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Journal of Geriatric Care Management

Geriatric Care Management and the Community: Building Partnerships and Coalitions

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Guest Editor's Message

By Lenard Kaye, DSW, PhD

A distinctive characteristic of geriatric care management practice has always been the natural inclination of those choosing this profession to seek out and nurture a variety of professional affiliations and relationships in the community. A strong professional network aids care managers in their ability to maintain high community visibility and recognition as an important player in the community's health and human services infrastructure. It also better insures that you will be privy to new opportunities which can help you advance and assume prominence as a leading provider of high quality professional care to older adults and their families. Not surprisingly, the degree to which the care manager has timely access to community resources and supports, delivers community sensitive programming, and provides responsive client service will, in good part, be determined by the quality of his or her strategic alliances that have been established and maintained with the social, economic, business and health care infrastructure in the community.

In today's scarce resource and highly competitive health care environment, a care manager with a "lone ranger" mentality will soon discover such a philosophy is not only short sighted, it is just plain dumb. Such a mentality will usually end up, sooner or later, isolating your practice from the community network of respected providers and preclude you from participating in potentially innovative and lucrative program initiatives. Additionally, that same mentality increases your organization's vulnerability to economic downturns and other unexpected changes in the landscape of the community.

Implicit in maintaining a collaborative community spirit

is continuous commitment to the value of resource sharing, partnerships, team work, and reciprocity. Such a spirit requires high levels of information sharing and communication flow to and from all parties engaged in a particular exchange. From a systems theory perspective, an orientation to care management that encourages the sharing of information will exhibit the properties of an "open system." An open system as opposed to a closed system reflects greater engagement in the life of the community and a willingness to accept differences in terms of individual and organizational values, attitudes, and modes of practice. Open systems have permeable boundaries between individuals, departments, and organizations and therefore encourage the establishment of effective and efficient pathways for communication, which, in turn, promotes allegiance, trust, and broad-based learning across entities and people.

The spirit of community partnerships can be contagious. Folks who do it often serve as role models for others. They become known in their communities for their willingness to share power, authority, and resources. They build a reputation based on their ability to "play well with others." And, they become known as positive forces in their communities—facilitators and advocates of innovation. They are among the first to be turned to when opportunities arise that require community partners.

This issue of the Journal of Geriatric Care Management presents different perspectives on and examples of care management practice participation in community partnership building and coalition development. Cohen, Lynch,

Gullett, and Miller report on a series of interviews they conducted with seasoned care managers that showcase a variety of diverse approaches that have been used in developing innovative community partnerships in the community including the coming together of both traditional and nontraditional organizations. Joan Davitt and associates describe a unique university-community partnership in Philadelphia that succeeded in strengthening community capacity to support the principle of one's right to age-in-place. Kolomer and Van Voorhis then trace the results of a community coalition entered into by a variety of stakeholders in the southern United States. The success of Northeast Georgia CARE NET is illustrated and the important role played by care managers is underscored. In the final article, Eastman places care management practice in the context of a public health perspective which serves to underscore the important role played by care managers in promoting public well-being incorporating a prevention mentality.

All the contributors in this issue send the message, loudly and clearly, that geriatric care management is best conceived as an open system of service planning and provision prospering most from on-going exchange with an exceedingly wide range of community-based stakeholders.

Lenard W. Kaye, DSW, PhD, is Professor of Social Work at the University of Maine and Director of the University of Maine's Center on Aging, a multidisciplinary research center offering research and evaluation, education and training, and community consultation services on issues of mid-life and aging with the intent of maximizing quality of life for older adults and their families in Maine and beyond.

Developing Community Partnerships: Private Geriatric Care Managers Respond to the Changing Older Population

By Harriet L. Cohen, PhD, LCSW, Elizabeth Lynch, LBSW, MSW, MPH,
Anntoinette Gullet, LBSW, and Lee Ann Miller, LBSW*

Abstract

The nature and quality of professional relationships are changing in the practice of geriatric care management as the population of older adults and their families continue to grow, public funds shrink, and the aging service network becomes more fragmented and discontinuous. Innovative partnerships are emerging, bringing together traditional and nontraditional organizations and practitioners to

build individual and community capacity. This paper presents three case studies of private geriatric care managers who are pioneering unique models of community partnerships and are building community capacity to expand quality services to older adults and their

Introduction

Over the past thirty years as a gerontological social work practitioner and educator, Cohen, the lead author

on this article, has observed significant transformations in our approach to practice with older adults and their families. Two examples of the changes are the emergence of geriatric care management as a specific area of practice and the expanding opportunities for negotiating interdisciplinary, intra-agency, and interagency relationships within the context of an increasingly diverse aging population.

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This article discusses the shifting nature and quality of these professional relationships for geriatric care managers as innovative models of geriatric care management that respond to the dramatic demographic, social, cultural, and economic growth in the older adult population. These changing trends reflect the complex and constantly evolving challenges confronting gerontological practitioners and specifically geriatric care managers. Some of the trends include a rapidly expanding older adult population, the shrinking of public funding resources, the inadequacy of the medical model for care management, expanding demand for services, and a shifting focus from identifying problems and limitations to recognizing individual and community resiliency.

In addition, the diversity of the older adult population demands the establishment of culturally competent home and community based services and the education of practitioners who honor and respect diversity. These services require holistic assessments, which include acknowledging the mental, physical, social, and spiritual strengths and resources of older adults and their families. Today, the steadily growing older adult population requires a greater number of qualified geriatric care managers to develop and foster positive relationships with older adults, their families and communities, and other partners on the care team. Examples of potential partners include public and private sector providers, mental and physical health care systems providers, and long-term care providers. These newly formed interdisciplinary and interagency partnerships and alliances, which involve participants from the public, voluntary, and corporate sectors, enhance practitioner and community

capacity to respond to the rapidly increasing population of older adults and their families.

Brief History of Services and Resources to Older Adults

In the 1970s through the late 1980s, the service delivery network involved a loose network of not-for-profit and government agencies, mostly funded by public dollars. On a sliding fee scale, these agencies provided care management services to frail, low income, older adults to prevent premature or inappropriate institutionalization. Public and private funding sources, including the Medicaid community waiver program, covered the actual cost for delivering the services. The assessment and care plans, linking clients with the available social services, identified limitations, problems, and deficits in the older adult. During this historical time, we rarely asked the older adults or family members what they wanted or what barriers they faced; consequently, we failed to identify values, interests, assets, strengths

During the late 1980s through the present, a new paradigm for successful aging has emerged, which has shifted our limited connotation of the elderly from vulnerable, sick, helpless, recipients of services, and a burden to society, to more positive and hopeful concepts of older adults...

and resiliency of the individuals, the family system, or the community.

This “one size fits all” social planning model relied on “experts” or “professionals” to plan and implement home and community based services “for” older adults and their families (Greene, Cohen, Galumbos & Kropf, 2007). The professionals “knew” what the clients needed. Services were concrete and prescriptive, assessments were linear, and services were agency driven. Funding decisions

at the federal level through the Older Americans Act were based on the “expert” rather than the “consumer” model and funding at the state level often followed the lead of the federal government. Although the funding significantly impacted the growth of home and community based services for older adults and reduced premature and inappropriate institutionalization, the funding failed to build community or service delivery infrastructure or to foster individual, family, or community capacity.

Transforming Service Delivery to Older Adults

During the late 1980s through the present, a new paradigm for successful aging has emerged, which has shifted our limited connotation of the elderly from vulnerable, sick, helpless, recipients of services, and a burden to society, to more positive and hopeful concepts of older adults as active, productive, resilient, valuable, and contributing members of families and society (Greene & Cohen, 2005). This newer

framework, based on a life course perspective, captures the impact and interplay of factors impacting older adults, including such factors as ethnicity and race, sexual orientation, economic status, gender, intergenerational interdependency, and chronic disability for older adults,

their families, and their communities (Hooymann, 2005). This new perspective shifts our thinking in four areas. First, it increases our understanding that resiliency and hardiness are accessible to people throughout their lives. Second, it recognizes older adults as significant partners in decision making about their lives and acknowledges older adults as contributors to community, not just recipients of services,

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bringing a myriad of life experiences to their lives as older adults. Fourth, it builds on the assumption that well-being includes psychosocial needs, social connections, safety, transportation, nutrition, giving back, spiritual and religious community, and good physical health (Greene, et al. 2007).

