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The Geriatric Care Workers' Role Care for Elderly of Sanatorium in Korea

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Abstract

This paper is to research the difference of care workers' role in Sanatorium between urban and rural areas. Interviews have been conducted with 100 care managers with structured questionnaires in community care settings. The findings of the study are as follows. In the analysis of working with carers a care manager acting as a counsellor in rural was required rather more than any other role in working with clients' carers. In working with formal and informal networks, an administrative specialist role was also important in both areas. With resource management, there were some regional variances between rural and urban. In the urban area, a care managers as a coordinator was more required than as a broker. In the rural area, a care manager as a broker, selecting service resources for elderly clients was the most suitable role. In conclusion, in general rural care managers' roles were similar to those of many core managers in urban area. Among the many possible roles of care managers that effective continuity of care is to be provided for elderly clients in community care, two have been specified as essential roles. The first is the role of care managers that provides coordination and integration of services at the clients' levels as a care manager as an implementer, a linkman, counsellor. The second is at the system level which is possible role for coordination and linkage of programs as a characteristics of care managers, task with formal & informal network, community resources, available residential & NHS resourcesw

▸Keyword: Elderly care, Care worker, Care manager, Long-Term Care Insurance, Community care

I. Introduction

In korea care managers are crucial to the delivery of services in community care for elderly people, but there is little understanding of what care managers actually do. Welfare equipment helpful for care and prevention is available to the beneficiaries who stay out of LTC facilities for rent with some charges. The conventional view of the care managers' role is narrow and neglects the integrative functions, for example service coordination for their clients. However, the expansion of community care services gives that care managers new opportunities to perform a variety of integrative rules. Previous researches have shown the care manager can assume several different roles, designed to increase the effectiveness of the care management process itself by enhancing the client's capacities to fulfill her own needs' at the system and clients' level. At the system level, a care manager involves in changing the behavior or performance of a system on behalf of the clients. A care manager must understand how the agency and the environmental systems can both positively and negatively affect clients and how to intervene to optimize conditions. Activities can include resource development, agency policy information, social action, program evaluation, and quality assurance. Reframing in this area can include the

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care manager as a linkman, a coordinator and a advocator. Also previous study performed by western researchers have provided some evidence that care managers in rural and urban areas have been required to exercise different roles. [1]

The purpose of this study is to reframe a care manager's role at the system, and client's level in the literature review and to explore the differences roles of care managers in community care between urban and rural areas.

II. Theological Background

1. Definition

Care management is a relatively new brand of service delivery mechanism for elderly people in Korea. The practice of Case Management, into a Korean version. Although American case management was introduced in a book or a journal in Korea earlier, it was not until the late 1990s that a first care management program was launched in community care for elderly people. Care management is not only to coordinate the services and to link members of service networks of a mixed economy of care, but is also the development of appropriate services needed by elderly people in a community.

2. Roles of care managers in community care

2.1 Care manager as an implementer

According to Rothman(1998), an essential aspect of the success of care management is that care manager should actively support the clients in actually connecting with service.[2] The care manager works with the clients in identifying the services that the clients require to fulfill their needs, and then implements services to the clients through the process of obtaining these services and supports. The care manager as a collaborator usually provides some services directly as part of the care package.

There are several reasons why clarifying the roles is an important task for the care manager. A care manager forms a collaborative relationship with the clients in which the care manager is directly involved in the process of obtaining services and supports. Secondly, successful execution of the role encourages the clients to develop problem-solving skills. Finally, the care manager can model ways for the clients to work with providers [3]

2.2 Care manager as a counsellor

The role of a care manager involver direct service provision such as supporting, counselling, interpersonal or medical therapy [4]. It means That a care manager has responsibility for a case and is responsible for providing specialist professional services. It is not unusual for a care manager to work directly with the clients in developing skills and counselling which are useful to the clients in subsequently fulfilling their own needs . A care manager operationalizes the role of an instructor when the clients are able to exercise a high level of self-direction.

