Case Management Services:
Social Work Approach to Transition of Care

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• Byron Cordes’ MSW is from Our Lady of the Lake University and has worked for over 20 years in social work including in medical social work, case management, geriatrics, and as an adjunct university professor.
• He owns and operates Sage Care Management, a professional geriatric care management agency. In 2012 he served as President of the National Association of Professional Geriatric Care Managers.
• He is a member of the American Society on Aging and NASW. He is a licensed clinical social work in the state of Texas and holds an Advanced Certification in Social Work Case Management from the NASW.

Janis Lasser, LMSW

• After a career as a New Jersey high school English teacher and fundraiser for Foreign Affairs magazine in New York City, Janis Lasser moved to San Antonio, Texas where she received an MSW with Honors from Our Lady of the Lake University’s Worden School.
• She is author of the popular book, You Promised Never to Put Me in a Nursing Home!: Five Steps to Find the Best Nursing Home – an Amazon.com Hot Pick. Ms Lasser frequently speaks on television and radio and recently addressed the Annual Case Management Society of South Texas Convention, speaking on Ethics for Social Workers.
• Ms Lasser is a Medical Social Worker specializing in Geriatrics and is a member of NASW and the Alzheimer’s Association. She has led a number of family support groups and is currently the Director of Social Services and Admissions at Emeritus Lincoln Heights in San Antonio.

Objectives

• Review Assessment Process for SW in a facility.
• Describe social and medical indicators recognizing the discharge level of care and understand psychosocial care.
• Identify “best practices” for facilities to deal with dilemmas in discharge planning.
• Understand potentially negative effects of unmet needs.

Discharge Planning

• The process of moving the patient from one level of care to another ensuring continuity of care.
• STARTS on admission by assessing needs and identifying resources available.
• Process should incorporate interdisciplinary approach.
Quality Discharge Planning

• Involvement of patient and family
• Effective communication (including documentation)
• Multidisciplinary approach
• Identify healthcare services, e.g., visiting nurses, home health agencies, religious, civic, hospice organizations, elder care attorneys, geriatric care managers, ombudsmen. Build a plan to assure needs are met.
• Affordable Care Act

Toolbox for DC Planning

• Bio-Psycho-Social
  • Bio-medical – rely on nursing and physician
  • Functional – PT & Our Assessment
• Psychological
  • MMSE/SLUMS/GDS/PHQ/CLOX
• Consultant
• Social history & assessment
• Follow-up post discharge

Our Challenges

• Promoting Self Determination
• Language Barriers (translator vs. interpreter)
• Knowing your community services
• Lack of follow-through
• Over dependence on pharmaceuticals
• Cultural limitations/bias

Psychosocial Care

• “The term ‘psychosocial’ describes a constellation of social and emotional needs and care to meet them. It includes recognition, diagnosis, and treatment of mental health disorders, e.g., depression, anxiety, dementia, delirium, all measured by the MDS.”1
• Addressing issues such as losses and end-of-life care


Possible Risk Factors for Less than Desirable DC Outcomes

• Insufficient transitional care planning; intervention effectiveness
• Poor support system
• Poor cognition
• Challenging socio-economic situation
• Multiple health problems & hospitalizations
• Sensory challenged
• Mental health issues
• Non-compliance
• Not fully addressing their losses; grieving residents
Case Study

Mr. B is a 78 yo Caucasian male. His out-of-state niece is his guardian, who utilized local geriatric care manager. Has been living in the secured unit of nursing home for four years. Resident had been declining some over the years. He was still ambulatory and at risk for wandering. He had trouble swallowing, and was on a pureed diet for about 1 year – although non-compliant. Resident would often take solid foods from other residents’ trays. The guardian had signed a dietary waiver for the facility, understanding he may get a hold of solid foods.

He ultimately had a series of strokes which placed him in the local hospital. While in the hospital, Mr. B failed a swallow study. The physician presented options to his guardian, including insertion of a PEG tube. The guardian felt this was contrary to her uncle’s desire, although there was no written documentation. The charge nurse at the facility STRONGLY recommended the PEG tube, arguing many of their residents did well with them. When presented with potential behavioral problems, the nurse had answers to all. He stated they could use an abdominal binder if resident tried to pick at PEG. If resident was difficult to bolus feed, they could have two staff members hold him down while a third did the feeding. Niece was very confused and concerned about appropriate care and doing the right thing for her uncle.

Self reflection is critical to effective practice.
Be willing to critically evaluate what, why, and how well we do what we do.

Resources

- National Transitions of Care Organization: http://www.ntocc.org
- National Association of Professional Geriatric Care Managers: http://www.caremanager.org
- You Promised Never to Put Me in a Nursing Home: 5 Steps to Find the Best Nursing Home. Janis Lasser

Q & A

Please type them in the Q & A box on the right side of your screen. Thanks!