

“Making It Real” Campaign: Human Face of Budget Cuts

Manhattan

Impact of Department for the Aging cut to Case Management for Homebound Elderly Residents of Manhattan

Council of Senior Centers and Services of New York City, Inc., November 2010
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Case Management Anecdotes

November, 2010

Manhattan

CM=	Case Manager
HC=	Home Care
HMDL=	Home Delivered Meals
MOW=	Meals on Wheels
APS=	Adult Protective Services

Anecdotes Concerning Case Mgt.

Agency	Council Member	Anecdote:
Kate Geitner: (212)744-5022 x1377 LMSW, Director, East Side Case Management Consortium Lenox Hill Neighborhood House	Lappin, Mark-Viverito	<p>Council Member Lappin</p> <p>1). Ms. D is a 72-year-old widowed female who came to us in an emergent state. She had been residing in an assisted-living facility in New Jersey until she exhausted her assets and had to return to her apartment on the Upper East Side. Her mobility was extremely limited due to a number of health issues. This rendered her unable to grocery shop or cook meals independently. She was also having difficulty bathing herself and cleaning her apartment. Ms. D had no informal supports available to assist with these tasks. Therefore she was going without food, bathing and cleaning. Ms. D was unable to get to the doctor or manage the 17 medications she had, including important medications to manage bipolar disorder and high blood pressure. She also presented a need for mental health services. Finally, Ms. D's income was less than her expenses and she had very little savings after having paid for the assisted living facility.</p> <p>Our case manager worked quickly to create a comprehensive care plan for Ms. D. The case manager immediately authorized home-delivered meals so that Ms. D was ensured at least one nutritious meal a day. She also secured a volunteer to assist Ms. D with grocery shopping. A referral was sent to visiting nurse practitioner Denis Tarrant, who completed a physical exam and reviewed all of her medications. He made the necessary adjustments and worked with Ms. D to develop a stable medication management plan. She is now taking all of her prescribed medications as directed. The case manager also initiated several benefit and entitlement applications to address the financial shortfall, including food stamps (in conjunction with Lenox Hill Neighborhood House's Food Stamps Advocate), NYC 210 and Lifeline.</p>

(cont.)

Agency	Council Member
Kate Geitner: (212)744-5022 x1377 LMSW, Director, East Side Case Management Consortium Lenox Hill Neighborhood House	Lappin, Garodnick and Mark- Viverito

Ms. D will be assessed for an ongoing stipend once all benefits and entitlements have been secured. Ms. D was placed on the waitlist for 20 hours a week of homecare and shortly thereafter began receiving 8 hours of homecare weekly. She is pleased that she is able to have bathing assistance and someone to clean her home. Finally, Ms. D was referred to Service Program for Older Persons (SPOP) and has begun receiving weekly mental health services in her home. Her case manager reports that Ms. D is doing well and is grateful for the support that has allowed her to reenter the community.

Council Member Mark Viverito

2). Mr. R is an 82-year-old Puerto Rican gentleman who lives in a Mitchell-Lama building in East Harlem with his grandson. Mr. R's ex-wife and his daughter, Julia, also live in the same building. Mr. R suffers from arthritis, poor gait, dizziness, and a smell impairment, among other things. Accordingly, he is unable to safely prepare meals for himself. Until our intervention, Julia was trying to prepare daily meals for Mr. R, herself and her children as well as care for Mr. R's ex-wife. This was becoming overwhelming. Our case manager determined that Mr. R is eligible for a daily home-delivered meal. This would provide him with one hot, nutritious meal each day and it would give some much-needed respite to his daughter. The case manager also assessed Mr. R to be eligible for a number of entitlements and benefits, including food stamps, NYC 210 and HEAP and will help to facilitate those applications. As it seems Mr. R's ex-wife is also eligible for these benefits and entitlements, the case manager supplied Julia with the materials to apply for her mom. The case manager also spoke with Julia about accessing other services for her mother like case management and home delivered meals.