At the same time, private foundations and government funding sources have challenged our assumptions about service delivery. For example, the Robert Wood Johnson Foundation brought the language of business - words like "self sufficient," "marketing," "fee for service," "consumer driven," and "private pay" - into our consciousness. The change in our language, attitudes, and beliefs about older adults and their families has moved care management from the traditional medical model where the care manager assesses problems and limitations of the client to a strength-based model, where problems become a backdrop rather than the foreground of the client-care manager relationships. The client is perceived as having a range of experiences, characteristics, and roles that determine who he or she is, rather than as someone who is old, disabled, or chronically ill (Fast and Chapin, 2000, pp. 1-2).

These shifts confront our thinking about what services to provide, how to deliver these services, who will provide the services, and what relationships exist between and among older adults, family members, traditional and non-traditions organizations and agencies, community members, and community professionals.

Developing professional relationships

Lewis and Harrell (2002) offer examples of the newer model of care management and the changing approach to practice with older adults. This approach to

care management, which nurtures resiliency in older adults, has three components. First, it promotes affiliations within the service delivery system to address issues of diversity. Second, it explores environmental and cultural factors that contribute to safety and support for the client and that foster self-determination. Third, it encourages relationships and connections with family, indigenous groups, and other community groups. The approach reflects the shifts that not only have occurred in the definition of care management, but also in the role of care manager, establishing and maintaining multiple professional relationships with individuals and organizations in the community that promote the well-being of frail older adults, their families, and their communities.

Under the new paradigm for geriatric care management, new terms, such as alliance, partnership, and collaboration have emerged to describe professional relationships. In addition, formal or informal describes the quality or nature of the professional association that supports the older adults in the community setting.

Interdisciplinary and interagency relationships are a significant component of service delivery to older adults and their families. Working with other community professionals can prove both beneficial and difficult for geriatric care managers. Collaboration ensures services are more accessible, better coordinated (Mattessich & Monsey, 1992), and more efficient in reducing the repeated request for the same information from different

professionals working with the same family. On the other hand, some of the potential obstacles in developing and negotiating these relationships include communication barriers, lack of respect or trust of other colleagues (Reese & Sontag, 1992), unwillingness to recognize interdependence and to pool resources (Graham & Barter, 1999), conflicting views of how best to meet clients' needs, and tension between professional cultures and values (Hall, 2005; White & Featherstone, 2004).

Case Studies

The research team members interviewed social work and nurse geriatric care managers. This article highlights three

case studies, providing viewpoints and perspectives of the opportunities and challenges of working in interdisciplinary and interagency partnerships. Two geriatric care managers serve in leadership positions in large eldercare companies and one works as a solo private practitioner. All are members of the National Association of Professional Geriatric Care Managers, hold degrees in nursing, social work, public health and/or gerontology, and worked with older adults for many years before becoming geriatric care managers.

Claudia Fine, MPH, LCSW, CMC, is the executive vice president and chief professional officer of the SeniorBridge in New York City. She was the former president of the National Association of Professional Geriatric Care Managers and worked to reform the US healthcare system to better meet the needs of

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older adults and to develop new approaches for solving the caregiver crisis and the crisis in caring for older adults.

Claudia's primary responsibility at the SeniorBridge is to develop alliances with other agencies and professionals, which requires that she work closely with teaching hospitals to help them grasp the advantages of care management. She also works with elder law attorneys, trust and estate attorneys, private physicians, rehabilitation centers, religious organizations and family planning advisors. She describes these relationships as informal. SeniorBridge has attempted to formalize partnerships with healthcare organizations and facilities, but Claudia states that these have generally proved less effective than developing informal collaborative relationships with individual health care providers. This approach is a more naturally occurring process through which agencies and individuals recognize their interdependence, acknowledge the scarcity of community resources, and combine efforts to establish needed services that are accessible, available, and affordable. Claudia believes that the most important element of collaborating with other agencies is to clearly define one's own niche because one "can't be all things to all people."

The biggest challenge that Claudia has experienced as a geriatric care manager is educating healthcare professionals about the benefits of the family focused geriatric care management model. Often physicians and other healthcare professionals initially consider geriatric care managers as an additional burden because they

are so overwhelmed by the complex needs of their patients and the inadequate health care system. The goal, however, of the professional geriatric care manager is to establish ad hoc teams for a given client and, through teamwork, support other professionals to provide the best care possible to older adults and their families. Claudia finds

Claudia finds that the frustration she generally experiences in healthcare settings can be somewhat reduced in teaching hospitals, where the interdisciplinary staff and the academic environment provide opportunities for recognition of the complex and multifaceted nature of the patients' needs.

that the frustration she generally experiences in healthcare settings can be somewhat reduced in teaching hospitals, where the interdisciplinary staff and the academic environment provide opportunities for recognition of the complex and multifaceted nature of the patients' needs.

Claudia worries that non-profit agencies sometimes lack awareness of resources available to older adults and their families offered by the private, for-profit sector. This lack of knowledge creates a barrier to care in cases where non-profits do not provide certain services to client populations. "Unfortunately, the idea that healthcare is an entitlement is a fantasy," claims Claudia, "and non-profits don't understand that people may have to pay out of pocket for it, especially long-term care." She adds that hospital discharge planners usually offer the families of patients a list of resources without adequately assisting them in understanding the benefits of each option so that they can make informed decisions.

Claudia is clear that the success of professional geriatric care management is contingent on the quality of the partnerships. She explains that developing trust in community partners and in the

quality of the services allows care managers to assist older adults and their family and to build community capacity. Open communication between partners helps to ensure success, measured not through formal, written contracts, but through the quality of services delivered to the older adults.

Shannon Martin, MSW, Graduate Certificate in Gerontology, is the director of community relations at Aging Wisely, Inc., in Clearwater, Florida. She has been working in geriatric care management since 2002, after working as a gerontological social worker in nursing home and hospice settings.

Shannon met the chief operating officer of Aging Wisely, Inc., at a networking function. The owner is an elder law attorney and former social worker, who initially tried having a care manager within the practice but decided that arrangement was not effective and thus started Aging Wisely. Now the agency and the elder law practice are separate and the care managers refer to other elder law attorneys so that neither the workers nor clients feel a conflict of interest. Currently, Aging Wisely, Inc., has eight care managers, who have earned bachelors and masters degrees in a variety of fields, a director of community relations and a chief operating officer, a bookkeeper, a daily money manager and an administrative assistant. All professional staff members are or anticipate certification as geriatric care managers.

The owners of Aging Wisely highly value community involvement and, as a result, Aging Wisely staff members represent the agency on a variety of aging, community, and professional committees. For example, staff members serve on the panel of experts developed by the trust division of the local bank for educational purposes and comprised of a CPA, a geriatric care manager, an estate

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planning attorney, representatives of insurance companies, hospice, American Heart Association, Alzheimer’s Association, and other not-for-profits. They have partnered with other community groups to create visibility, to network with others in the community, and to provide community education about the benefits of care management for older adults and their families. In addition, staff members of Aging Wisely sit on various coalitions, such as the Florida Coalition for Optimal Mental Health and Aging, the Estate Planning Council, the Pinellas Falls Prevention Coalition, the Dunedin Committee on Aging and the AAA Aging Disability and Resource Center Advisory Task Force. Shannon stressed the importance of these informal relationships, which constitute a network of resources and enhance the quality of care for the clients served by all of these agencies.

In addition, Shannon has become involved with the Life Care Ambassadors, a program initiated in Florida by a financial planner, a nurse, an attorney, and a geriatric care manager. The program is comprised of not-for-profit and for-profit entities that have a shared vision and purpose of providing a comprehensive and holistic approach to the delivery of quality services to older adults and their families. The interdisciplinary and interagency members of the Ambassadors contribute ideas, resources, and a commitment to build community capacity.

Shannon explained the importance of building trust, not through a formal written document, but through understanding and respecting the work of other professionals and the needs and concerns of older adults and their families. She said that sometimes not-for-profit agencies and providers express a lack of trust in the “for-profit” professionals, such as financial planners, private

care, and attorneys. Care managers build trust by demonstrating the value of their services to clients and the other professionals involved. Shannon emphasized that geriatric care managers must be diligent in researching the quality of care provided by other agencies and professionals in the community, but it is also “important to know the personalities” of their clients and community resources to insure positive working relationships.

Andrea Eisenstein, MSW, LCSW, is the owner and sole employee of Andrea Eisenstein and Associates. She has been a gerontological social worker for over twenty-five years and a geriatric care manager for over six years. Andrea has developed successful relationships with traditional and nontraditional community partners that intersect various disciplines and organizational affiliations.

