of her encouraging and supportive grandfather. She is fond of your boss and thrives in their relationship, while you are feeling insecure and resentful. In this example, if you feel insecure and bitter when relating to your boss, he will likely respond in kind through his own counter-transference and the two of you will unwittingly recreate that old relationship you had with your critical father.

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Vince Brim is a licensed clinical psychologist and certified care manager, specializing in clinically complex cases. He incorporates wrap-around services for clients unable to live independently, selecting and managing clinical teams to meet clients’ special needs. Vince currently serves as the Clinical Director at Eldercare Services in Walnut Creek, CA.

How does counter-transference fit into all of this? In the context of psychotherapy, counter-transference is the phenomenon that occurs between patient and therapist when the therapist experiences feelings generated as a result of the way the patient is relating to him/her. Psychotherapists are trained to recognize their own counter-transference and to use it profitably in the therapeutic setting. An example might be when a therapist finds herself being pulled to act like her client's mother. She would likely notice the tug to keep the sessions easy and positive, if her own relationship with her mother was better when she behaved that way. Discussing unpleasant feelings with her client might bring up discomfort that she wouldn't normally experience with other clients. If this counter-transference went unnoticed on the part of the therapist, the temptation to avoid difficult feelings in the session would continue, colluding with the client's pressure to do so.

To use counter-transference constructively, the therapist would be very aware of her own feelings and use them to inform her client of the client's feelings, experience, and needs. Counter-transference in a clinical setting can be quite significant and, when not kept in check, can tempt a therapist to act inappropriately. A skilled clinician will be aware of such pitfalls and make use of the important information provided by her own counter-transference. Of course, entire books have been written on the topic of counter-transference, so I am using only a more rudimentary explanation here for the purposes of this brief article.

How does this all apply to the field of care management, and how can supervisors in care management benefit from understanding transference and counter-transference? Transference and counter-transference occur in daily living and color our interpersonal relationships, often without our awareness. Awareness on our part as care managers will improve effectiveness of our work considerably. By understanding the needs and feelings of our clients and their families more accurately, we can develop more successful interventions and more effectively serve them. Clients and their families often display transferences to their care managers. For example, care managers have all worked with people who will respond negatively to our best intentions, leaving us puzzled as to why. When this occurs, transference may be at play. And a good response may be to utilize our counter-transference in planning and executing our responses.

Without having to learn all the complexities of counter-transference, as care managers, we can simply learn to understand our own feelings in response to our clients. Utilizing our counter-transference at this basic level is enough for profitable use in our field. For example, your client with advanced dementia is easily agitated and can become threatening to the degree that he frightens others in his presence. You are exposed to his aggression and feel fearful. Without considering your own counter-transference, you might conclude that his problem is aggressive behavior, and conventional interventions might include medication to control agitation. However, you are now in touch with your own counter-transference and use it to inform you more about your client's experience.

If you can notice that you feel fearful in the face of your client's outbursts, you can conclude that your client's experience is likely fear which is causing anxiety. Many of us will become aggressive when we feel threatened or frightened, so this human response isn't foreign. You can relate to your client at a level that transcends dementia. Responding to the emotional experience of who we are working with will always help us to understand, connect, and be effective. So, in this case, you might redirect your efforts at developing an intervention to address his fear, and not necessarily his aggression.

Now let's apply the same concept to the above client's family member who calls you to complain about your inadequate service as a care manager. Your client's son goes on and on about how you are incompetent, how you don't know his father well, how you can't understand him, and how your absence from his father's life would be inconsequential. Your reaction without considering your counter-transference might be to respond defensively and to explain and justify all you have done, asserting how much experience you have in these matters. However, if you were to tap into your counter-transference, you would notice that your client's son made you feel shame, incompetent, and as if all your efforts didn't really matter. How might you respond

differently to your client's son's attacks? By empathizing with his feelings of shame, incompetence, and sense of insignificance related to his failed attempts to help his demented father, you would probably reply in a manner that would be in the service of him, instead of defending yourself.