The essence of the role of a counsellor is that the care manager supports the self-advocacy of the clients and the movement of the clients towards higher levels of self-direction empowerment.

The most basic role that must be played by a care manager in any system is to remain aware of the comprehensive needs of the clients. This means that a care manager must be aware of, though not necessary directly involved in, the initial intake and assessment of their clients. The care manager as an administrator organize and leads teams of professionals in care decision-making and planning the delivery of clients' services.

To sum up, in the client's-level role, a care manager provides a means of building and strengthening the self-care capacities of clients. However, client's-level intervention, according to Moxley (2012), is not the only means of providing services to a client. Environmental intervention also is an important component of care management[6]. Therefore, the community care system and social networks are legitimate targets of the intervention armamentarium of a care manager (Nancy & Beth, 2012)[7].

2.3 Care manager as a linkman

Linkage is a strategy used by a care manager to connect the clients to the services available in order to assure utilization. Implicit in the role is a need to liaise with other professionals and informal carers to provide a human linkage between the clients and a range of the services social networks [7].

As Rothman argued, linkage requires the use of

organizational skills and community-oriented skills (eg. what new services are developing, what legislative policies are applicable, and what funding is available) to optimize service connections.

2.4 Care manager as a co-ordinater

Care management is designed to enhance coordinated service delivery to assure that services are being implemented in 'harmonious and compatible ways by the social service providers and social network members who have been organized by a care manager to respond to the clients' needs'[4]. Awareness of local resources makes the care manager an authority on service gaps and overlaps that exist in a community. The care manager strives to reduce the service duplication that can occur when multiple providers each prepare separate care plans for the same clients[5].

To sum up, care management is a complex function. If effective continuity of care is to be provided for clients, coordination must take place at many levels within the system. Among the many possible structural elements that could be developed to implement care management, two have been specified as essential. The first is the care management, two have been specified as essential. The first is the care manager who provides coordination and integration of services at the client's-level. The second is at the systems-level which is responsible for coordination and linkage of programs[8].

Ⅲ. Research Method

The factors to be examined in the choice of sample size include: implication of the sample size and design for sub-population analysis, adjustments for in eligibles and non-response. Expense of the design given the sample size and credibility. It is proposed to interview 100 care worker or managers in health center, nursing home, welfare center, group home center in Seoul Metropolitan City and Gyeonggi Province. The samples are chosen from both rural and urban areas. The study has used random sampling. Interviews have been conducted with care managers with structured questionnaires. The list of care managers tasks comes from the personal social service research unit experiments at Long Term Care Insurance of National Health Insurance Service .

Ⅳ. Findings

4.1 Characteristics of care managers

The mean age of care managers was about 42.4 years old in both urban and rural settings. The majority of care managers were women only 76.4% in urban and 13.8% in rural care managers were male. It is a commonly held view that the typical care manager is woman[9].

Table 1. Characteristics of Care Managers (Unit: %)

Category		Area		P-Value
		Urban	Rural	
mean age		38.4	46.4	*
sex	male	23.6	13.8	*
	female	76.4	86.2	
qualification	social work	41.7	27.2	*
	nurse	39.1	68.3	
	others	19.2	4.5	

Note: NS non-significant, *<.05, **<.01, ***<.001

4.2 Task with clients

Care managers were asked to tick the main actives they had undertaken (see table 2). The main activities of care managers were intake, need assessment and care planning at system level in both areas.[10] The data suggested that care managers in the urban area were more active with their elderly clients than those in the rural one, affecting most tasks given in table 2. In particular, urban care managers were less concerned with almost all tasks compared to rural care managers. It might be inferred that urban care managers had more other tasks, continuing responsibility for elderly clients than those in the rural area, associated with difference in caseload sizes, around 100 cases a care manager in the rural area.

