An Analysis of Caseloads in Case Management Agencies contracted by the New York City Department for the Aging (DFTA)

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Introduction

New York City has one of the fastest growing older adult populations in the country. More than 1.4 millionNew Yorkers are now 60 or older, up from 605,000 in 1950, and the number is expected to reach 1.84 million by 2030 (New York City Department of Health and Mental Hygiene, 2010). The older adult cohort represents approximately 17% of the city's total population. A significant percentage of New York City's older adult population happens to be poor, lacks sufficient resources, suffers from higher incidences of chronic diseases and lives alone (DFTA, 2013). Approximately 18% of all elderly-headed households earn an annual income below $10,000. A larger proportion of minority elderly live in poverty – 24.9% of Hispanic, 23.2% of Asian, and 20.1% of black elderly (American Community Survey, 2010). In 2007, 32% of persons age 65 and over in New York City lived alone, while half of all older adults 85 and older live alone (American Community Survey, 2010).

The New York City Department for the Aging contracts with 16 agencies to offer case management services for frail, home-bound elderly. The average age of a case management client is 85. Their average incomes range from only $12,000-$20,000 – too high to be eligible for Medicaid, but clearly too low to privately pay for care (Council of Senior Centers and Services [CSCS], 2012). Most clients are frail and homebound – and isolated. Currently, based on DFTA's Annual 2013 Report, there are approximately 19,500 older adults receiving case management, and 17,800 of those individuals also receive meals-on-wheels in NYC.

However, due to a combination of reduced funding as a result of city budget cuts in recent years and an increased need for services, DFTA and the contracted case management agencies have struggled with limited resources. An influx of a large number of new cases has led to caseloads that are higher than what this report recommends. This high caseload average not only affects the nature of services provided to the older adults, but has also led to increased stress among case managers and social workers, and perhaps higher turnover and lower morale.

Purpose of the Study

The main purpose of the study was to investigate the issues and factors related to effective case management with respect to adequate caseload size. Specifically, the aims of the study were to:

(i) Identify the tasks and responsibilities of case managers and the time spent completing them;

(ii) Illustrate the challenges faced by the case managers and their agencies in accomplishing their work;

(iii) Evaluate the impact of current caseloads on the quality of work and well-being of the case managers and other staff;

(iv) Identify potential solutions to improve the current situation and suggest an approximate optimal caseload size that would be manageable, feasible and beneficial.

Literature Review

A primary contributor to the quality of life for an older adult is their ability to remain independent and in their homes for as long as possible. Home-based case management is increasingly used in the community and usually focuses primarily on controlling costs and organizing care to maximize efficiency (Boult, Boult, &Pacala, 1998; Schore, Brown, &Cheh, 1999). Although community-based case-management programs are still diverse and somewhat "fragmented" (Quinn, 1995), there is a growing consensus that in-home care yields positive outcomes and is cost-effective.A 2010 report on the costs of long-term care revealed that the average annual cost of a semi-private room in a nursing home in New York City was $115,000 while the average expenditure on home-based case management was roughly $13,000 per older adult (Egan, 2011).

There is limited research on the outcomes of community-based case management services. Most of the research has focused on nurse-centered case management services provided to older adults after being hospitalized and upon discharge. These studies have shown positive health outcomes such as reduced isolation and depression (United Neighborhood Houses, 2005), lower frequency of hospitalizations (Shapiro & Taylor, 2002), a delay in

degenerative disability and institutionalization (Stuck et al., 1995), and an increase in program or care satisfaction (Cummings et al., 1990). A more medically oriented version of case managementhas been shown to decrease mortality (Boult et al., 1994), increase care satisfaction (Morishita, Boult, Boult, Smith, &Pacala, 1998), and reduce caregiver burden (Weuve, Boult, &Morishita, 2000).

There is only one large-scale study that has evaluated the outcome of a social work centered case management program (Shapiro& Taylor, 2002). From a waiting list for home-based services, 105 "moderately at-risk" community-dwelling elders were recruited by the authors. Forty of these persons were randomly assigned to receive the intervention (case management), and the remainder did not receive the intervention. Participants were interviewed every 3 months for 18 months. Primary outcome measures were depression, satisfaction with social relationships, environmental mastery, life satisfaction, permanent institutionalization, and mortality.Those older adults who received the intervention had significantly higher subjective well-being and were less likely to be institutionalized or die than those in the comparison group across the 18-month period (Shapiro & Taylor, 2002).

Few studies have specifically evaluated optimal caseload sizes for case managers working with older adults. In a Canadian Study, Dalby&Hirdes (2008) found that the average caseload size was 121.3. They also found a strong negative correlation between caseload size and quality of service provided ($r= -0.80$; $p < 0.05$). Weiner, Stewart, Hughes, Chalis&Darton (2002) evaluated case management agencies in England and found that only 19% of case managers had caseloads higher than 50, while 52.4% had caseloads under 50. Contrary to those findings, a report on licensed social workers in the gerontological field found that more than half of all agencies reported caseload sizes greater than 50 clients per case manager (NASW, 2006). Alkema, Reyes & Wilbur (2006) found that in a cohort of clients receiving home-based services, there was a critical mass of “high risk” clients that would need substantial attention and would utilize a greater proportion of services than the other clients.

Methodology

This study employed multiple methods to collect data from the various stakeholders in order to develop a comprehensive understanding of this complex issue. The following steps were taken to develop and collect data from the field:

(i) An anonymous survey of all case managers, social workers and supervisors was conducted via Survey Monkey.

(ii) Focus group sessions were held at 10 case management agencies with case managers, social workers, intake workers and supervisors.

(iii) Case managers at six (6) case management agencies were shadowed for a day to get an in-depth understanding of tasks engaged in by case managers on a daily basis, and the challenges they face.

Note: During the conduct of this study, the case management agencies were transitioning from the use of the PDS database to the STARS database. Thus, some of their responses and concerns may have been affected by the challenges they experienced during this time.

Findings

The findings are divided into three sections:

(i) Online survey of 83 case managersand a report on the work of five (5) randomly selected groups of case managers with caseloads greater than 85;

(ii) A discussion of the focus group sessions with case managers, social workers, intake workers and supervisors at ten (10) agencies; and

(iii) A summary of findings from the shadowing of twelve (12) case managers at 6 agencies.