Andrea is involved in community groups that provide visibility, opportunities to educate others about geriatric care management, and enhancement of professional growth. She participates in the Jewish Federation’s Business and Professional Women’s Breakfast group, a monthly business networking group, comprised of approximately sixty women who own or work in various businesses. She serves or has served on the boards of directors of the National Association of Social Workers

Houston Chapter, the Houston Gerontological Society, and the regional chapter of the National Association of Professional Geriatric Care Managers. She has fostered relationships with traditional care

management partnerships, such as other social work professionals, hospital discharge planners, marketing people with residential facilities, nurses, nursing home administrators, and staff of the Alzheimer’s Association, the Area Agency on Aging, and Sheltering Arms Senior Services.

In addition, Andrea is a partner in a newly formed community public-private partnership Care for Elders, funded by the Robert Wood Johnson Foundation, through its Community Partnerships for Older Adults (CPFOA) national initiative, and comprised of 85 organizational and 11 individual partners (Sheltering Arms, 2007). Organizational partners include public sector providers and funders, private not-for-profit agencies, long-term care and mental health providers, and business and corporate partners. Other partners are the media (television and newspaper), academic institutions and planning organizations, private sector funders, health care systems

and providers, local government, and advocacy and special interest groups, such as the Better Business Bureau, the Chamber of Commerce, and the League of Women Voters. By participating in this innovative community partnership, Andrea has learned about community services and the development of creative new services to expand needed services and to improve access to existing

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services. Andrea strongly agrees with the goals and values of the Care for Elders partnerships—to improve accessibility, availability, affordability, and quality of services

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for older adults and to increase personal, organizational, and community preparedness for people to age in place.

Andrea has developed and fostered alliances with individuals and organizations to address specific concerns that have emerged in geriatric care management. For example, Andrea attends a monthly case consultation with a geropsychiatrist, hired by Jewish Family Services of Houston. Her participation in the consultation, as an independent practitioner and the only geriatric care manager, is made possible because she has continued to nurture a previous relationship with the agency. A second example of a creative alliance is the development of a relationship with a geriatric pharmacologist, located as a result of an Internet search. After reading about the emergence of this professional group, Andrea searched the Internet for the Society of Geriatric Pharmacologists and found someone located in her community to help evaluate issues of concern. These relationships with a geropsychiatrist and geriatric pharmacologist demonstrate the changing nature of geriatric care management, creating and nurturing alliances with professionals in newly created geriatric specializations. In addition to reaching out to new community resources and professionals, Andrea identified communication between and among professionals and building trust with older adults, their families, and community providers and practitioners as important components of

geriatric care management.

Some common themes about partnerships and alliances emerge from these interviews with private care managers. First, these care managers agree that although not-for-profit organizations have traditionally dominated the geriatric care management service network, the growth of for-profit entities necessitates innovative alliances to enhance service delivery to older adults and their families regardless of the funding mechanism. Second,

the care managers emphasize the importance of establishing and maintaining trusting relationships with other professionals based on the quality of services provided to older adult clients/patients and their families. No one has suggested that formal relationships using contracts helped to ensure quality services. Third, all of the geriatric care managers interviewed highlighted the significance of effective and frequent communication between the geriatric care managers, their older adult clients/patients and their families, and other service providers. Fourth, a holistic approach to providing quality services involves innovative alliances with partners, such as banks, insurance companies, chambers of commerce, healthcare organizations, and for-profit geriatric practitioners and organizations. However, the fifth theme that emerged from the interviews is that many potential partners need educating about the advantages of geriatric care management and the shift to the concepts of positive aging. This task easily falls within the role of educator that the geriatric care managers already accomplish successfully. Based on these themes, Table I offers strategies for developing community partnerships and alliances.

Conclusion

Since geriatric care managers are skillful in helping older adults and their families during times of transition and crisis, they also may possess the ability to assist agencies and the community during times of transition. Care managers, as system change agents and advocates, are in a unique position to strengthen and broaden the long-term care

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T A B L E I

Strategies for Developing Community Partnerships and Alliances

- Take time to educate potential partners about the benefits of geriatric care management
- Identify individual and community assets and resources, not just unmet needs and deficits
- Involve older adults and their families in decision making around planning, implementing and evaluating service delivery
- Participate in community coalitions that address special topics, such as housing, fall prevention, or mobility, which affect the quality of life of your clients/patients and their families
- Recognize that service delivery to older adults and their families is changing and invite for-profit practitioners and organizations to become members of community coalitions
- Develop positive working alliances with interdisciplinary team members
- Recognize that the demands of managed care and cost containment, with increasing caseloads and decreased staff, may result in stress on healthcare professionals
- Explore offering interdisciplinary services in a common location for "one stop shopping" such as a shopping mall or stand alone office
- Assess organizational and individual willingness and readiness to participate on interdisciplinary teams
- Determine what tangible or intangible organizational or community support may be needed to participate on community coalitions
- Acknowledge the skills needed in relationship building and in healing strained relationships that are critical in establishing and maintaining interdisciplinary collaboration

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delivery system for older adults and their families. In addition, community partners from not-for-profit and for-profit agencies, representatives from long established and innovative programs and services, and new partners such as the business and media sectors expand the community's capacity to respond to the growing older adult population and the complex needs of older adults and their families.

These new and creative partnerships between geriatric care managers and other partners can promote nontraditional services, such as education, prevention, and improvement in quality of life for older adults and their caregivers, while continuing to reduce inappropriate or early institutionalization, decrease hospital use, and increase access to community based services to maintain people in their homes as long as possible. Geriatric care managers and their partners, using a strengths-based and resiliency perspective, can involve older adults in decision making, value older adults as developers of service and not just recipients of services, recognize that both families and individuals are aging, and promote services that are

culturally appropriate, accessible, and affordable. In addition, they can endorse federal, state, and local legislation and funding to build community capacity and develop elder friendly communities.

Clearly, much work is needed to meet the challenges of an aging population. The growing number of older adults and their families will require a flexible, well-coordinated, consumer-driven, culturally appropriate, well-financed aging service delivery system that promotes individual, family, and community resiliency (Greene and Cohen, 2005). Care managers link older adults with community services and actively participate in interdisciplinary and interagency partnerships, alliances,

and collaborative relationships. As a result, they are in a unique position to play a pivotal role in the transformation of the aging service delivery network and the quality of care to older adults and their families.

Since geriatric care managers are skillful in helping older adults and their families during times of transition and crisis, they also may possess the ability to assist agencies and the community during times of transition.

** Harriet L. Cohen, PhD, is an Assistant Professor of Social Work at Texas Christian University. Please direct any correspondence regarding this article to Harriet Cohen. At the time of this project, Annetoinette Gullet, Elizabeth Lynch, and Lee Ann Miller were students in the BSW program at Texas Christian University, Fort Worth, Texas.*

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Care Management: Building Community Capacity to Support Aging in Place

By Joan K. Davitt, PhD, MSS, MLSP, Eileen Sullivan-Marx, PhD, RN, FAAN, Rachel B. Cohen, MUP, MSW, Lucy Kerman, PhD, Dina Schlossberg, JD, Harris Steinberg, AIA, and Diane-Louise Wormley

Introduction

Community is a critical element to successful aging in place. It provides for the production, distribution and consumption of goods and services while generating opportunities for social participation and mutual support (Warren, 1969). In other words it provides access to those resources and activities that are required for daily existence (Schriver, 2001). Community encompasses bonds of social relations, that are the base for collective action, and spaces for interaction (whether physical space or psychosocial), that offer opportunities for identity development and a sense of shared experience (we-ness) (Rubin and Rubin, 2001). Community is comprised of subsystems including, individuals, families, groups and organizations (Schriver, 2001). It also plays a mediating role between individuals and other groups/social structures (Weil, 1996). Community is embedded in a larger environment which influences the community and is affected by the community. Community thus plays a critical role in meeting the needs of the elderly through affective bonds which help to meet psycho-social needs (friendship, nurturing and informal support) and instrumental relationships which meet basic needs for food, services, and other essentials.

Community can be seen as an important component in enhancing or reducing the ability to age in place depending on the capacities or assets of the community. It can be more difficult for older adults, especially

as they age, to obtain the necessary goods, services, and support from outside of their geographic community when that community is lacking in certain assets. Thus, care managers need to look to the community itself as a system of resources to promote aging in place. However, not all communities are equally enabled to support aging in place. Care managers are therefore likely to find themselves in the role of community capacity builder, in order to secure the ultimate goal of aging in place for their clients.

