

# The Circumscribed Sometimes-Advocacy of the Case Manager and the Care Provider

By Rosalie A. Kane

Advocacy means vigorous representation for a person or a cause. In contrast to advocates for a person, advocates for a cause typically strive for specific goals. National health insurance, increased affordable housing units, or the election of a particular candidate are all understandable objectives that might be advanced by advocates for old people. Disagreements may surround the means to achieving the goals and the constraints or conditions that proponents would observe in the pursuit of success, but generally the advocate knows when progress or setbacks have occurred. Advocacy for a person is a much more difficult notion to describe and enact. These difficulties multiply when the advocate is also a service provider fulfilling a variety of other functions.

Many professional practitioners in agencies serving older people assert that they are advocates for their individual elderly clients. Case managers, care coordinators, and hospital discharge planners who help older people navigate the complexities of services and benefits are apt to see themselves as advocates for particular old people. Indeed, the role of advocate is enshrined as one that all case managers

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*Where does advocacy end  
and gatekeeping begin?*

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are expected to embody. Similarly, advocacy is considered a core function of social work practice. The following discussion considers the nature of what might be called "case advocacy," a term often used in the social service literature. One useful definition reads, "Case advocacy can perhaps be most accurately defined as partisan intervention on behalf of an individual client or identified client group with one or more secondary institutions to secure or enhance a needed service, resource or entitlement" (McGowan, 1987).

#### FOUR BARRIERS TO CASE ADVOCACY FOR ELDERS

First, providers of service typically use their professional judgment to draw conclusions about what their clients need. Service providers are more likely to advocate for presumed client needs than expressed client desires. When the professional judgment always is the trump card, advocacy is limited to a narrow "best interest" standard applied by the professional.

Second, providers of service often construe an entire family constellation as their client. When

working for a good general solution, what has sometimes been called the "aggregate best interests," they may end up acting against the interests and wishes of a particular client. Such action would be the opposite of advocacy.

Third, providers of service have many masters and are typically expected to maximize the interests of the organization that employs them. Fulfillment of this expectation may mean limiting resources allocated to a particular client, whether those resources be the provider's time and energy or more tangible benefits. They also have an interest in maintaining smooth working relationships with other organizations in the community, which could limit the extent to which they push for a particular client.

Fourth, providers of service may have concerns about liability for their agency or for themselves as professionals if they strive too vigorously for unconventional approaches or outcomes. A client may wish to remain at home, for example, but conventional wisdom may consider this course of action too risky. A provider may be fearful of incurring liability if he or she goes to battle against other professionals and organizations to arrange for what the client most wants.

#### CASE MANAGERS AS ADVOCATES

A web-based Health Insurance Resource Center (2004) defines advocacy at the case level as "any activity done to help a person or group to get something the person or group needs or wants." The same Resource Center defines case management as "a system that insurance companies and HMO's use to ensure that individuals receive appropriate, timely, and reasonable health care services." The difference between those two definitions illustrates the chasm between simple advocacy and the functions case managers perform.

Case managers in long-term care, who often share the world view of the aging network regarding the rights of older people as enshrined in Title I of the Older Americans Act, may well define themselves as advocates in the pure sense of being there to help clients achieve what they want. To that end, the case managers can employ their superior knowledge of community resources, their skills of persuasion and bar-

gaining to help clients realize benefits and services, and their networking abilities based on reciprocal relationships they have in the community. The advocacy function is consistent with helping the clients understand the ramifications of their wishes and the possible risks as well as benefits associated with various care plans. The advocacy function is also consistent with helping the clients work out creative ways to achieve their own ends. But long-term-care case managers typically, as in the definition above, are concerned that their clients receive appropriate, timely, and reasonable services, and even may have money to pay for them and the authority to order them, which also means the power to withhold that payment or authority.

Advocacy stops and gate keeping begins when case managers impose their own solutions because the plans will be more affordable for the budget on which the case manager draws. If case managers apply silent cost filters before even informing clients about possibilities, then they have definitely abandoned the advocacy role.