As a supervisor, you can help your supervisee make use of his/her counter-transference to work more effectively with his/her clients as has been illustrated. Remember that attempting to analyze the transference and counter-transference between your supervisee and yourself would be inappropriate, as your role is not to psychoanalyze your supervisee. Your role is to help your supervisee serve clients optimally. Helping him/her to identify what he/she is or was feeling in response to the client can be very helpful in supervision, and a powerful learning experience.

Intellectual comprehension of these concepts can be more easily achieved than their application. Even those well-versed in the practice of utilizing counter-transference often cannot identify it as events occur, but instead can be coached to refrain from responding until there is an opportunity to understand their counter-transference. In supervision, encourage the practice of slowing down and raising awareness of the supervisee's own emotional responses to clients. Supervisees can learn to develop skill at using counter-transference to form responses and interventions only after understanding how their own feelings might be affected in their work with a particular client or family.

Therefore, having frequent discussions about counter-transference in supervision is helpful in developing this skill. Ask supervisees to identify the way they felt/feel in response clients, and not what they thought/think. For some, this is foreign territory as we are often trained to "think," hence the importance of aiding supervisees to become aware of their own emotional responses. Hopefully by understanding the most basic fundamentals of transference and counter-transference, we can all become better care managers, supervisors, and benefit in our own interpersonal relationships as an added bonus.

Topics: Supervision

One thought on "Using the Concepts of Transference and Counter-transference in Care Management Supervision"

1.  Paula Atwood says:

March 12, 2015 at 11:35 am

I would love to be able to share a copy of this wonderful article you have written with the participants of my workshop on Transference and CounterTransference I do for Benjamin Institute on Aging, the first workshop to be given June 17, 2015. Thank you,
Paula Atwood, MSSA, LISW-S, EMBA, LICDC-CS

[Reply](#)



Find the Root Cause: Ask Why 5 Times

Phyllis Mensh Brostoff, CISW, CMC

How do you manage challenging situations when you or someone you are supervising has made a mistake and a client is upset with you or someone working for you? One method is a form of root cause analysis: asking “why” 5 times.

This is a relatively easy way to get beneath the surface and determine the reason for a mistake, find an effective solution, and avoid this problem in the future. Its purpose is to foster a culture where it is safe to admit a mistake and avoid a culture of blame.

Case Study

Mr. and Mrs. A reluctantly accepted care management and care giving services after they were both seriously hurt in a car accident when Mr. A was driving. When the Care Manager assessed the As, what they wanted was someone to drive them to the mall twice a week so they could have lunch and meet their friends. The Care Manager got an angry call from Mr. A complaining about the caregiver and her car. The Care Manager asks, “Why are you so angry?” “My wife just can’t get into her car and it’s always breaking down.”

Since one of the requirements for assigning this caregiver was that she had a car, the Care Manager asks her “why is your car breaking down frequently and why is it so hard for Mrs. A to get into?” The caregiver explains that the car she is using is an old, two-door model. She has a nicer car with four doors but she doesn’t want Mrs. A in that car because Mrs. A insists on going to the mall in clothes soiled by feces and urine. Why was this happening when giving Mrs. A a bath was in the care plan? Mrs. A has refused to allow the caregiver to assist her with a bath, insisting that she has already taken a bath before the caregiver arrives.

Why was the Care Manager not aware of this problem? The caregiver was reluctant to admit that she couldn’t get Mrs. A to take a bath. Why was the caregiver reluctant to admit this? She was embarrassed but afraid that the Care Manager would be angry with her. The Care Manager reassures the caregiver that she will address this with the As. She talks frankly to Mr. and Mrs. A about the need to bathe and dress in clean, dry clothing if they want the caregiver to take them to the mall in her better car. Mrs. A agrees to take a bath on the two days a week the caregiver comes to the home, so that she can go to the mall, and the caregiver agrees to drive her 4 door car on those days.

When you are confronted with a challenging situation you are supervising, ask “why” 4 or 5 times and see if you can uncover the underlying cause and figure out a solution.

References

<https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/>

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