I. Online Survey Report

a. All Case Managers (detailed data in Appendix B)

A total of 83 case workers participated in the online survey posted in October 2013 for the DFTA Caseload Analysis Study. This represents an approximate 60% response rate of all eligible case managers in the system. An additional 30 supervisors and intake workers also completed the survey. For the purpose of this report we will focus on the responses of the case

managers only. This is being done because many supervisors reported on their overall caseload sizes (accounting for all case managers under their supervision) and so their individual information is skewed.The average time the caseworkers have spent in their current position is 3.5 years. The average time they have worked in aging case management is almost 6 (5.9) years. Nearly three out of five (59%) had a bachelor's degree, while the remainder reported a master's degree. Approximately half of the case managers (51.8%) had an undergraduate or master's degree in social work. The remainder majored in diverse subjects such as human services, sociology, psychology, etc.

The average number of cases each worker had was **75**. However, approximately 40% of all the case managers served an average of 85 clients. The average number of clients the case managers worked with each week was 24. Case Managers reported spending nearly 25 hours per week directly working on behalf of clients. This does not include any staff meetings, supervision, documentation, data entry or paperwork associated with their work. Most caseworkers did not have case aides, with the average number of aides per worker being only 0.23. Case managers averaged 4 home visits per week and almost 3 intakes per week. Case managerscompleted almost 2 in-home assessments per week and 3 re-assessments per week.

Case managers surveyed were asked about the frequency with which they offer 52 different services to their clients. Below are the results of which services were offered **most frequently** on a weekly, monthly, or annual basis.

On a **weekly** basis, case managers and social workers offered many services to their clients. The 5 most commonly offered weekly services were:

- Provide Linkage - Home Delivered Meals (69.9%)
- Benefits & Entitlements - Provide Information (63.9%)
- Benefits & Entitlements - Screen Clients (60.2%)
- Provide Information on a Program or Resource for the Client (59%)
- Provide Support to Client and/or Caregiver (57.8%)

On a **monthly** basis, the 5 most commonly offered services were:

- Provide Linkage - Nutrition Counseling (42.2%)
- Provide Linkage - Personal Emergency Response System (38.6%)
- Benefits & Entitlements - Apply for Medicaid (37.3%)
- Benefits & Entitlements - Apply for SCRIE (37.3%)
- Benefits & Entitlements - Apply for Food Stamps/SNAP (36.1%)

On an **annual** basis, the 5 most commonly offered services were:

- Refer to Heavy Duty Cleaning (39.8%)
- Benefits & Entitlements - Apply for IT-214 (33.7%)
- Provide Linkage - Tax Assistance Program (33.7%)
- Provide Linkage - Elder Abuse Specialist/Elder Crime Victim Services (32.9%)
- Benefits & Entitlements - Apply for SSD/SSI (31.3%)

b. Case Managers with high caseloads (detailed data in Appendix C)

In order to develop a better understanding of the challenges faced by case managers with high caseloads, we focused on five (5) case managers with caseloads greater than 85 clients each. These 5 case managers were randomly chosen from the online survey.

These workers had worked an average of six (6) years in their current positions and had all attended the DFTA Core Training. They had an average of 91.6 cases, spending 25.4 hours per week working directly on behalf of their clients (not counting staff meetings, supervision, paperwork, documentation or data entry). On a weekly or monthly basis, these five (5) workers offered 39 different services to their clients. Since these five workers had higher than average caseloads, we wanted to highlight how they serve their clients and manage their time.

On a weekly basis, the most commonly offered services to their clients were:

- Home delivered meals
- benefits and entitlements screening
- provided information on benefits and entitlements
- applied for emergency services, applied for SNAP
- referred for personal emergency response systems
- provided information about programs and resources, and provided linkage to DFTA funded home care program

On a monthly basis, the most commonly offered services their clients were:

- end of life discussion of medical advance directives, health care proxies, and living wills
- applied for Medicaid
- referred to home health care agencies
- provided linkage to friendly visiting
- provided linkage to support groups

II. Focus Group Sessions

Focus group sessions were held with the staff at ten (10) case management agencies at the time of this report being written. The respondents comprised case managers, social workers, intake workers and supervisors. Each session lasted 60-75 minutes and respondents were asked a wide range of open-ended questions. The focus of these sessions was to develop a better understanding of the roles and responsibilities of case managers, their frequently performed tasks and the challenges they face in accomplishing their goals. The following table provides details on the agencies that participated in the focus groups:

Agencies where Focus Groups were held		
Name of Agency	**Date of Focus Group**	**Director**
New York Foundation Case Management	11/4/2013	Amanda Forsman
Self Help Case Management- Flushing	11/7/2013	HananSimhon
CCNS Benson Ridge	11/12/2013	Lorraine Thomas
Neighborhood SHOPP	11/13/2013	Miguel Laracuente
Queens Community House	11/18/2013	Blanca Goris
JASA Storefront Case Management	11/19/2013	Russell Nislow
JCC of Staten Island	11/20/2013	Esther Jacobson
Sunnyside Case Management	11/21/2013	Wendy Zinman
Isabella Case Management	12/10/2013	Noel Graziani
Heights and Hills Case Management	12/12/2013	Judy Willig
Agencies where Case managers were shadowed		
Name of Agency	**Date of Shadowing**	
Queens Community House	12/5/2013	
Self Help Case Management- Flushing	12/11/2013	
Isabella	1/24/2014 & 1/27/2014	
New York Foundation	1/24/2014	
Neighborhood SHOPP	1/28/2014	
CCNS Benson Ridge	1/31/2014	

The following is a summary of the responses from the focus group sessions:

a. Rationale for being a case manager

- The work is exhausting but fulfilling.
- Like to be able to help people in need and provide critical services.
- Enjoy the personal relationships that develop with clients over a period of time.
- The ability to make a difference in clients' lives and home environments.
- Working as a team with colleagues and other community agencies to develop a comprehensive plan for clients' well-being.