Some time ago, the lawyer-ethicist Nancy Dubler (1992) suggested that nobody who allocates resources without freely offering individuals all services to which they are legally entitled could be considered a true advocate. Her view, therefore, was that case managers, preoccupied as they are with resource allocation and budgets, could not fairly hold themselves out as advocates. Dubler was particularly concerned when the programs offered in the case manager's repertoire did not cover the range of the client's needs or preferences. Noting that during that time period in New York City, about 90 percent of all contested cases of Medicaid or Medicare denials were won, she asked rhetorically whether case managers should be obliged to disclose such facts to their clients and inform them of alternative approaches to getting services. At that time I took the position that the case manager's advocacy can be construed as directed toward an entire population with long-term-care needs. As long as the dollars saved on one care plan went to somebody else's care plan (and not back into a general revenue stream), case managers could see themselves as advocating for an entire group (Kane, 1992). The claim

that case managers promote individual case advocacy even when they are denying services that the older person might benefit by and wants in order to allocate them to someone else is more tenuous.

"But wait!" someone is sure to protest. Haven't we all seen case managers who have fought valiantly for a client, who have argued their right to live in the community even when some professionals and family members think that they would be safer tucked away elsewhere? Haven't we seen case managers, in the words of the definition I began with, tirelessly pursue "partisan intervention" to help a client "secure or enhance a needed service, resource, or entitlement?" Yes, those examples abound, but case managers do have limits. My view is that case managers can present themselves to their clients as willing to advocate for them as part of their role, but that informed consent requires that case managers also indicate the limits to this advocacy, whatever these may be. If case managers are required by their programs to refer clients to various types of caregiving organizations by rote rather than by individualized considerations, they must say so. If they are required to push for the use of voluntary family help regardless of the role the client wants relatives to play in their care, they must say so. Clients need to know how much and in what ways the advocacy of their case managers is circumscribed.

#### HOSPITAL DISCHARGE PLANNERS

Compared to case managers, hospital discharge planners typically play a briefer part in their clients' lives, but their interventions may occur at desperate times for individuals and families. A discharge planner may intervene at the exact moment when consumers and their family members need help, and those consumers may, therefore, be tempted to abandon their usual caution in trusting a stranger. Typically, the idea of consulting the social worker or nurse who serves as discharge planner is introduced to the client by a physician. For example, the referring physician might inform the patient that she will be ready to leave the hospital in a day or so and that the discharge planner will help arrange follow-up care, including a nursing

home, a rehabilitation program, or a convalescent home, when indicated. With this kind of casual handoff to a discharge planner, the patient and her family have every reason to think that the discharge planner—after all, an extension of the doctor, whom they would be terrified not to trust—will act in her best interest and will recommend only programs or facilities that the planner deems excellent. They might be astonished to know that the discharge planner's main mission is to facilitate departure, and that the first criterion for a recommended facility would be that it has room for the client and is willing to consider her. Similarly, they would be surprised to know that the discharge planner often issues referrals in rote order so as not to be unfair to providers in the community, a common custom in our nation's hospitals. Finally, the hapless patient and family might think the discharge planner actually has visited the facilities and programs recommended or has current knowledge of their quality and idiosyncrasies, but that too is rarely the case.

Although some discharge planners some of the time may make heroic efforts to help an individual achieve a plan with all the nuances the client prefers, such attention would be impossible as a routine matter, given caseload sizes. As in the example of case managers, honest disclosure is the key. The patient should know the basis for any recommendations. She should know how much time the discharge planner has available to spend helping her. She should know if she would be well advised to ask a family member or other trusted agent to check things rather than take referrals on face value.