Table 2. Care Manager's Tasks with Clients(Unit: %)

Tasks	Area		P-Value
	Urban	Rural	
intake	48.2	55.7	*
assessment	45.5	47.2	NS
care planning	38.3	51.6	*
monitoring	27.5	58.2	*
review visit	25.3	53.5	*
coordinating	28.5	45.2	*
linking resource	21.7	62.5	**
counselling	23.5	55.7	*
social skills education	34.5	52.3	*
advocacy	41.5	47.2	NS
group work	34.5	58.6	*
financial application	33.2	41.2	*

Note: NS non-significant, *<.05, **<.01, ***<.001

In categories of social skills education and advocacy, Rural care managers were more likely to be involved than urban managers. Overall, compared with the urban, care managers' tasks allocated in the rural setting were not relatively simple. The results confirmed that care managers not required for different tasks between countryside and the city.

4.3 Tasks with Carers

When care managers tasks with carers were studied, the main activities were information exchange, advocacy, emotional, support and counselling, and carers' needs assessment (see table 3). It was noticeable that counselling was important in both rural (53.3%) and urban(46.7%)area.

This implied that the carers under considerable stress from caring work with elderly people needed emotional support. For information exchange, urban care managers were the same as the rural care managers to get in touch with carers. Advocacy(66.7%) was a the major care management activity in the urban area. Compared with rural care manager(33.3%), urban care managers were more likely to be involved in advocacy. As the possible explanations of this difference was the Korean cultural tradition, in which more rural people than urban

dwellers tended not to courage the expression of feelings about personal matters to other people.

Table 3. Care Managers' Task with Carers

Tasks	Area		P-Value
	Urban	Rural	
information exchange	38.5	40.5	NS
advocacy	66.7	33.3	*
emotional support	46.7	53.3	*
carers' needs assessment	27.5	28.0	NS
education for carers	35.0	50.0	*
Note: NS non-significant, *<.05, **<.01, ***<.001			

4.4 Tasks with Formal & Informal Networks

Table 4 sets out the data on care managers' contacts with formal and informal networks. Care managers were most frequently in contact with formal networks for information exchange and negotiation over changes in services. For negotiation over changes in service, urban care managers(46.4%) were more often likely than rural ones(33.3%) to contact formal networks. This implied that there were relatively more services in formal urban networks than rural ones to provide for changing needs of elderly people.

In care managers' tasks with informal networks, linking informal resources (49.6) was most frequently performed by urban care managers, followed by the development of new resources(46.7%).

Table 4. Care Managers' Task with Formal & Informal Network

Tasks	Area		P-Value
	Urban	Rural	
A. With formal networks	-	-	*
a. informal exchange	42.9	35.7	
b. negotiation exchange	46.4	33.3	
B. With informal networks	-	-	*
a. develop new resources	46.7	47.7	
b. linking informal resources	49.6	32.3	
c. volunteer training	27.0	60.0	
Note: NS non-significant, *<.05, **<.01, ***<.001			

4.5 Available resources in community care for elderly people: Community resources

A broad using of community resources was essential to the successful implementation of community care in the light of the advanced countries' experience. To make use of such resources, the care managers required both knowledge and skills for service environmental modification.

Table 5. Available Community Resources

Tasks	Area		P-Value
	Urban	Rural	
home help	53.0	24.7	*
private paid help	32.5	47.5	*
private paid nurse	60.2	24.3	*
night sitter	23.8	56.7	*
volunteer involvement	25.3	53.5	*
meals on wheels	28.5	45.2	*
laundry service	21.7	62.5	**
transport	23.5	55.7	*
ocupational therapy	34.5	52.3	*
material improvement	55.5	17.2	*
social club	54.5	28.6	*
hair cut	58.2	41.2	*
Note: NS non-significant, *<.05, **<.01, ***<.001			

As shown in table 5, community resources mobilized by care managers in community care were from the state sector such as home help(53.0%), meals on wheels (28.5%), or hair cuts(58.2%) in urban area. From other sectors, the services used most often were private paid help(32.5%), followed by services which used a private

paid help, followed by services which used a private paid nurse, asocial club(54.5%) and material improvement (55.5%). In general, rural care managers were less likely than urban ones to use community resources in the majority of categories.