b. Experience with the initial intake process

- Intake seems more time consuming when done by case managers since they have to attend to other critical and urgent tasks.
- The presence of a designated intake coordinator seems to alleviate some of the workload stress for case managers.
- Some agencies set aside days when a case manager only handles intakes – but it may take time away from their regular clients.
- Work load is also better organized and more efficient by having a designated intake coordinator, because they can be specifically trained and are skilled at eliciting in-depth information.
- In any given year, CMs may be assigned cases for intake which require 45 minutes to conduct after which the client may refuse service. These clients are not considered part of the caseload. Additionally, some intakes are conducted and cases opened, services are provided, but cases may be closed within a year. Since caseload averages are based on a point in time calculation, some portion of the cases may not be considered part of the active caseload.

c. Managing high caseloads

- Dealing with caseloads leads to prioritization of response
    - Older and frailer clients tend to receive more attention.
    - Greater reliance of families (often not available)of clients to help with care.*(Note: Friendly Visitor and Telephone Re-assurance programs are available to case management agencies through their community senior centers which might alleviate this pressure.)*
- Greater focus on crisis intervention rather than building therapeutic rapport.
    - Tracking clients (even those who only receive home delivered meals and have low needs) who don't answer the door for a meal – frequently a non-emergency but time-consuming.
    - Weather related emergency phone calls (Emergency Responder Status).
- Less time to focus on prevention and education

- Time is spent on documentation, assessments, basic forms of assistance such as home delivered meals and benefits/entitlements, and other protocols after taking care of crises leaving very little time to work on health promotion, education and prevention.
- Less time for building rapport with clients.

d. Reassessments

- Although they are to be conducted annually, sometimes they may be conducted more than that in one year due to client need or crises.
- Some case managers felt that reassessments should be done every 6 months, instead of every year, because they were able to form a better relationship with their clients. But the current time that it takes to conduct them and enter data may not make that feasible.
- They felt that their clients had significantly deteriorated over the year, which was not noticeable to them through the 2-month follow up phone calls;
    - However, caseloads would have to be much lower in order to achieve these outcomes.
- The NYS mandated reassessment is too lengthy - case managers felt that it was similar and repetitive, if not equivalent, to the paperwork for initial assessments.*(Note: NY State requires most of the questions and items included in the assessments. STARS is a web-based database that DFTA has been building over the past year for use by providers and by DFTA staff. When fully implemented, it will serve as the system of record to track clients in all DFTA programs and services offered to them, as well as other data elements that will allow for better management of programs, improved measurement of program impact, and reporting to oversight agencies.)*

e. Challenges faced by case managers on a regular basis

- Current caseload sizes are too high -- usually around 80 clients. Approximately 70% of clients have low needs like home delivered meals(this does not imply that all clients who receive home-delivered meals have low needs; even with limited needs, some of these cases turn out to be crises or emergencies that take up significant time). But the remaining 30% of clients on a caseload have such intensive needs that the case managers end up spending a significant portion of their time dealing with this sub-group. And as a result of having to spend so much time, they feel they have limited time to attend to the regular needs of the other clients on their caseload.
- DFTA has just switched to the STARS databasefrom the former PDS system – this caused some distress as the case managers had to take time out of their daily routines to learn new standards and procedures. Initially the trainings were only offered to supervisors of the agencies. The CMs did not directly receive the training on STARS which may have hindered the mastery of the new program and data entry. But currently DFTA offers training for all staff as needed.

- New clients coming in are younger and appear to have more intense mental health issues, which leads to greater time spent on case management. Also, the case managers feel like they need additional training and manpower to deal with these serious issues.
- Lack of family and social support – most clients are isolated or lonely – thereby placing greater pressure on the case managers to attend to their needs.
- Unpredictability of home visit length
    - Travel time alone may take 30 minutes-1.5 hours each way and assessments during home visits may take 1-3hours per client (depending on the client's cognitive and physical health status).
- Performing home visits in unsafe areas
    - Case managers assigned to clients residing in unsafe neighborhoods often feel more comfortable going to clients' homes in pairs. This takes the case managers away from other clients and other work to be completed for their caseloads.

f. Most Frustrating/Time Consuming Tasks

- Documentation
    - Some case managers take work home to complete because there is just not enough time in the day.
    - Case managers feel that the documentation is onerous and takes time away from developing a therapeutic rapport with the clients on their caseload.
- Trainings
    - DFTA requires case managers to receive 49 hours of training for CMs and 35 hours for supervisors if they are a new employee. All staff must attend 24 hours of training in year 2 and 16 hours in year 5. These totals do not include training for Elder Abuse Prevention which is offered on a one-time basis. The allotted space often fills quickly and it is difficult for case managers to obtain their required training hours.Trainings take a full day (9am-5pm) and workers get behind on their work or it falls under the responsibility of another case manager in the agency.
- Unrealistic time frame to complete their work – would like more flexibility.
- The biggest frustration is coordination with other NYC agencies (especially HRA's APS and SNAP).
    - Case managers do not have any priority access in contacting these agencies. They must call the same number and wait the same amount of time as anyone else calling these agencies on their own. Frequently, the time spent on connecting with agencies like SNAP can take hours if not weeks of calling to get any assistance for the client.
- Low morale
    - Case managers have received no raise in salary in at least 5 years. Overworked, stressed and burnt-out, they feel unappreciated for their efforts.

        - Many case managers leave the agencies, creating crises in transitions, and increasing the caseloads of those who remain.
        - Also, this adds additional burdens on agencies to train new staff and the work suffers as a result.
- Volume of clients increasing, but resources are either the same or decreasing, making work unmanageable.
- Having to go to the home, once services have changed for the clients (including hospitalizations), and the requirement to complete an event-based report within 15 days is onerous.
- CMs have limited time to develop a strengths-based psychosocial assessment prior to entry into the STARS system due to the high caseloads. This hinders them from developing a comprehensive profile of their clients.
- CMs are required to make phone calls during weather emergencies like Hurricane Sandy. These calls have to be made even after office hours and on weekends with no compensation to the CMs.