#### NURSING HOME SOCIAL WORKERS

Nursing home social workers are expected, and required by regulation, to be engaged in helping residents plan for discharge. These social workers also have responsibilities to assist the individual to have the best life possible while living in the facility (McGowan, 1987). On the day the residents move in, the good social worker tells them and their family members the equivalent of, "I'm here for you. Don't hesitate to contact me if there is anything I can do to make things work out for you. This is your

home, now; we want you to be happy here." In actuality, the social worker who vigorously assists long-stay residents to move out (as is expected under the Supreme Court Olmstead decision) may work herself out of a job. A few such success stories a year may be well received, but if the social worker seriously examined the claims of every person who yearns to move back home, her successes would translate into a census problem for the nursing home. The social worker more often strives to promote "adjustment" to the nursing home rather than exit from it. Furthermore, the social worker perceives herself as constrained by facility rules and state regulations as far as promoting anything out of the ordinary for the resident, such as a trip alone out of the facility for some social purpose. Too many resources and too much risk (with attendant fears of liability) would ordinarily be involved. Nursing homes in particular have rampant fears of being sued, especially in states with highly litigious climates. Once again, advocacy is compromised.

#### BOTTOM LINE

Other provider roles and vantage points could have been discussed for illustration to make essentially the same point. Advocacy is compromised if professionals withhold from clients what they know or suspect about other care providers to whom they refer, or if they withhold the general constraints under which they operate. Yet, we surely hope that the advocacy impulse is strong among those who offer services to older people. Were care providers and case managers to present themselves and perceive themselves as bureaucratic functionaries, able to act and advise within only the narrowest window, they would offer scant comfort to consumers. What to do?

First, sometime-advocates who are full-time providers or case managers should take care to avoid self-deception. They should resist the lure of believing that what they offer and suggest is at all times best for their clients, even if it is far from what the clients want or prefer. Sometimes the nurse or social worker or case manager may well know best, but too often they simply assume they do. For that reason, the

entrenched views of professionals sometimes stand in the way of the freedoms long-term-care consumers seek to live lives as they please. Providers may genuinely believe that consumers' wishes are impossible to fulfill without huge cost shifts, and that what they recommend is at all times best for their clientele, and still see themselves as advocates. It would be more helpful instead if care providers could live with the cognitive dissonance entailed in taking note of the times when what they did was *not* best for the client, when it in fact engendered a great deal of misery, but was simply the best that this professional could offer at the time. One check against self-deception is spot-checking to see how one's advice has worked out and how clients feel about the services or settings recommended to them.

After forsaking self-deception, the provider must also abandon client deception, however subtle. The unspoken limits of the advocacy an individual provider can offer should become spoken.

Observing those two principles—no self-deception about one's advocacy and no client deception about the limits of one's role—the care provider can proceed to be an important if circumscribed advocate. Such advocacy goes beyond advocacy for a particular benefit or outcome to a more generalized advocacy, a stance of being on the side of the client in an overall way rather than just related to a particular problem. Fiona Hanley (2003) suggested that such personal advocacy relies on an interpersonal, empathic relationship between advocate and service-user, where the advocate is driven by a wish, however unarticulated, for fairness, decency, and respect for the client, a view also promulgated in a British monograph (Henderson and Pochin, 2001). Surely, each client would crave that kind of stance from a case manager or care provider.

Finally, providers, including clinicians, who wish to be advocates should commit themselves to helping clients develop the skills and attitudes needed to become their own advocates. The movement for self-advocacy, as it is called, has about a forty-year history. Its origins seem to trace back to people with developmental disabilities who were encouraged and taught to

formulate for care providers their demands and requirements. Self-advocacy includes knowing one's rights and responsibilities, pressing for those rights, and making choices about one's life. Too often, care providers and case managers are too busy reconciling older people to the plans they as professionals prefer that little time is left for the subversive efforts of assisting their clients to be self-advocates for their own wishes and preferences.

Finally, case managers and care providers exercise advocacy functions if they move from "case to cause." To do so, they or their agency need to keep records of gaps in services and repeated instances of inability to meet a consumer's preference because of those gaps. Then they or their agency need to make those deficits known and to engage in informing the public and lobbying, alone or collectively with other organizations, to achieve a more responsive service system. ❧

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