4.6 Residential and the NHS Resources.

Table 6 summarized the main residential and the NHS resources frequently used by care managers in community care. The most significant residential resource appeared to be a day care center in urban shelted housing in rural, which reflected a particularly close working arrangement with the local office negotiated by care managers. Although all residential resources were not frequently used in both areas, they were relatively more mobilized by urban than rural care manager.

Table 6. Available Residential & NHS Resources

Category	Area		P-Value
	Urban	Rural	
group home	0	20	*
sheltered housing	27.5	58.2	*
private nursing home	48.5	21.5	*
non-paid nursing home	39.6	32.1	*
day care center	78.2	3.8	**
GPS	31.2	42.3	*
district nurse	31.2	38.5	*
Note: NS non-significant, *<.05, **<.01, ***<.001			

The most important single NHS resource with whom the care managers were in contact was the general practitioners(GP) access in the rural and district nurse in the urban area,

Ⅴ. Discussion and Conclusion

Care managers involved in community care played several important facilitative roles with clients, carers, involved in formal and informal networks, and using community, residential and the NHS resources in Korea. In terms of roles with elderly clients, care managers associated several roles at the system and client levels. At the system level, as shown in theological background, care managers undertake several tasks related to the process of providing services in community care. On the basis of the result of the field research(see table 2), a care manager as a processor, charged with the process of community care interventions, and as a broker, involved in selecting appropriate service networks and resources for the best package of service or support, was most required in both rural and urban areas. At the clients' level, care managers focused on the task related to direct work with elderly clients in community care. In both areas, a care manager acted as a counsellor to support the self-advocacy of clients and the movement towards higher levels of self-direction. In considering the statistical difference between rural and urban areas in the category of going to the bank application, which was one of most frequent involvements in working with rural elderly clients, a rural care manager was more likely than the urban to be weaken acting as an instructor, teaching rural clients problem solving skills. In the analysis of working with care workers(table 3), advocacy and counselling were the leading roles of an urban care managers, urban managers demonstrated a frequent advocacy role, coaching clients through the maze of service.

In working with formal and informal networks (table 4), an information specialist role was also important in both areas. The care manager were often in the unique position of knowing exactly where to guide the elderly clients to make her impact on the system more effective. A care manager as a link person was required in the urban area in order to assure the service utilization. On the other hand, a care manager as a service developer was most required in the rural area because of a lack of services to meet clients' needs. With resource management, there were some regional variances between rural and urban area(see table5 & 6). In the urban area, there were a variety of services in all categories, including residential and NHS resources used by care managers.

The conclusion, the study extends discussion in the context of similarities and differences of care managers' roles between rural and urban area. In general, rural care managers' roles were similar to those of care managers in urban area. Among the many possible roles of care managers that effective continuity of care is to be provided for elderly clients in community care, two have been specified as essential roles. The first is the role of care managers that provides coordination and integration of services at the clients' level. The second is at the system level which is possible role for coordination and linkage of programs. It is a long-term care benefit that

supports physical activity and provides education or training to maintain or improve the mental & physical functioning of the elderly who are residing in aged care facilities or senior congregate housings (operated by a long-term care institute) for a long period of time.

A long-term care staff visits a beneficiary's home and helps in home service benefit. Other In-Home Service Benefits Provide materials required for a beneficiary's daily life and physical activity or visit a beneficiary's home and support her rehabilitation.

In the future, the research of the Geriatric Care Workers' Role Care needs to be compared to various conditions that fit the local characteristics. To compare the score of functional independence measure (FIM) between urban and rural residents living in long- term care facilities in urban and rural areas, is lacking in the diversity of local characteristics.

In general, a rural or urban area is a geographic area that is located outside towns and cities[11]. The Health Resources and Services Administration of the Long term care insurance defines the word rural as encompassing all population, housing, and territory not included within an urban area, Whatever is not urban is considered rural. Typical rural areas have a low population density and small settlements[12]. Agricultural areas are commonly rural, as are other types of areas such as urban different countries have varying definitions of rural and urban for statistical and administrative purposes

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