An interdisciplinary effort, the Senior Collaborative, sponsored by the University of Pennsylvania has been looking at these very issues in West Philadelphia. Arising out of the Penn Compact, an initiative to achieve eminence in collaborative local and global engagement with communities, a forum of faculty, students, and administrators from the disciplines of nursing, social work, design, urban planning, law, and government began an integrated effort to better understand issues facing older adults living in the neighborhoods surrounding Penn's campus (West Philadelphia). We came together initially to address two main questions: What is the role of the University to its aging community and what are the needs of the West Philadelphia aging community?

Older adults in West Philadelphia are confronted by heightened health risks, disparities in access to care, physical disabilities, need for functional home adjustments, and financial vulnerabilities. They are

impacted by crime and exposure to violence, an aging and diminishing civic leadership, lack of available community amenities (shopping, banking, transportation), and the challenges faced by family to support older family members. Older adults face great barriers when electing to remain in their own homes, often having to choose between staying or leaving the neighborhood entirely. The ultimate goal of our work under this project is to create alternatives to enable older adults in West Philadelphia to age in place in their own home and/or in the community, thus promoting elder friendly environments within the community.

Geriatric Care managers (GCMs) are in unique positions to build community capacity toward promoting elder friendly communities. Such efforts will only enhance the GCMs ability to address client need. For example, efforts to promote responsible commercial development (e.g. more grocery stores or medical providers) or to enhance access to public transportation within a community can dramatically improve access to essential goods and services for the elderly. Such access may prevent or delay physical health problems which could result in more costly care needs. Also by making the community more accessible and resource rich, the GCM serves multiple clients. Thus, this article will offer a description of community capacity building, its value to care managers, and strategies for building community capacity including

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community organizing and coalition development. We will explicate this process by highlighting the work of the Senior Collaborative at the University of Pennsylvania.

Community Capacity

Community capacity refers to those elements of a community which help to sustain the well-being of the community.

Community capacity is the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community. It may operate through informal social processes and/or organized efforts by individuals, organizations, and social networks that exist among them and between them and the larger systems of which the community is a part. (Chaskin, Brown, Venkatesh, and Vidal, 2001, p.1)

Communities are dynamic entities with ever changing and multi-dimensional capacities (Chaskin, Brown, Venkatesh, and Vidal, 2001) that vary across communities.

Community capacity consists of a set of assets that enable development and sustainability. These may include individual and organization resources (from human to social capital), networks of social relationships, leadership, and support for collective action and problem solving (Chaskin, Brown, Venkatesh, and Vidal, 2001). Such assets are essential to community capacity but are not sufficient for community change.

In addition to access to resources (both within and beyond the community) there must be a feeling of connectedness to the community and a mutuality of experience and purpose (McMillan & Chavis, 1986). Along with this feeling of community must be a sense of responsibility to the community and an ability to translate that sense into action to resolve problems (Chaskin, Brown, Venkatesh, and Vidal, 2001). All

communities vary in the amount of any one of these assets, and these characteristics may change with time.

In our work in West Philadelphia, for example, we found a tremendous asset in indigenous leaders, many of whom are older adults. The older residents have a strong sense of connection to the community, as many have lived in these neighborhoods for more than 30 years. We also were keenly aware of other community-based collaborative projects successfully implemented in the past in some of these neighborhoods. For example, in 2004 the University

sponsored a series of public forums to create a civic conversation about neighborhood change that produced principles for equitable development along the 40th Street commercial corridor. This was in response to concerns about the impact of both residential and commercial real estate increases on vulnerable residents. During the initial forums we were told that many seniors were not attending due to the weather and timing of the events. The university conducted a special session at an elder high rise apartment complex near 40th Street to ensure that older resident's concerns were heard. Thus was born the intergenerational Friends of 40th Street which grew out of a successful civic engagement series sponsored by the university. Such assets would need to be mobilized for our Senior Collaborative project in order to generate and sustain community capacity to address the barriers to aging in place. New capacities would also have to be developed.

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Capacity Building

So why should care managers engage in community capacity building? First, such activities can generate new and enhanced capacity in a given community enabling that community to better handle problem solving. More importantly it can lead to more positive outcomes such as increased services, safer environments or increased access to specific goods. Community capacity building rests on the premise that capacity is generative rather than a fixed property of a community. Thus interventions can enhance capacity within a community (Chaskin, Brown, Venkatesh, and Vidal, 2001).

Community capacity building includes a focus on the strengths (or assets) of the community and a mobilization of those assets to promote positive change within and around the community (Minkler, 1997). It begins with local conditions, outlining a course of action based on the local experience (Schriver, 2001). Critical to its success are principles of reciprocity, respect, inclusiveness and accountability (Fabricant and Fisher, 2002), collaboration and engagement (Martinez-Brawley, 2000; Minkler, 1997).

As suggested earlier, the GCM is in a unique position to initiate capacity building efforts due to ongoing work in the community. However, this work cannot be accomplished alone. The GCM will need help/advice from a variety of perspectives (e.g. residents of all ages, community based organizations, businesses, etc.).

Several strategies can be used for building community capacity. Chaskin

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and colleagues (2001) suggest four broad strategies: leadership development, organizational development, community organizing and inter-organizational collaboration. In the following sections we discuss the specific strategies used for the Senior Collaborative as examples of the types of activities that a GCM might employ.

Building Elder-friendly Urban Environments: The Early Stages

Early in the process we began to realize that we were embarking on a community capacity building endeavor. To be successful the project would require:

- local engagement to improve and sustain quality-of-life for older adults in West Philadelphia;
- integration of knowledge related to aging needs from different disciplines and perspectives; and
- the provision of support to the community in West Philadelphia.

In order to have an impact we needed to move beyond the walls of the academy to engage the community. We began by expanding our collaborative effort to include community-based organizations. Various community agencies such as, Philadelphia Corporation for Aging, the Community Design Collaborative of the Philadelphia Chapter of the American Institute of Architects, the SeniorLAW Center, the City of Philadelphia Department of Health, the Commonwealth of Pennsylvania Departments of Aging and Public Welfare, People's Emergency Center Community Development Corporation, Homeownership Counseling Association of Delaware Valley, and Rebuilding Together Philadelphia, were invited to join the coalition. Coalition members benefited immediately from their participation. They were given the opportunity to meet with a diverse group of community based organizations with complementary missions. This enabled increased communication

and education of the members which led to greater understanding of available resources for their clients and networking to improve service delivery. By expanding the coalition we also acted as the initial enabling system, by networking and bringing additional resources to bear on the problem (Chavis, Florin and Felix, 1993).

The importance of increasing the diversity of the coalition cannot be underestimated (Mizrahi & Rosenthal, 1993). These organizations provided different perspectives on the plight of vulnerable older adults in West Philadelphia, through their first-hand experience with the population. Coalition expansion thus broadened our perspectives but also increased the problem solving capacity of the group and enabled us to manage change on a sustained basis – all critical aspects of community organizing (Hardcastle, Wenocur, and Powers, 2004). Also, these organizations are active in the community in a variety of ways benefiting older adults both directly and indirectly. They had built trust, rapport, and contacts within the community and thus could provide a conduit to the community itself.

By broadly defining the coalition's goal we enhanced the collaborative's capacity in two ways. First, additional invitees agreed to join the coalition because the goal was acceptable and relevant to their agency's mission. In this way, we increased the diversity of the coalition and thus its capacity. Second, this broad goal was essential to securing members' investment and active participation in the process and an ongoing connection to the collective

agenda (Mizrahi and Rosenthal, 1993). By increasing the diversity and capacity of the coalition we indirectly enhanced the community's capacity since this group was now acting as an enabling system for the community (Chavis, Florin and Felix, 1993).

Leadership of the expanded coalition was also critical. We were lucky to have a community based agency representative with the vision and resources (mainly time and energy) to take on this role for the expanded coalition, thus convincing the community representatives that the effort was truly collaborative. This

would not be an effort initiated by researchers and imposed upon the community.

Geriatric care managers can play a similar role in this process, as they have built relationships based on trust, reciprocity and accountability within communities, and have first-hand information about the needs and assets of the communities they serve (Weil, 1996). It is also critical for GCMs to know about the range of services and other resources available in

Geriatric care managers can play a similar role in this process, as they have built relationships based on trust, reciprocity and accountability within communities, and have first-hand information about the needs and assets of the communities they serve

a client's community. Although creation and facilitation of or even simply participation in such a coalition requires time and resources, it can offer GCMs a wealth of information and support in tackling client problems. In addition, it can be the initial step in generating increased capacity which in the long run results in greater program efficiency or even reduced need.