g. STARS – The new documentation system

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- Expectation by DFTA that case managers should enter their paper case files into the STARS system, back dating to August 2013, with no overtime or extra help offered to them, is difficult, and adds to their already overloaded task list.
        - DFTA told case managers that a data migration would occur from PDS into STARS, which would carry over information from their caseloads. However, there were many errors noted after the migration that the case managers were expected to correct.
        - Workers are asked to fill out a 30+ page assessment for individual clients and a 60+ page assessment for couples, not including supplemental and financial sections, on-site during home visits.
        - Case managers are then expected to enter the data into the computer, which can take up to 4 hours.
- Clients have asked case managers to return for a second home visit due to becoming fatigued with the lengthy assessment process.
- New state-mandated questions in STARS are too intrusive and make both the case managers and clients feel uncomfortable. They are especially referring to the assessments of elder abuse, sexual orientation and substance abuse.
- Supervisors must review all documentation before it is officially entered into the system. This adds significant time to the documentation process.
        - When a case manager tries to delete anything in a client's file, they must wait until the supervisor reviews and approves the request before being able to finish any work for that particular client.
- There is no auto fill feature in STARS, making it even more time consuming for the case managers to enter data, especially when having to enter the same data into the system in several different sections of the clients' files.

- Expressed fears that STARS is not user friendly for beginners (*Note: Upstate users of this system, who have had a longer time to acclimate to their versions of this system, report greater ease of use than the previous data management systems used.*)

h. Suggestions offered by Case Managers

- A manageable caseload is between 60-65 cases. This would include clients with limited needs and those with more intense needs.
- Hiring more staff would help reduce caseload size, help deal with high levels of burnout, and improve client service.
- Salary increases with consistent raises/incentives over time would enhance the morale of case managers and increase retention.
- Provide laptops or tablets for case managers to bring along with them on home visits to enter data directly from the assessments into STARS, in order to avoid duplication of work. (*Note: DFTA is working on increasing access to tablets or I-pads for those agencies that opt for them to help facilitate data entry.*)
- Provide designated intake workers to help with intake assessment. A case manager may perform several intakes in any given year, but if the client is found ineligible for services, those intakes are not accounted for. Therefore, there is a greater amount of time taken away from clients who are eligible and are on the roster.
- Special hotline number and a designated staff person for each city agency that would deal with DFTA cases only – this would significantly cut down the time on connecting clients with critical services.
- Require escorts for case managers when performing home visits or emergency visits in the event of being in an unsafe situation in the home or the surrounding area of the clients' homes.
- Hiring temporary workers to enter data from the data migration period of PDS to STARS. Or pay current case managers an additional per-diem to help with this transition after their regular work-hours.

III. Shadowing Case Managers

The study associates spent days atsix case management agencies and shadowed several case managers, social workers and a few supervisors. During the visits, the research associates were exposed to the following tasks:

(i) Intake assessments
(ii) Initial home-based assessment
(iii) Supervision meeting between case managers and supervisors
(iv) Follow-up with clients in crises
(v) 2-month follow-up calls
(vi) Using the STARS system
(vii) Administrative tracking
(viii) Review of client binders

The following is a summary of some of the knowledge gained from these visits:

a. Intakes

- The intake assessment by phone took approximately 45 minutes to complete.
- The client did fine with the assessment process until she was asked if she needed homecare. When she responded positively, a separate portion of the assessment was initiated. The client found the questions about incontinence and other issues "too intrusive" and declined homecare.
- The data entry for intakes took approximately 1 hour.
- Client also refused to provide financial information to the CM.
- Case managers reported that if they did not have an intake worker or coordinator, they would have to spend 1-2 hours daily on conducting intake assessments.
- For agencies this is frustrating because not all potential clients who complete the intake process are found eligible. This takes time away from current clients, and the agency does not receive reimbursements for the ineligible client intakes.

b. In-home assessments

- Several in-home assessments were observed.
- The total time for the assessment was 2.5 hours. In addition, the travel to and from the client's residence was an additional 1 hour. The travel time was more manageable because the agency provides its own transportation to the case managers.
- Assessments may take longer with clients with complex needs and limited social supports, of if a couple needs to be assessed.
- One agency has purchased I-pads. This allowed case managers to enter data from the re-assessment to be directly entered into the data management system and avoided duplication.
- But in the other 5 agencies – data is still entered manually. Data entry on the new STARS system takes approximately 3 hours per case.
- One client found some questions intrusive – such as those about substance abuse, gender identity and sexual orientation. However, she participated fully in the assessment.
- Issues with data entry – STARS system locks CM's out suddenly; repetitive portions in the Financial section & Benefits and Entitlements; some sections only allow for 500 characters; but CM has more to write; sections do not have auto-fill features so they must enter information repetitively;medication section can be very time consuming.
- Clientswith cognitive or hearing impairments make the process slower than usual.

c. Administrative tracking

- This process refers to tracking clients who did not answer their door when home-delivered meals program arrived.
- Case managers reported that this was a frequent issue that they dealt with on a daily basis. They assume that clients forget to inform the agency and this causes significant time being wasted on tracking the "missing clients". This is even more

significant because many of these clients have low needs but the time spent on tracking them adds to the workload of the staff.
- Case managers reported tracking 6-10 clients daily.

d. 2-month follow-up

- CMs must set their own reminders for calling
  - CMs first review the case
  - CMs then review the services being offered to their clients in order to see if the clients are happy with the services they have, no longer need certain services, or if they have a greater need for additional services.
  - CMs then have designated questions from the calling form that must be asked and documented in the STARS system.
- 2-month follow-ups take about 30 min to 1 hour between conversation and data entry.

e. Annual Re-assessments

- Done every year -- unless there is an emergency
- Take approximately1-2 hours for the home visit, and an additional 30 minutes to 90 minutes for travel
- Data entry is nearly the same as initial assessment because there are as many questions to review and takes approximately 2 to 3 hours.

f. Additional challenges observed

- In order to deal with the high caseloads, case managers have learned to prioritize – address the needs of clients in crises first, then work on tracking "missing" clients and then work on documentation. In between these daily tasks, they must attend to assessments, follow-ups, linking clients to services and other related issues. This takes away the ability to develop a healthy rapport with the clients, and the clients who complain the most or have the most critical needs seem to get served first.

g. Issues with meeting deadlines – they cause more stress and are not feasible

- 6 business days to turn in the initial assessment to the supervisor after home visit
- Once an initial assessment is completed, it is corrected by the supervisor and needs to be returned within 3days
- Must be turned into DFTA within 10 days
- CM's must call new case assignments within 24hrs
- If a client is only interested in meals, CM's must see them within 30 days
- If a client is interested in homecare, CM's must see the client within 10 days

Limitations

It would be prudent here to note the limitations of the study:

(i) Not all case managers in the network completed the survey. Thus, the report may reflect the concerns and work experiences of a large proportion of case managers but not of the entire network.