Mr. R's apartment is a duplex and the only bathroom is on the second floor. This poses a fall risk as Mr. R suffers from dizziness. The case manager spoke with him about environmental modifications and other options that may reduce his risk including a downstairs commode, a

(cont.)	<p>personal emergency response system (PERS), grab bars and requesting an apartment transfer. She also facilitated a discussion about end of life and burial planning and will be working with Mr. R and his daughter to complete advanced directives. In the end, our services had a positive impact not only on Mr. R., but also on his daughter Julia and his ex-wife. By taking a comprehensive look at the client’s situation, we were able to maximize the family’s strengths and provide support where it was needed.</p>
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Agency	Council Member				
<p>Eli Brett: (212) 787-8106</p> <p>Program Director, Selfhelp Project Pilot</p> <p>Selfhelp Community Services, Inc.</p>	<p>Gale Brewer</p>				

(cont.)

Agency	Council Member
Eli Brett: (212) 787-8106 Program Director, Selfhelp Project Pilot Selfhelp Community Services, Inc.	Gale Brewer

Council Member – Gale Brewer**Time spent: 105 hours 45 min (over a 3-year period)****Approx. cost: \$4,150**

We have a client who is 100 years old, F. R., who was also a caregiver to her son who is 73 years old and is mentally disabled. Frances and They both had been transferred to Selfhelp Project Pilot during the 2008 transition. At the time of the transfer, they were not receiving any services except meals-on-wheels from WEME.

They soon applied for Medicaid homecare which the son needed greatly. The mother, who was 98 years old at the time and needed homecare herself, had a power of attorney and was her son's only caregiver. She was overwhelmed by the amount of care she needed to provide: pay her son's bills, feed him three times a day, administer his medications, and accompany him to all medical appointments.

After the Medicaid homecare started, EISEP homecare was arranged for the mother (she was not eligible for Medicaid home care due to excess resources). The case Manager also applied for food stamps for her and submitted an NYC 210 for 3 years retroactively.

Currently, the mother is 100 years old. Both the mother's and the son's quality of life has improved considerably after Selfhelp Project Pilot started providing case management for them.

Story 3.**Council Member – Gale Brewer****Time spent – 66 hours 30 min (services provided over a 2-year period)**

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Agency	Council Member
Eli Brett: (212) 787-8106 Program Director, Selfhelp Project Pilot Selfhelp Community Services, Inc.	Gale Brewer

Approx. cost - \$2,700

Client is 92 and lives alone. She suffers from macular degeneration, high blood pressure, history of mini strokes, mobility problems (uses a cane) and anxiety. She is widowed for many years and has one living son (another son passed away several years ago). Her son is very involved but was overwhelmed when she first became a Project Pilot client, and this led to a strain on their relationship.

Even though the client initially was referred to us for meals-on-wheels only, we helped the client apply and receive food stamps and Medicare Savings Program. We referred the client to Visions, and Visions provided her with two weekly volunteers who read her mail and help her with her budget. Visions have also given her many assistive devices for vision impaired, including a special telephone, coffee maker and many audio books. We also referred the client to DOROT for escort and shopping services.

When client came to us she had high anxiety over her money issues and her loss of independence due to poor vision. Client has been with us for over 2 years and now has a better relationship with her son and her anxiety decreased. She seems to be really thriving with her current services, and she is able to enjoy her time with her son and friends.