Understanding The Community: Essential Strategy For Building Capacity

After several meetings we realized that we needed much more

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information on the community to begin to understand how to prioritize the problem. We employed multiple tools and methods to gain further insight about the community and the needs of older adults residing in West Philadelphia. We relied on existing research to understand issues and problems for the elderly in Philadelphia in general. Much of this information was obtained through coalition members' awareness of local agency research. Therefore, coalition members were able, with minimal time and effort, to generate tremendous resources to begin the discovery process. This information highlighted conditions related to:

- the high proportion of residents age 65 and older (Brookings Institution, 2003);
- high rates of disability among older residents;
- high homeownership rates among older adults in Philadelphia;
- the age (many homes built before 1940) and need for repair of many of these homes;
- the need for adaptation to accommodate the changing needs of residents; and
- the high poverty rates for older adults. (Philadelphia Corporation for Aging, 2006.)

We needed, however, to know more about the specific details of West Philadelphia in relation to the concerns of older adults. Using the existing data as a guide to generate questions we employed spatial analysis for specific zip codes in West Philadelphia. Spatial modeling is a particularly helpful method to integrate different types of data to emphasize the role of place and its impact on the quality of older adults' lives, an important mission of this project. Through spatial modeling we gained a more specific understanding not only of older adult homeowners but also of the specific neighborhoods that are served by multiple agencies for potential matching on the needs of a clustered group of individuals.

Utilizing expertise of the University of Pennsylvania's Cartographic Modeling Lab (CML), maps were created to illustrate the demographic characteristics of West Philadelphia. The maps more clearly conveyed the complexity of issues resulting from an aging population living in aging housing within the greater context of an aging community. The understanding generated with these maps became the basis for further analysis of the needs of older adults in specific neighborhoods of West Philadelphia. Spatial analysis demonstrated the following about West Philadelphia:

- overall it is an "aging" neighborhood;
- a large majority of older residents are long time residents in the neighborhood moving in before 1969;
- a large percentage of older homeowners reside in homes built prior to 1939;
- many long term homeowners live in older homes which most likely were not designed for older residents (e.g. no first floor bathrooms);
- there are areas of concentration of homeowners age 85 and older;
- many older homeowners (70%) have high mortgage burdens;
- there are high concentrations of disabled older adults throughout the area;
- the housing stock in many of these neighborhoods is very old and likely to need repair; and
- many of the older residents have strong ties to the community.

SWOT Analysis

It became clear after reviewing the maps and other data sources that the next step for the collaborative would be to develop a prioritized list of needs. Informed by spatial modeling data, an analysis of the Strengths, Weaknesses, Opportunities and Threats regarding community

issues for older adults was conducted through a series of brainstorming meetings of coalition members (Bryson, 1998). Two themes emerged that identified the following threats:

- 1) Increasing home property values and the implications of gentrification for older residents who wish to remain in their homes:
 - potential home loss due to increased property taxes; and
 - predatory lending practices targeted at older and financially naïve homeowners with increasing property values.
- 2) Home adaptation and maintenance to remain in their neighborhoods of residence:
 - changing physical abilities might prevent them from independently completing necessary chores, etc. to maintain the home;
 - changes in physical abilities might require home adaptation to the changing needs of the residents;
 - increased costs of home repairs for older residents on a fixed income; and
 - problems with unscrupulous contractors.

Due to extremely limited resources (initially we had no budget for this project) we had to work with what information existed and what we could generate for little to no cost. In other words, we started where we could with regard to a needs assessment for the community. At each phase we were keenly aware of the need to seek the input from older adults in the community, which we had yet to undertake. One benefit to working with available sources of information was that each new body of information shed additional light on the problem and seemed to reenergize the coalition members without asking for major investments of time from the members.

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Seeking the Community Perspective

A critical element of organizing is keeping members invested in the long term goals, when little concrete change can be implemented immediately (Mizrahi & Rosenthal, 1993). By maintaining member investment and generating increased energy we were able to push the members to the next level and seek input/feedback from older adults in the community. Coalition members, in particular the community-based partners, developed focus group procedures and recruited participants for the interviews. Thirteen participants attended the first focus group, provided information via a group discussion, and completed a written survey that asked for additional details on their living situations, health conditions, concerns about their neighborhood, and provided an opportunity for them to share any additional concerns they might have about legal matters, transportation, home repairs, and finding affordable housing alternatives. Major results of the focus group mirrored what we had learned via the other data sources:

- most of the participants owned their home;
- a majority indicated the need to make repairs to the home and a lack of knowledge about how to get such repairs done;
- the vast majority indicated that they need information on obtaining assistance with and financing home repairs, and modifying a house to create a safe environment;
- participants wanted more information on various legal aspects of home ownership (e.g. transferring a deed);
- the benefits of a reverse mortgage; and
- how to modify their homes to make them safer.

Community leaders and advocates present provided resources

and information on these issues to the participants at the end of the discussion, ensuring a beginning level of reciprocity and the development of trust and rapport with the community. This initial outreach to the community would not have been so successful without the active investment of the coalition members and the organizing work they had been doing even prior to this project. In a similar way, GCMs can use their wealth of knowledge about and intervention in the community to begin such a process. By coordinating with other providers and community groups much can be accomplished with small investments of time and other resources from each coalition member.

Throughout this community capacity building process the coalition acted as an enabling system for the community, playing the role of resource network, and intermediate support organization (Chavis, Florin and Felix, 1993). The coalition conducted an exploratory needs assessment combining multiple sources of information to further knowledge and understanding. By expanding membership in the coalition the group embraced the concept of capacity building by furthering networks of relationships and identifying community-based resources which might be drawn upon to aid the community. In addition, the coalition applied for and received University support through the Penn Institute for Urban Research to expand the interdisciplinary forum bringing together a wide variety of Penn faculty in conjunction with community based groups to pursue our goals to:

1. develop new interdisciplinary research collaborations to

examine challenges of older adults in urban environments (to further our understanding of the problem);

2. explore rigorous community-based participatory research methodologies that can be used to address issues of older adults living in urban environments (to further understanding of the community); and
3. develop and implement civic engagement in West Philadelphia that will foster community-based action to inform policy makers and sustain elder-friendly urban

communities (to begin the change process).

Focus For The Future

This project will build upon the critical knowledge of West Philadelphia generated from the initial needs assessment, the extensive engagement of our community partners already active in the West Philadelphia community, and on the research of faculty

from around the University who are studying the health, housing and social needs of older adults to sustain an elder friendly community. Future efforts under this initiative will expand on the community organizing component by increasing citizen involvement and promoting community ownership of the problem and investment in change. This process will begin with a series of educational programs to provide detailed information on issues of concern identified via our initial needs assessment and reiterated by participants in the focus groups. Such programs will be developed

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by the coalition and provided in the community, based on the focus group data. These initial efforts will serve to build a sense of reciprocity, accountability to the community and investment in the needs of the community in order to generate active community involvement and connection to this collective agenda. In order to support elder friendly communities, the process requires participation from the entire community, not simply older adults. In fact, if the focus was simply on organizing/mobilizing older adults, it would be very difficult to sustain capacity and growth. Thus we hope to build a community-based response that is multigenerational, and reflects community diversity.

We also want to harness the capacities of the University and the community-based partners to increase the community's capacity by increasing its social capital. Our ultimate goal is to increase the voice of the community in this process, through participatory action research, direct coalition participation and reflective practice.

Conclusion

GCMs operate in communities on a daily basis. Older adults are embedded in communities which can either enable them to age in place or generate obstacles. In order to support older adults, therefore GCMs must look to the community as a potential resource for care. However, as with all potential resources, the community will require organizing and mobilizing to enhance and generate capacities to support aging in place.

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Creating a Community Coalition for Caregivers: A Case Example

Stacey Kolomer, PhD, and Cara Van Voorhis, MSW

Abstract

Collaborative efforts in communities to develop coalitions are often a long process in which many times the initial founders bow out before the effort is realized. The following article discusses the development of a coalition focused on care giving in Northeast Georgia. Founded in 2004, Northeast Georgia CARE NET has been successful in creating a local network of private and public social service and health care agencies committed to enhancing the lives of caregivers. The coalition collaborated to design a survey to acquire information about the needs of caregivers in the community. Results from the survey will be presented and discussed. Discussion of future activities and the direction of the coalition will also be presented.

Literature Review

The collective development of coalitions within communities has become a “prominent intervention” for systemic change in regards to human services over the past two decades (Wolff, 2001, p. 165). Individuals within communities often form voluntary alliances because they share the common interests of exercising the power of unification and advocating for changes on behalf of a chosen platform (McAreavey, 2006). Collaborative efforts among individuals and groups can be an effective way to conserve resources and advance public recognition of established causes in an efficient manner. With the combined efforts and interactions of individuals and groups within a community, the essence of collaboration towards coalitions illustrates an effort to improve the

quality of life for at-risk populations (Russell & Flynn, 2000).