(ii) Personal biases and concerns may have affected how the participants answered questions on the survey as well as in the focus groups.

(iii) This report reflects the perspectives and viewpoints of the case managers who have direct contact with the clients on a daily basis. This may not reflect the perspectives of DFTA staff or the administration of the case management agencies.

Recommendations

The following are recommendations developed by the author of this study based on feedback from various stakeholders – DFTA, case management administrators, social workers, case managers and intake workers. The recommendations are based on the working conditions of the case managers, their daily challenges and the impact of these services on the clients.

(i) The current caseload size of 80 and higher is challenging and not optimal. While the agencies are doing their best to serve their clients effectively with limited resources and manpower, the impact of these caseloads is critical. The current focus on completing regular administrative functions and attending to critical needs, rather than prevention and education, undermines the rationale and promise of case management. It is therefore suggested that caseload sizes average 65. We are basing this recommendation on the regular tasks that need to be completed by the case managers on a weekly basis, thetime taken to complete these tasks and the need for time and case management. Our recommendation is based on the calculation below:

	60 clients	**65 clients**	**70 clients**	**80 clients**
Time spent on intakes per week	4 hours, 40 minutes	4 hours, 40 minutes	4 hours, 40 minutes	4 hours, 40 minutes
Time spent on In-home	10 hours	10 hours	10 hours	10 hours

assessments per week				
Time spent on Re-assessments per week	5 hours, 12 minutes	5 hours, 38 minutes	6 hours, 5 minutes	6 hours, 57 minutes
Time spent on Follow-ups	7 hours, 49 minutes	8 hours, 30 minutes	9 hours, 8 minutes	10 hours, 26 minutes
Total time per week on scheduled tasks	**27 hours, 41 minutes**	**28 hours, 48 minutes**	**29 hours, 53 minutes**	**32 hours, 3 minutes**
Total time LEFT per week left for administrative tasks, follow-up, client check-up, trainings and crisis interventions	**Less than 8 hours**	**Less than 7 hours**	**Less than 6 hours**	**Less than 4 hours**

- Assuming 46 weeks of work per year (subtracting time for holidays, illness, vacations, etc.)

Note: For additional details about the calculation, please see Appendix A.

(ii) The case managers have heavy workloads, and their wages, while comparable to others in similar social services functions in first-line titles, are quite low. Reimbursement rates for agencies need to be examined and a raise in base salary for case managers, social workers and intake workers is recommended. Given the high caseload sizes and lack of fiscal incentive, the most skilled and experienced case managers will leave. This would put an undue pressure on agencies to recruit and train new case managers, which in turn, affects clients' well-being.

(iii) Another issue that was not the focus of this study was the caseload size of supervisors. However, it is important to note that with higher caseloads for CMs, supervisors have very high, overall caseloads for oversight, in addition to attending to administrative duties like supervision, training, etc. This issue needs to be addressed as well.

(iv) Another related issue is the educational level of the case managers. Only 40% have a master's degree. Although workers with a bachelor's degree are performing wellunder current conditions, the need for higher skilled workers is important when

dealing with the significantly frail clients and those with significant mental health issues. This may also add expertise to the agencies helping facilitate the various assessments, thereby lowering the time commitments to some extent. But current budgets and accompanying salary ranges does not always allow for the recruitment of master's level professionals.

(v) Agencies would benefit from technological assistance to enter data directly into the STARS system. The current protocol of gathering information on paper and then entering it into the online system is duplicative and takes time away from other essential tasks. Using tablets or I-pads could significantly reduce the redundancy in entering data twice.DFTA has offered this service to the administrators of the case management agencies and it should be seriously considered. Given that those case managers who utilize such technology have been very positive about its efficiency, expansion of such technology would be greatly beneficial.However, it must be noted that agencies would need assistance with the purchase of data plans if they were to adopt this technology as this might be an added burden on their budgets.

(vi) In-service trainings are frequently provided by DFTA. Specifically, training on screening for depression and suicidal ideation, as well as for STARS has been provided. While case managers find training useful and have asked for additional training, they also are cognizant of their limited availability for trainings. Given their current caseload sizes and administrative tasks that need to be completed weekly, case managers may see trainings as taking time away from their regularly scheduled tasks. It is hoped that once caseload sizes have been lowered, more time can be allocated to training that enhances assessment and technological skills.

(vii) It may be beneficial if a different system of tracking "missing" clients were developed. These are clients who are not answering their phone or have forgotten to notify the home-delivered meal service of their absence. Tracking these clients takes considerable time away from more serious tasks and data management. Additionally, given the current systems of city departments and agencies, it may be beneficial for DFTA and HRA to strategize on collaboration and coordination between the two agencies to facilitate client needs for benefits and entitlements.Perhaps an MOU could be developed whereby specific personnel at these agencies are designated to

work with DFTA clients or a hotline to deal with client concerns could be implemented.

(viii) One of the concerns for the CMs and the supervisors is the creep-up factor of caseloads. They are concerned that even if caseload sizes were reduced slightly, eventually they would rise again to the higher levels. Some mechanism to be mindful of this, within the parameters of fiscal pressures, would be helpful. Maybe, a trigger could be set in place and tied to adjustment of reimbursement contracts if caseload sizes increase significantly above the 65 average.

(ix) This study did not evaluate outcomes for case management clients. An additional study that compares outcomes based on caseload sizes, organizational characteristics and educational backgrounds of CMs might be beneficial.

