Case Study 1: Meet “Walt”.

“Walt” is a 68 year old who is suffering from multiple sclerosis, emphysema and has symptoms of depression and anxiety. He must utilize oxygen regularly and requires weekly blood testing due to his current medications. Walt became homeless after losing his housing following a landlord dispute. His health began declining more rapidly, both physically and mentally, and he became a frequent user of the emergency room.

Walt was referred to the Area Agency on Aging Case Manager. His Case Manager established trust with the client over time and facilitated coordination of food, medical care and temporary shelter. Due to Walt’s precarious housing status, his Case Manager visited him in a variety of settings – his apartment, the hospital and on the streets after becoming homeless. The ability of his Case Manager to visit Walt where he lived kept his care plan moving forward, even while his living situation remained unstable. Walt’s Case Manager worked closely with him to make sure he was well informed of all care options so that he felt ownership in care plan. Walt’s Case Manager also remained in nearly daily contact with his primary care physician, social worker and his health plan so that all those involved in his care were kept up to date. This coordination of care via the Case Manager avoided duplication of services, increased coordination among care providers and most importantly, kept Walt’s care needs and personal preferences at the forefront of the planning process.

Walt now has temporary housing that allows him to receive the consistent care he requires. His health has stabilized and Walt has avoided unnecessary emergency room visits and hospitalizations for almost a month. Walt’s Case Manager will continue this coordinating role moving forward to help Walt achieve better care, better health and ultimately lower costs overall to the health care system.
Case Study 2: Meet “Gus”.

“Gus*” is 88 years old. He was referred to the Area Agency on Aging for help by the local CCO. Gus had hoarding issues resulting in multiple code violations at his home, where he has lived most of his life. Among other health issues, he has a history of mental illness. Through coordination between the acute and long-term care systems, appropriate mental health services were arranged for Gus. His Area Agency on Aging Case Manager was able to facilitate a service intake so that placement in a more structured and appropriate care setting was available to him following the eviction from his home. Continued communication and coordination between Gus’s Case Manager and the CCO staff has been critical in addressing new care needs as they have emerged, including housing, emotional support and access to other community resources. This partnership has also helped to stabilize his ongoing medical and mental health needs, significantly limiting more cost intensive interventions and keeping him as independent as possible.

Case Study 3: Meet “Joanne”.

“Joanne*” is 68 years old. Adult Protective Services referred Joanne to an Area Agency on Aging Case Manager. The APS investigation revealed that Joanne was suffering from self-neglect. This self-neglect was exacerbated by alcoholism, hypertension and alcohol related dementia. Following a comprehensive needs assessment Joanne’s Case Manager arranged a series of home visits. The Case Manager learned that Joanne had recently been admitted to the emergency room and had a practice of contacting the hospital social worker at these times. A plan was developed that involved the social worker flagging Joanne’s electronic medical record so that when she was readmitted to the hospital or Emergency Department (ED) her Case Manager would be contacted. After implementing this plan, Joanne’s Case Manager received 4 or 5 notifications of emergency room visits. Through timely follow up visits with Joanne, either at home or in the emergency room, the Case Manager was able to be directly involved and was in a position to fully understand the issues prompting the ED visits. Joanne’s Case Manager worked to identify natural supports to provide medication management, transportation to doctor’s appointments and money management. The CCO and Case
Manager collaboration was also a major contributor to the client’s enrollment in an intensive Alcohol and Drug Treatment program. They will continue to work together to facilitate her care after she is discharged to help her begin a new path of better health and greater stability at home.

Case Study 4: Meet “Anna”.

“Anna*” is a 51 year old woman who was referred to the Case Manager at the Area Agency on Aging through its Diversion/Transition program, which works to avoid unnecessary facility placement. Anna had a diagnosis of diabetes and alcoholism, though she had been in recovery for 2 years. The nursing facility rehabilitation team had concerns that Anna was going to be leaving the facility, where she had been receiving Medicare covered rehabilitation for a fall, without any Medicaid services in place at home. The nursing facility had expressed significant concerns to the Case Manager about Anna’s continued decline. Specific concerns voiced were increased cognitive decline, concerns about potential alcohol use and missed appointments for medical care. The Case Manager reached out to Anna who agreed to a home visit. The Case Manager shared the concerns from the rehabilitation staff with Anna. Anna had been experiencing highs and lows with her blood sugars which were causing periodic states of confusion. The Case Manager conducted a SLUMS (St Louis University Mental Status) dementia screening and Anna scored high which means “No indication of cognitive problems.” Anna’s home was clean and there were no signs or admission of drinking. Through this process, Anna shared that she had problems coming up with bus fare and this resulted in missed appointments. Anna’s Case Manager arranged for transportation assistance to address this barrier. Once this simple assistance was in place, reported concerns about Anna were eliminated, and services through Medicaid were no longer necessary. Through careful assessment and outreach, Anna’s situation resulted in a higher quality of life and lower costs to the acute and long-term care systems.
Case Study 5: Meet “Cory”.
“Cory” was a nursing facility resident who was to undergo an amputation and would require care assistance upon discharge from the inpatient stay. A Case Manager from the Area Agency on Aging worked with an MSW at Cory’s health plan to get medical records and have as much information as possible to prepare for meeting his care needs once his surgery and his rehabilitation/skilled care was complete. After conducting a comprehensive assessment with Cory regarding his needs, the Case Manager arranged for a prospective Adult Care Home provider to meet Cory in the nursing facility to complete her assessment and to ensure a good placement match for both Cory and the Adult Care Home. Having all the information ahead of time from the MSW made the assessment and care planning process go smoother. The MSW was also present during the assessment, which was extremely helpful due to the trust she had already established with Cory. Her presence made it much easier to obtain the necessary financial records and was beneficial in helping Cory understand the process and the information being requested when he became confused. Cory successfully moved into the Adult Care Home.

*Names have been changed to protect the identity of clients*