In collaborating to successfully organize coalitions, community agencies develop a certain level of organizational capacity which leads to the overall development (Shields, 1992). There are several key stages included in the successful collaboration of community organized coalitions which include identifying stakeholders, defining the shared vision of the organization, implementing the vision, and developing and maintaining momentum (Donaldson, 2005). Communities concerned with organizing coalitions must first identify stakeholders, or those individuals or groups with an invested interest in the issue being addressed (Donaldson, 2005). These stakeholders may come from a variety of backgrounds and experiences, but overall should be able to address experiences pertaining to the issue from a variety of perspectives and determine the primary focus of the coalition’s efforts.

Once the initial stakeholders have been identified, the group moves towards developing a collective vision in order to address the identified deficiency in the community. This stage of community collaboration elicits input from those individuals and groups involved in advocating for the established issue or population in general by addressing questions including the definition of the problem, causes and barriers to addressing the problem, outcomes of the problem, as well as possible solutions (Donaldson, 2005). The final stage involves formalizing the organized group in order to begin

developing goals and tasks to be completed and building momentum.

Communities often band together and collaborate for the formation of coalitions in order to build more competent helping systems (Wolff, 2001). This is accomplished through increasing the coordination around cases, populations, and issues that are growing in prevalence in the greater society, for example, the increasing numbers of older adults and family caregivers. According to Dodd (2004), the most important means for community organization and collaboration towards coalition building is effective leadership often in the form of a steering committee to guide the foundational organization. Using the issue of care giving as an example, individual community leaders must be approached, encouraged, and challenged to participate in the creating of a collaborative network in response to the needs of the care giving population in order to embrace the primary role of a coalition leader.

Once leadership has been established, Dodd (2001) outlines the primary steps that are taken in organizing and collaborating for the formation of coalitions, specifically in the area of caregivers. Identifying those community groups that are interested in and knowledgeable about the issues and consequently garnering their partnership in the establishment of the coalition is critical. Subsequently, those involved in the coalition must gain a basic understanding of the community’s overall culture and attitudes towards care giving, demographics of those

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providing or receiving care giving assistance, an understanding of the boundaries in which the coalition will operate within the community, an understanding of the primary needs of the care giving population, as well as identify resources and enlist the support of community members (Dodd, 2001). Upon the establishment of this basic foundation, the community organized coalition begins to identify goals and strategies to work towards garnering support for their mission to empower the care giving population.

As highlighted by Dodd (2001) and others in the empirical literature, “creating a collaborative network...is no easy undertaking;” however, once the commitment to helping those in need is verbalized and the primary leaders are identified, the most difficult aspect of organizing a coalition is accomplished and forward progress is inevitable. Community collaborations ultimately tend to provide more effective and efficient means of achieving common purposes through partnership rather than individually (Russell & Flynn, 2000).

Case example: The creation of Northeast Georgia CARE-NET

First Lady Rosalyn Carter recognized a need within communities to support family caregivers. From this vision came the creation of the Rosalyn Carter Institute for Care giving (RCI). RCI’s headquarters are in Southwest Georgia and many of the first programs of the institute were started within Georgia. RCI has four levels of programs and services: Financial support for graduate and undergraduate students and curriculum development, creation of a caregiver resource center, 12 State care giving coalitions, and nationwide care giving awards (RCI, 2006).

As a prominent leader in coalition formation, the Rosalynn Carter Institute for Care giving (RCI) sets the standard for coalition development in care giving through the formation

of partnerships with professionals, groups, and individuals to address care needs, as well as advocacy efforts “that promote healthy individual development and increase community care giving capacity” (Dodd, 2004). The first CARE-NET coalition started in South West Georgia in 1991 and the second in 1997 (personal communication, M. Farley, January 19, 2007). The last CARE-NET to form was the Northeast Georgia Care-Net in 2004. The purpose was to develop a regional coalition to provide caregiver support and education (personal communication, M. Farley, January 19, 2007). The uniqueness of CARE-NET is the recognition that the challenges of care giving cuts across age, illness, and disability (RCI, 2006). The Northeast Georgia CARE-NET covers a 12 county region which are outlined by the Northeast Regional Development Center (NEGRDC). The NEGRDC has responsibility for local and regional planning with regards to transportation, aging services, solid waste, job training, recreation, historic preservation, natural resources and economic development (NEGRDC, 2006). The Area Agency on Aging is part of the RDC and therefore a major contributor to the initiative of the Northeast Georgia CARE-NET.

Key Stakeholders

Inclusion of private, public, religious organizations and family members is one of the keys to the success of the CARE-NETS. At the present time the Northeast Georgia CARE-NET has 69 affiliated agencies and care providers. Types of agencies of the Northeast Georgia CARE-NET Coalition include hospitals, hospices, senior centers the Area Agency on Aging, schools, advocacy groups, the Institute for Human Development and Disabilities, home health agencies, case management services, geriatric case managers, adults protective services, and the local University. There is no cost for membership to the CARE-NET.

A staff person from the Area Agency on Aging is the organizer of the coalition; however, members annually elect leaders of the coalition

from the membership. The staff person maintains contact with the members of the coalition and informs members when programs of interest are taking place. The leaders organize bi-monthly meetings, plan seminars, and plans future meetings.

The coalition has bi-monthly meetings for all members to address coalition business, events and the planning of future meetings. Coalition leaders also meet bi-monthly with the staff person to plan future meetings. During meetings for all members decisions are made about what programs should be presented in the community. Two agencies present information about their programs per meeting so that all members will be familiar with available services and programs in the local community. Other presentations are made, for example, a presentation about emergency preparedness was given by a representative from Homeland Security for all members.

Semi-annual seminars are offered to formal and informal caregivers in the community regarding issues about care giving. Resources and services, as well as information on how to take care of ones’ self have been presented. Many of the affiliated agencies provide co-sponsorship of the caregiver conferences and seminars. The local adult daycare center assists with providing their services to care recipients so that family caregivers may participate.

Some key challenges for the coalition are the lack of financial support, participation and recruitment. Since many of the counties in the region are in rural areas, transportation is an issue for family caregivers and prevents many caregivers from participating in meetings or attending seminars. Another major issue for family caregivers is the availability of respite so that they can attend meetings. Not having someone available to watch the care recipient during meetings limits participation of caregivers. In addition, some caregivers do not view care giving as an issue that requires special assistance or attention. Many family

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caregivers do not recognize that they are in need of support or assistance until a crisis occurs.

The coalition also is challenged by keeping momentum up among key stakeholders. Times and locations of the meetings frequently change to be more accommodating for members. Initially there was great interest among agencies to participate. As with other coalitions it is a challenge to keep existing members active and recruiting other stakeholders can be time consuming. In addition, as representatives from organizations leave, gaining interest and investment of other agencies in the endeavor is critical for the stability and sustainability of the coalition.

Defining a Shared Vision

Early on the Northeast Georgia CARE-NET coalition decided a main concern for the region was to understand what the experiences of care giving for families in the area were. Trying to better comprehend what the needs of caregivers in the region were was a priority for Northeast Georgia CARE-NET. The coalition collectively made the decision to go forward with a needs assessment of family caregivers in the region. With this information the coalition hoped to be able to tailor future programs and services to the care giving population of the region.

Method

Locating family caregivers in the region proved to be a challenging task. Many of the support groups for family members of persons with Alzheimer’s Disease, Parkinson’s disease, or in nursing homes were either defunct or had very small attendance. Despite many of the agencies approaching clients to participate in the assessment it proved to be difficult to systematically recruit caregivers. A decision was made to focus on one set of caregivers for this needs assessment, custodial grandparents, as this was a group that

was more easily accessible than other care giving groups.

Two organizations within the 12 county regions were already providing services to grandparent caregivers so recruitment would be less challenging. In addition, with new funding provided by the Agency Area on Aging to kinship programs, support groups were being started in all senior centers in the 12 county regions for custodial grandparents. Recruitment to participate in a needs assessment for this specific type of caregiver became manageable. Financial support was

provided by the John A. Hartford Foundation via the Faculty Scholars’ program for the data collection. This funding provided participants who completed the needs assessment with an honorarium.