Appendix A: Calculation of Caseload Size

According to the survey, on average, it takes the following amount of time for:

- Intakes – 55 minutes + 30 min to 1 hour for data entry (average 45 min)
  TOTAL 100 min per case

- In-Home Assessments – 116 minutes (plus 30 min to 2 hours for travel = avg. 1 hour) + 2 hours for data entry
  TOTAL 5 hours per case

- Re-assessments – 75 minutes (plus 30 min to 2 hours for travel = avg. 1 hour) + 2 hours for data entry
  TOTAL 4 hours per case

- Follow-up calls – 30 minutes + 30 minutes for data entry
  TOTAL 1 hour per case

According to the survey, each week on average, CM's conduct:

- 4 Home visits
- 3 Intake assessments
- 2 In-home assessments
- 2 In-home Re-assessments

(i) Calculating the frequency of scheduled weekly tasks at the respective caseload sizes:

	60 clients	**65 clients**	**70 clients**	**80 clients**
Number of intakes per week	3	3	3	3
Number of In-home assessments per week	2	2	2	2
Number of Re-assessments per week	1.3	1.41	1.52	1.74
Number of Follow-ups per week (*assuming that each client must be assessed 6 times in any year*)	7.83	8.5	9.13	10.43

- Assuming 46 weeks of work per year (subtracting time for holidays, illness, vacations, etc.)

(ii) Calculating the hours per week that would be required to be spent on scheduled tasks at the respective caseloads:

	60 clients	**65 clients**	**70 clients**	**80 clients**
Time spent on intakes per week	4 hours, 40 minutes	4 hours, 40 minutes	4 hours, 40 minutes	4 hours, 40 minutes
Time spent on In-home assessments per week	10 hours	10 hours	10 hours	10 hours
Time spent on Re-assessments per week	5 hours, 12 minutes	5 hours, 38 minutes	6 hours, 5 minutes	6 hours, 57 minutes
Time spent on Follow-ups	7 hours, 49 minutes	8 hours, 30 minutes	9 hours, 8 minutes	10 hours, 26 minutes
Total time per week on scheduled tasks	**27 hours, 41 minutes**	**28 hours, 48 minutes**	**29 hours, 53 minutes**	**32 hours,3 minutes**

- Assuming 46 weeks of work per year (subtracting time for holidays, illness, vacations, etc.)

If caseloads remain at 80 or higher, CM's would spend approximately 32 hours per week just on scheduled tasks like intakes, in-home assessments, annual reassessments and 2-month follow-

ups. This would make it impossible to complete any other tasks, attend to client crises or administrative duties (tracking clients, scheduling meetings, advocating for their needs, etc.).

If caseloads were reduced to between 60-70 clients, assuming a 35-hour work week, that leaves CM's 6-8 hours per week to take care of:

- Clients in crisis, distress or need – phone calls and home visits
- Follow up with clients who did not respond to meal services (6-10 clients daily)
- Follow up on benefits and entitlements – phone calls to SNAP, etc.
- Other administrative tasks

At 60-65 clients, there would roughly be 16.67% of time reserved for other tasks and responsibilities.

Note:

(i) If agencies could hire or appoint designated intake coordinators, that would relieve nearly 5 hours of weekly time from each CM.

(ii) Having the designated intake coordinators make the 6-10 administrative calls daily would free up some time for the CMs.

(iii) It seems (after further shadowing of the CMs) that the differentiation between "high need" and "low need" is not as critical. It's just that the scheduled tasks outlined above take time.

Appendix B: Survey of 83 Case Managers

Case Manager Information	Mean
Time in Current Position (Months)	42.86
Time in Aging Case Management (Months)	70.69
Number of Cases	75.41
Number of Clients Seen Per Week	24.32
Hours Spent on Behalf of Clients Per Week	25.28
Number of Case Aides	0.23
Home Visits Per Week	4.13
Intakes Per Week	2.91
In-home Assessments Per Week	1.93
Re-assessments Per Week	3.00
Time taken for Intakes	55.08 minutes*
Time taken for in-home assessments	116.6 minutes*
Time taken for re-assessments	51.5minutes*
Time taken for 2-month follow-up	30 minutes

**These times do not include travel for in-home assessments and annual re-assessments.*

Caseload Sizes

Caseloads	Percent (%)
Less than 65 cases	24.1
65-74 cases	19.0
75-84	27.8
85 and higher	29.1

Most frequently offered services:

Services	% performed weekly
Provide Linkage - Home Delivered Meals	69.9
Benefits & Entitlements - Provide Information	63.9
Benefits& Entitlements - Screen Client	60.2
Provide Information on a Program or Resource for the Client	59
Provide Support to Client and/or Caregiver	57.8
Provide Advocacy on Behalf of Client and/or Caregiver	50.6
Provide Linkage - DFTA funded Home Care Program	49.4
EndofLifeDiscussMedicalAdvanceDirectivesHealthCareProxyLivingWil	36.1
Refer to Home Health Care Agency (CHHA) or Private Pay Personal Care/ Housekeeping Services	36.1
End of Life - Discuss Financial Instruments: Will, Trust, POA	32.5

Services	% performed monthly
Provide Linkage - Nutrition Counseling	42.2
Provide Linkage - Personal Emergency Response System	38.6
Benefits & Entitlements - Apply for Medicaid	37.3
Benefits & Entitlements - Apply for SCRIE	37.3
Benefits & Entitlements - Apply for Food Stamps/SNAP	36.1
Refer to Home Health Care Agency (CHHA) or Private Pay Personal Care / Housekeeping Services	33.7
Refer for Personal Emergency Response System Company	33.3
Provide Linkage – APS	32.5
Provide Linkage - Telephone Reassurance	31.7
Benefits & Entitlements - Apply for Emergency Services	31.3

Services	% performed

	annually
Refer to Heavy Duty Cleaning	39.8
Benefits & Entitlements - Apply for IT-214	33.7
Provide Linkage - Tax Assistance Program	33.7
Provide Linkage - Elder Abuse Specialist/ Elder Crime Victim Services	32.9
Benefits & Entitlements - Apply for SSD/SSI	31.3
Provide Linkage - Mental Health Specialist	29.3
Provide Linkage - Not-for-Profit, Free or Sliding Scale Legal Services	29.3
Benefits & Entitlements - Apply for Medicare Programs	28.9
Benefits & Entitlements - Apply for Tax Exemptions	26.8
Provide Linkage – APS	26.5