Agency	Council Member	Anecdote
<p>Noel Graziani:212-342-9876</p> <p>UMPSI</p> <p>NGraziani@isabella.org</p> <p>Tracey A. Sokoloff:212-342-9525</p> <p>Isabella Home & Community Based Services</p> <p>tsokoloff@isabella.org</p>	<p>Ydanis Rodriguez</p>	<p>Presenting Problem Early Dx of Alzheimer's Advocacy for Home Care</p> <p>1).Our agency has been actively assisting Ms. C. She is a 79-year-old woman who resides alone however; her grandson stays with her periodically. Client's POA (Power of Attorney) and Health Care Proxy is her daughter who resides in Texas, her daughter is actively involved and will fly up to attend major medical appointments.</p> <ul style="list-style-type: none"> • At initial meeting Case Manager (CM) noted marked memory loss and brought it to the attention of the UMPSI Supervisor • CM along with The Upper Manhattan Partnership for Senior Independences' RN, evaluated client utilizing a mini-mental assessment tool and found client needed further assessment by a professional • CM linked client and family to neuro-clinic where was subsequently diagnosed with Alzheimer's • CM completed and submitted Medicaid application for client, application was denied, for insufficient financial information. CM appealed on client's behalf and attended Fair Hearing as well. Medicaid was not only approved but coverage extended to cover months application was "pending", since Human Resource Administration was found at fault for denying services • CM referred client for evaluation by CASA for Medicaid Homecare, as client was only receiving 12 hours weekly of Extended In-Home Service for the Elderly Population (EISEP) temp care services • Client referral to CASA V was deferred because the RN

(cont.)

Agency	Council Member
Noel Graziani:212-342-9876 UMPSI NGraziani@isabella.org Tracey A. Sokoloff:212-342-9525 Isabella Home & Community Based Services tsokoloff@isabella.org	Ydanis Rodriguez

evaluator stated that the client was mentally capable of performing her IADL's without assistance. CM appealed on behalf of client and is waiting second Fair Hearing date while also applying to other Medicaid Managed Care Programs or Nursing Home due to lack of consistent family support. Client also currently receives home delivered meals 7 days/week.

- Client has being referred to our Co-Op Grant Program for caregiver assistance and additional respite services.

It is my firm belief that without our one-on-one case management services the above client would not be receiving this early intervention of her Alzheimer's disease and prevention of serious self-harm due to this progressive disease.

City Councilman Ydanis Rodriguez

Case Manager has spent 30 hours to date helping this client. This is an ongoing process since the CM will continue to advocate for client.

Cost: Case Management

\$1,379.28

Presenting Problem

Client Abuse

2).Client is a 90-year-old African American woman who resides with her grandson (40 years old.) Client's daughter suffers from Multiple Sclerosis and resides in the Bronx.

Case Manager provided client with home delivered meals, 7 days/week, and EISEP Personal Care Aide (PCA) 12 hours a week, and a Department for the Aging Nutritionist.

On October 6, 2009, the PCA stated to the Case Manager that she

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<p>Noel Graziani:212-342-9876</p> <p>UMPSI</p> <p>NGraziani@isabella.org</p> <p>Tracey A. Sokoloff:212-342-9525</p> <p>Isabella Home & Community Based Services</p> <p>tsokoloff@isabella.org</p>	<p>suspected the client's grandson was physically abusing the client. The PCA also believed that the grandson was a substance abuser who was using the client's monthly, income to support his drug habit. The client informed the Aide that the grandson only feeds her once a day. The CM immediately called in a report to Adult Protective Services.</p> <p>Shortly after the referral to APS, the Case Manager received a call from a church member on a Sunday night on her cell phone stating the client had fresh bruises on her and appeared dehydrated. The Case Manager informed the church member to call 911 and have the police go to the client's apt as soon as possible.</p> <p>The following day the Case Manager visited the client at Columbia Presbyterian Emergency Room where she had been taken the night before. In the hospital ER, Case Manager spoke to the doctor, nurse and the social worker alerting them of the suspicion that the grandson was neglectful and physically abusive to client.</p> <p>CM spoke to the client and her family members and they all agreed that the client should go to a Nursing Home because the client would no longer be safe in her own home. Case Manager called Adult Protective Service worker to inform her that the client was admitted to a Nursing Home.</p> <p>City Councilman Ydanis Rodriguez</p> <p>Case Manager dedicated about 35-37 hours working with this lady Cost of CM care: \$ 1,701.11</p>



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