One hundred-three care giving grandparents in total were interviewed in person, typically in their own homes. The instrument included questions about the demographics of the grandparent and grandchild(ren) living in the household, and measures of health status of grandparent,

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T A B L E I

Caregiver Demographics

		% (n)
Gender	Male	16.5% (17)
	Female	83.5% (86)
Race	Hispanic or Latino or Spanish Origin	1.9% (2)
	Black or African American	47.6% (49)
	White	50.5% (52)
Marital Status	Married	51.5% (53)
	Separated	8.7% (9)
	Divorced	16.5% (17)
	Widowed	14.6% (15)
	Unmarried	8.7% (9)
Education	Junior High School	9.7% (10)
	Some High School	40.8% (42)
	High School Graduate	21.4% (22)
	Some College	15.5% (16)
	College Graduate	12.6% (13)
Financial Situation	We cannot make ends meet	27.2% (28)
	We have just enough	42.7% (44)
	We have enough with a little extra sometimes	24.3% (25)
	We always have money left over	5.8% (6)
Employment Status	Working part time	12.6% (13)
	Working full time	11.7% (12)
	Unemployed	45.6% (47)
	Retired	28.2% (29)
Housing	House	65.0% (67)
	Apartment	4.9% (5)
	Mobile Home	9.7% (10)
	Retirement Community	1.0% (1)
	Subsidized Housing	19.4% (20)
Number of Children in Care	1	38.8% (40)
	2	33.0% (34)
	3	19.4% (20)
	4	5.8% (6)
	5	2.9% (3)

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physical/developmental disability status of grandchild(ren), level of perceived stress, symptoms of depression of the caregiver, and information about the informal and formal social support in their lives. A representative from the Area Agency on Aging and a faculty member at the local University developed the instrument with input from all members of the Northeast Georgia

CARE-NET. In addition, focus groups were conducted with two support groups for grandparent caregivers from two different senior centers in the region to better understand what information the caregivers themselves thought was valuable to collect.

Results

Table one outlines the demographic information of the grandparent caregivers interviewed for the needs assessment. The age range for the group was 43-

87 years with the mean age for the group 59.6 years, s.d. 9.56. Almost 84% of the grandparent caregivers interviewed was grandmothers. Fifty percent were African American and 48% percent were white. More than half of the caregivers were married. All of the male participants were married. Almost half of the caregivers interviewed did not graduate high school. In terms of financial stability, over one quarter reported that they did not have enough to make ends meet at the end of each month and over 45% were unemployed. Despite the financial struggle of this group, most caregivers lived in their own home. Nearly ¾ of the caregivers were caring for one to two children.

Table two portrays the services being used and needed by the grandparent caregivers. Most of the grandparent caregivers were already connected to services which accounts for why almost 70% of the sample received case management services and over 60% were involved in a support group. Twenty-eight percent of the grandparent caregivers had received individual counseling. This group was highly active in religious activities with nearly 69% stating that were active in religious organizations.

Health related service usage was high for this group with 42% having been hospitalized and nearly 20% utilizing speech, occupational, or physical therapy. Twenty-two percent were using some type of adaptive equipment including, but not limited to, wheelchairs, canes and walkers. Almost 11% of the grandparent caregivers had received home health care and nearly 7% received homecare services. Approximately 84% were within 10 miles of the nearest doctor and 68% were within 10 miles of a hospital.

The greatest need for this group of grandparent caregivers was transportation. Almost of 13% the caregivers reported needing transportation. Another need for this group was residential information for placement of the grandchild in care. This was also apparent in the grandparents' response to what other

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T A B L E 2

Services Used and Needed

Service	Used	Needed
Residential Program	9.7% (10)	8.7% (9)
Hospital – inpatient	42.7% (44)	1% (1)
Day Care	16.5% (17)	3.9% (4)
Speech, Physical, or Occupational Therapy	19.4% (20)	3.9% (4)
Home Care	6.8% (7)	2.9% (3)
Meal Service	4.9% (5)	4.9% (5)
Information & Referral	12.6% (13)	6.8% (7)
Support Group	60.2% (62)	4.9% (5)
Individual Counseling	28.2% (29)	7.8% (8)
Family Counseling	12.6% (13)	5.8% (6)
Equipment	22.3% (23)	
Transportation	5.8% (6)	12.6% (13)
Social Activities	47.6% (49)	1.9% (2)
Religious Organizations	68.9% (71)	1.0% (1)
Case Management	69.9% (72)	3.9% (4)
Assistance with Housing	18.4% (19)	5.8% (6)
Home Attendant	1.9% (2)	2.9% (3)
Home Health	10.7% (11)	1.0% (1)
Assistance with the Child's School	24.3% (25)	5.8% (6)
Guardianship Information	20.4% (21)	9.7% (10)
Other	2.9% (3)	2.9% (3)

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needs did they have that were not included on the list. Respite was a big concern for these grandparent caregivers. Needing a baby sitter to help with care was also a common response to the open-ended questions of what their additional needs were. Needing information about how to obtain legal guardianship of the grandchild (ren) in care was also a concern for these caregivers.

Developing and Maintaining Momentum

The results of the needs assessment

reinforced what the coalition already suspected. There is a great need within the region for transportation, respite, and financial assistance for caregivers. Since the report of the needs assessment the coalition has attempted to create ways to address the needs of the local care giving community. Working on solutions for the

problems identified is a priority of the coalition. To increase the availability of services for caregivers in the region partnerships will need to be cultivated outside of the existing CARE-NET coalition, such as with local government. Northeast Georgia CARE-NET can also be a resource for local politicians to keep themselves informed about the needs of their care giving constituents.

The coalition has taken measures to think outside of the box for delivering services. For example, the Athens Community Council on Aging, a coalition member and sponsor, opened a new building for Adult Day Health. With the new facility it may

be possible to provide overnight respite to older adults, persons with disabilities or even grandchildren in care. The coalition is working on developing innovative ways to collaborate and provide assistance to family caregivers that are outside the traditional ways that services are delivered.

Following the results of the survey the Northeast Georgia CARE-NET coalition has decided that more outreach is needed to connect with other types of family caregivers. Focus groups are being conducted in most of the 12 counties to learn from caregivers about what needs they have. Outreach activities to connect with caregivers of older adults have also increased.

The coalition has decided to interview parents of children with disabilities to assess what their needs are and if these differ from other care giving populations.

Moving forward and keeping members interested is critical to maintaining the momentum of the coalition. Fortunately the affiliated

staff member and the leaders of the coalition have remained stable and active. Keeping focused on the vision of the coalition has helped to maintain the activity of the Northeast Georgia coalition.

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Public Health Perspectives on Care Management

By Martha A. Eastman, RN, PhD, CMC

Introduction

Recently I talked with the partners at an elder law practice about our mutual goals in serving older adults. We discussed the desire of many elders to remain living in their own homes and how barriers exist for maintaining both autonomy and safety. When these attorneys asked me what I thought would help I said, "We need to be aggressive about prevention!" By this I meant pro-active about home safety modifications, improving physical mobility, closely monitoring those at-risk, and advocating for programs that prevent injury and promote health, even for the oldest old. Early in my career I worked as a public health nurse, visiting mothers and babies at the time when "early intervention" received much attention as a strategy for both reducing service costs and improving health and learning for young children. After reflecting more on the importance of prevention for the older adult population, I think "early" as well as "aggressive" prevention is needed.

One benefit to elders and families of geriatric care management (GCM) services is prevention. By anticipating possible difficulties and avoiding accidents, social isolation, or non-compliance with recommended medical or self-care practices, care managers help extend life and improve its quality for both elders and caregivers. GCMs need to take a broad view of prevention if they are to maximize their value and develop sustainable practices. While some may see "public health" services as the opposite of "private" care management, these perspectives

intersect, particularly when meeting the needs of older adults.

Much like the field of public health, geriatric care management involves interdisciplinary collaboration as well as prevention. This article focuses on outreach, collaboration, and the application prevention to GCM practice, highlighting how utilization of public health resources can enhance care management.

Care Management Scenario

In mid January 2007 CDC-Maine (formerly the Maine Bureau of Health) issued a public health advisory memo regarding Norovirus, indicating its presence in several long-term care facilities and highlighting its mode of transmission and prevention advice. This information was readily available on the CDC-Maine web site, which is also a portal to other Internet sites of interest to older adults and care managers, including a variety of topics related to health, safety, and prevention.