All case manager tasks performed – weekly, monthly or annually:

Service	**Weekly N (%)**	**Monthly N (%)**	**Annually N (%)**	**Not performedin the last year N (%)**
End of Life - Discuss Financial Instruments: Will, Trust, POA	27 (32.5%)	16 (19.3%)	14 (16.9%)	10 (12%)
EndofLifeDiscussMedicalAdvanceDirectivesHealthCareProxyLivingWil	30 (36.1%)	16 (19.3%)	13 (15.7%)	7 (8.4%)
End of Life - Discuss Burial/Funeral Planning Options	15 (18.1%)	16 (19.3%)	17 (20.5%)	19 (22.9%)
End of Life - Discuss wishes with Family/PCP	17 (20.5%)	13 (15.7%)	17 (20.5%)	20 (24.1%)
End of Life - Discuss Emotional, Family and Other End of Life Issues	27 (32.5%)	13 (15.7%)	15 (18.1%)	12 (14.5%)
Benefits & Entitlements - Screen Clients	50 (60.2%)	7 (8.4%)	7 (8.4%)	2 (2.4%)
Benefits &Entitlements - Provide Information	53 (63.9%)	11 (13.3%)	4 (4.8%)	DK
Benefits & Entitlements - Apply for Discount RX Card	15 (18.1%)	19 (22.9%)	18 (21.7%)	11 (13.3)
Benefits & Entitlements - Apply for Emergency Services #	16 (19.3%)	26 (31.3%)	18 (21.7%)	4 (4.8%)
Benefits & Entitlements - Apply for EPIC	13 (15.7%)	24 (28.9%)	21 (25.3%)	8 (9.6%)
Benefits & Entitlements - Apply for Food Stamps/SNAP	22 (26.5%)	30 (36.1%)	12 (14.5%)	1 (1.2%)
Benefits & Entitlements - Apply for HEAP	16 (19.3%)	25 (31.3%)	19 (22.9%)	6 (7.2%)

Service	Weekly N (%)	Monthly N (%)	Annually N (%)	Not performedin the last year N (%)
Benefits & Entitlements - Apply for IT-214	8 (9.6%)	14 (16.9%)	28 (33.7%)	15 (18.1%)
Benefits & Entitlements - Apply for Medicaid	19 (22.9%)	31 (37.3%)	12 (14.5%)	5 (6%)
Benefits & Entitlements - Apply for Medicare Programs	16 (19.3%)	18 (21.7%)	24 (28.9%)	7 (8.4%)
Benefits & Entitlements - Apply for Public Assistance	11 (13.3%)	11 (13.3%)	14 (16.9%)	29 (34.9%)
Benefits & Entitlements - Apply for Section 8	6 (7.2%)	7 (8.4%)	18 (21.7%)	33 (39.8%)
Benefits &Entitlements - Apply for SCRIE	15 (18.1%)	31 (37.3%)	17 (20.5%)	2 (2.4%)
Benefits & Entitlements - Apply for SSD/SSI	12 (14.5%)	10 (12%)	26 (31.3%)	16 (19.3%)
Benefits & Entitlements - Apply for Tax Exemptions	8 (9.8%)	13 (15.9%)	22 (26.8%)	23 (28%)
Benefits & Entitlements - Apply for Telephone Discount	11 (13.3%)	20 (24.1%)	22 (26.5%)	15 (18.1%)
Refer to Home Health Care Agency (CHHA) or Private Pay Personal Care / Housekeeping Services	30 (36.1%)	28 (33.7%)	8 (9.6%)	1 (1.2%)
Refer to Heavy Duty Cleaning	5 (6%)	17 (20.5%)	33 (39.8%)	11 (13.3%)
Refer to HIICAP	5 (6.1%)	6 (7.3%)	13 (15.9%)	38 (46.3%)
Refer for Personal Emergency Response System Company	15 (18.5%)	27 (33.3%)	16 (19.8%)	6 (7.4%)
Provide Information on a Program or Resource for the Client	49 (59%)	13 (15.3%)	5 (6%)	1 (1.2%)
Provide Linkage - APS	9 (10.8%)	27 (32.5%)	22 (26.5%)	6 (7.2%)
Provide Linkage - Bill Payer Program	4 (4.9%)	23 (28%)	16 (19.5%)	22 (26.8%)
Provide Linkage - Caregiver Program	17 (20.5%)	24 (28.9%)	19 (22.9%)	6 (7.2%)
Provide Linkage - Elder Abuse Specialist/ Elder Crime Victim Services	7 (8.5%)	18 (22%)	27 (32.9%)	13 (15.9%)
Provide Linkage - Disease Specific Resource	7 (8.4%)	14 (16.9%)	16 (19.3%)	29 (34.9%)

Service	Weekly N (%)	Monthly N (%)	Annually N (%)	Not performedin the last year N (%)
Provide Linkage - Friendly Visiting	23 (27.7%)	25 (30.1%)	16 (19.3%)	4 (4.8%)
Provide Linkage - DFTA funded Home Care Program	41 (49.4%)	24 (28.9%)	3 (3.6%)	DK
Provide Linkage - Home Delivered Meals	58 (69.9%)	6 (7.2%)	4 (4.8%)	DK
Provide Linkage - Mental Health Specialist	11 (13.4%)	23 (28%)	24 (29.3%)	5 (6.1%)
Provide Linkage - Not-for-Profit, Free or Sliding Scale Legal Services	11 (13.4%)	19 (23.2%)	24 (29.3%)	10 (12.2%)
Provide Linkage - Nutrition Counseling	12 (14.5%)	35 (42.2%)	17 (20.5%)	3 (3.6%)
Provide Linkage - Personal Emergency Response System	15 (18.1%)	32 (38.6%)	14 (16.9%)	6 (7.2%)
Provide Linkage - Senior Center Rec./Congregate Meals	12 (14.5%)	23 (27.7%)	17 (20.5%)	16 (19.3%)
Provide Linkage - Support Group	10 (12%)	20 (24.1%)	21 (25.3%)	16 (19.3%)
Provide Linkage - Tax Assistance Program	4 (4.8%)	7 (8.4%)	28 (33.7%)	29 (34.9%)
Provide Linkage - Telephone Reassurance	13 (15.9%)	26 (31.7%)	12 (14.6%)	15 (18.3%)
Provide Linkage - Telephonic Class	4 (4.8%)	11 (13.3%)	10 (12%)	40 (48.2%)
Provide Linkage - Transportation Program	25 (30.1%)	23 (27.7%)	15 (15%)	3 (3.6%)
Provide Linkage - Veteran's Administration	6 (7.2%)	13 (15.7%)	21 (25.3%)	24 (28.9%)
Health - Advise of Wellness Programs in the Community	12 (14.5%)	21 (25.3%)	19 (22.9%)	15 (18.1%)
Health - Provide Disease-Specific Literature	4 (4.8%)	16 (19.3%)	11 (13.3%)	33 (39.8%)
Health - Counsel Client to see Physician	23 (27.7%)	25 (30.1%)	15 (18.1%)	4 (4.8%)
Health - Provide Information on BMI	7 (8.4%)	14 (16.9%)	15 (18.1%)	27 (32.5%)
Home Safety - Advise/Remove cords from walkways	19 (22.9%)	21 (25.3%)	18 (21.7%)	8 (9.6%)

Appendix C: Analysis of 5 Case Managers with high caseloads (>85)

ID #	Current Title	Attended DFTA Core Training	Months (Years) in current position	Months (Years) in case management with older adults
1	Case Manager	Yes	196 (16.3)	196 (16.3)
2	Case Manager	Yes	27 (2.25)	66 (5.5)
3	Case Manager	Yes	67 (5.6)	114 (9.5)
4	Social Worker	Yes	9 (0.75)	17 (1.4)
5	Social Worker	Yes	63 (5.25)	116 (9.7)

ID #	Number of cases	Number of clients in contact with each week	Hours spent each week on behalf of clients	Number of Case Aides	Number of home visits per week
1	90	18	20	1	3
2	90	50	15	0	10
3	89	50	25	1	4
4	95	30	35	1	4
5	98	20	20	0	10

ID #	Intakes per week	Time each intake takes	In-home assessments per week	Timeeach in-home assessment takes	Re-assessments per week	Time each re-assessment takes
1	2	1 hour	1	1.5 hours	3	60 minutes
2	4	100 minutes	12	2 hours	7	60 minutes
3	2	45 minutes	1	3 hours	5	30 minutes
4	1	1 hour	2	2 hours	3	100 minutes
5	3	1 hour	2	1.5 hours	7	50 minutes

39 services offered weekly or monthly by 5 case managers with high caseloads (>85):
Note: The case managers are identified by their ID#s – 4, 5, 10, 64 and 66

Service	ID # Offers Service Weekly	ID # Offers Service Monthly
End of Life - Discuss Financial Instruments: Will, Trust, POA	10	64, 66
EndofLifeDiscussMedicalAdvanceDirectivesHealthCareProxyLivingWil	10	5, 64, 66
End of Life - Discuss Burial/Funeral Planning Options	-	64, 66
End of Life - Discuss wishes with Family/PCP	-	10, 66
End of Life - Discuss Emotional, Family and Other End of Life Issues	10, 64	66
Benefits & Entitlements - Screen Clients	4, 10, 64, 66	5
Benefits & Entitlements - Provide Information	4, 10, 64, 66	-
Benefits & Entitlements - Apply for Discount RX Card	-	66
Benefits & Entitlements - Apply for Emergency Services #	10, 64, 66	-
Benefits & Entitlements - Apply for EPIC	-	4,66
Benefits & Entitlements - Apply for Food Stamps/SNAP	4, 64, 66	-
Benefits & Entitlements - Apply for HEAP	-	66
Benefits & Entitlements - Apply for IT-214	-	4
Benefits & Entitlements - Apply for Medicaid	-	4, 64, 66
Benefits & Entitlements - Apply for Medicare Programs	-	64
Benefits & Entitlements - Apply for Public Assistance	10	64, 66
Benefits & Entitlements - Apply for Section 8	-	66
Benefits & Entitlements - Apply for SCRIE	10	4, 64, 66
Benefits & Entitlements - Apply for SSD/SSI	10, 64, 66	4
Benefits & Entitlements - Apply for Tax Exemptions	10, 64, 66	4, 5
Benefits & Entitlements - Apply for Telephone Discount	10, 64	5, 66
Refer to Home Health Care Agency (CHHA) or Private Pay Personal Care / Housekeeping Services	10	4, 64
Refer to Heavy Duty Cleaning	-	4
Refer to HIICAP	10	-
Refer for Personal Emergency Response System Company	10	66
Provide Information on a Program or Resource for the Client	10	4, 64

Service	ID # Offers Service Weekly	ID # Offers Service Monthly
Provide Linkage - APS	10, 64	4, 5, 66
Provide Linkage - Bill Payer Program	4, 5, 10, 64, 66	-
Provide Linkage - Caregiver Program	10	-
Provide Linkage - Elder Abuse Specialist/ Elder Crime Victim Services	10	-
Provide Linkage - Disease Specific Resource	10	-
Provide Linkage - Friendly Visiting	10	-
Provide Linkage - DFTA funded Home Care Program	-	10
Provide Linkage - Home Delivered Meals	10	-
Provide Linkage - Mental Health Specialist	-	4, 10, 66
Provide Linkage - Not-for-Profit, Free or Sliding Scale Legal Services	10, 66	-
Provide Linkage - Nutrition Counseling	10	-
Provide Linkage - Personal Emergency Response System	10	-
Provide Linkage - Senior Center Rec./Congregate Meals	10	-
Provide Linkage - Support Group	-	4, 10, 66
Provide Linkage - Tax Assistance Program	10, 66	-
Provide Linkage - Telephone Reassurance	10	-
Provide Linkage - Telephonic Class	10	-
Provide Linkage - Transportation Program	66	64
Provide Linkage - Veteran's Administration	4, 5, 10, 64, 66	-
Health - Advise of Wellness Programs in the Community	10	-
Health - Provide Disease-Specific Literature	10	-
Health - Counsel Client to see Physician	10	-
Health - Provide Information on BMI	10	-
Home Safety - Advise/Remove cords from walkways	10	-