During a cold snap in late January this highly contagious gastro-intestinal virus led several long-term care and assisted-living facilities in Maine to implement emergency infection control measures. At one facility, residents of both independent and assisted-living units reported sudden changes in activities, transportation, and meal services. For over a week the facility restricted visitors, provided no tours to potential new residents, and canceled group activities. The facility first closed its main dining room, but allowed independent-living residents to pick up meals and take

them back to their homes. Eventually, though, the facility suspended this meal service, requiring independent-living residents to either prepare their own meals or obtain them elsewhere. With quick action the facility implemented temporary measures that quelled the disease, but these changes led some residents to experience unexpected difficulties.

While the outbreak control measures prevented the spread of the illness and normal activities resumed within a couple weeks, this situation highlighted the value of collaboration with local and state public health authorities. The need for additional support to clients during the outbreak paralleled the services needed in a disaster response situation. By sharing information about the virus and reiterating the advice of state and local public health authorities to family members of "quarantined" independent living residents, I reinforced that the measures made sense. Armed with up-to-date information about methods of prevention and progress of the outbreak, I felt better equipped to discuss the infection control measures with clients and families and to anticipate emerging care management needs. For some the interruption in the facility's services meant changes in doctor's appointments, social isolation, and added risks of injury. Some residents who normally do not to drive at night, ventured out to restaurants for their evening meal because they were too tired or did not have enough groceries on hand to cook their own supper. By checking in with clients more frequently and offering additional support, I helped to maximize client safety and health.

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Levels and “Spectrum” of Prevention

Practitioners in the field of public health have long focused on the “levels” of prevention, including primary, secondary, and tertiary prevention.¹ Primary prevention involves health practices and interventions to avoid illness or injury. When a client has risk factors for illness secondary prevention strategies early diagnosis and treatment limit the disease. These strategies might include close monitoring, medications, or adaptation of the environment, etc. Tertiary prevention involves corrective treatment to solve health problems, to cure symptoms, and or to improve safety and wellbeing following injury, disease, or limited function. In addition to their ongoing usefulness in preventive medicine and public health, the levels of prevention can also be part of a framework for providing GCM services that values advocacy, community involvement, and elder independence.

Primary prevention seeks to promote wellbeing and avoid problems experienced by many older adults when they lack adequate support to live independently. When a care manager checks for safety in the home and recommends night lights, attendance at a balance class and removal of scatter rugs, even though the client is not currently unsteady on his/her feet and has never fallen, the GCM is practicing primary prevention. Recommending a safe-return identification bracelet for a man with mild dementia who enjoys walking around his neighborhood, even though he has not yet “wandered”, may be viewed as either primary or secondary prevention. A GCM may see it as primary prevention because to date the client has not yet become lost when walking; calling it secondary prevention would also fit because of his dementia diagnosis.

Secondary prevention seeks to minimize difficulties in situations

where a person may be at increased risk because of a medical condition, crisis, or limitation. Monitoring blood pressure of a person taking medication for hypertension or encouraging use of walking aids, such as a cane, with a person who has a history of falls, is also secondary prevention. Once a person has a diagnosis, injury, or difficulty, the remedy that seeks to maximize functioning and minimize disability is known as tertiary prevention. For a person who has an acute medical condition this may involve surgery, medication, or a variety of rehabilitation services. Care coordination is an important tertiary prevention service of GCMs. Since most care management clients have at least one chronic illness or functional deficit, though, even a short walk with the client to the mailbox (at the end of the driveway or in the facility’s lobby) or assistance with transportation to the pharmacy to fill prescriptions may be considered part of tertiary prevention.

There are numerous examples of prevention programs that may be useful to geriatric care managers who want to improve their clients’ health and safety. “A Matter of Balance” classes that help older adults learn and practice exercises to improve balance may be a primary prevention intervention for a person who has never fallen or a secondary prevention activity for someone who has.² Physical therapy services to build strength and stamina would be a secondary preventive measure if the person were at risk for falls, but tertiary prevention if the person was recovering from an injury sustained in a fall. Promoting immunizations (a classic primary prevention measure) among older adults decreases the incidence of vaccine-preventable diseases, both in older adults and in the general population. Education about safe driving, including information about medication effects, adaptive equipment, etc. may also represent an example of either primary, secondary, or tertiary prevention.

The more recent concept of the “spectrum of prevention” further expands the concept of primary prevention. Larry Cohen and Sana

Chehimi advocate a “comprehensive” approach that “requires a shift from a focus on ‘programs’ to a focus on more far reaching prevention initiatives, and from a focus on the individual to a focus on the environment.”³ The levels in “the spectrum of prevention” include: 1) “strengthening individual knowledge and skills,” 2) “promoting community education,” 3) “educating providers,” 4) “fostering coalitions and networks,” 5) “changing organizational practices,” and 6) “influencing policy and legislation.” Care managers who provide care coordination and ongoing monitoring are in an ideal position to strengthen client skills. Visibility in the community and involvement in voluntary organizations will help increase awareness of safe home care options and care managers’ roles in prevention. By teaching all who have a part in an older adult’s care about prevention, care managers can further expand their preventive influence. Participation with coalitions and networks can result in sharing of information and resources that may help older adults well beyond the private care management caseload. Care managers in private practice can make their organizational practices congruent with primary prevention and those employed in agencies can encourage this change. Influencing governmental policy and legislation further expands the scope of prevention by making prevention a priority at the community and statewide levels.

Outreach

A 1982 policy statement of the American Public Health Association noted that public health nurses “exhibit concern for those who do not present themselves for care.”⁴ In a more recent publication, the Quad Council of Public Health Nursing Organizations identified the “obligation to actively reach out to all who might benefit from an intervention or service” as one of the “eight tenets of public health (community health) nursing.”⁵ Like public health nurses, GCMs might become more mindful of casefinding. This may seem incongruous with a private service, since many will not have the financial resources to hire a

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GCM. Seeking those who understand the value of GCM services and who can afford them may seem more appropriate to care managers who rely on their private earnings for their sole income. While GCMs may not participate in “casefinding” in the same way that public health practitioners do, by reaching out they identify people to refer to local agencies on aging or other services. Also, when GCMs view the family as the client, they may “casefind” within the family, identifying caregivers who need screening for health problems or who are at risk for a variety of social, physical, or mental health concerns. Indeed, a GCM may be in a casefinding role whenever he or she identifies a need and makes a referral.

When GCMs look beyond the home environment to the older person’s neighborhood, town, or extended support system, many more opportunities for outreach and casefinding emerge. One client of mine regularly expresses concern for her next door neighbor who lives in a retirement community and is becoming increasingly forgetful; although my client often has difficulty preparing her own meals, she sometimes cooks for her neighbor. Another client reported how one of her closest friends was dying of cancer while still functioning as primary caregiver for her husband. Although this client struggled each day caring for her own husband, who had dementia, she wanted to do more to help ease her friend’s burden. The friend had hospice services and the adult children had returned home to assist her with their parents’ care. While not all outreach leads to referrals or direct GCM involvement in new cases, awareness of a client’s wider environment can be therapeutic.

Interdisciplinary Collaboration

Just as GCM practice presents many opportunities for case finding, interdisciplinary collaboration is

essential. The interdisciplinary collaboration involved in private GCM practice is well-known.⁶ In order to establish referral networks GCMs frequently become acquainted with financial planners, accountants, bank trust officers, attorneys, and staff of local aging service organizations. Those GCMs with clients residing in assisted living or long term care facilities also collaborate with LTC care staff, including administrators, nurses, dietitians, and nurses’ aides, etc. Also, GCMs frequently make referrals to physical therapists, OTs, and physicians among others. To collaborate effectively GCMs must have a basic understanding of each discipline and its role in the older person’s life as well as excellent communication skills for sharing information and advocating for the client.

Care manager Joseph A. Jackson has noted how “At first glance the care manager’s role may appear at best redundant, at worst, presumptuous.”⁷ Colleagues will want to know why they should collaborate with the GCM. Jackson recommends discussing the GCM’s role at the outset of a new client or collaborative relationship.⁸ Interdisciplinary collaboration may be challenging at times, particularly when the GCM’s advocacy role results in conflicts with the cultural norms in a long-term care facility, or when the GCM is acting on behalf of the client or family in opposing recommendations of a particular team member.

Conclusion

Attention to public health concepts is important for GCM practice, both to improve quality of care and to promote elder independence. While some may assume that aging means deficits and health problems, all levels of prevention are important, even for the oldest old. Not all public health resources are for only the impoverished segments of society. By definition, “public health” also includes those with adequate or abundant financial resources. GCMs will find many useful resources and

programs at local and state health departments as well as governmental web sites that can augment private GCM services. By developing a public health perspective of care management, GCMs can add value to their services, collaborate more effectively with others, and better promote the well being of older adults.

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Endnotes

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