Growing Needs Blossom into Innovative Care Management

For a major Catholic healthcare system, care management was the key to responding to managed care. The system's wake-up call came when, under changes to the Medicaid program, it began to serve new needy populations, including people dually eligible for Medicare and Medicaid, Alzheimer's patients, the chronically ill, and the uninsured and underinsured. Facing the need to serve these people more efficiently and cost-effectively, Franciscan Health System, Aston, PA, began strategic planning for their care. Nancy Gorshe, who was Franciscan Eldercare's president, explained the system's efforts and philosophy at the national meeting of the American Association of Homes and Services for the Aging in October. Since initiating its care management planning and the development of key programs, Franciscan, along with several other systems, has become Catholic Health Initiatives (CHI), Denver. Gorshe is now president, Continuum Integration Services, an independent consulting firm.

The Franciscan system comprised 13 medical centers and 7 long-term care facilities, as well as Alzheimer's and assisted living units, adult day centers, and geriatric assessment clinics. Gorshe said several factors persuaded the system to develop care management:

- State Medicaid cuts
- Federal budget deficits that affected funding for Medicare and Medicaid
- Demonstration funding opportunities for the dually eligible
- Critical ethical issues in patient care, including care of the dying
- Pressures for better outcomes, which forced the system to look at how it could monitor care across the continuum

"For the first time, we began to plan across the continuum," Gorshe said. "We tried to build new relationships, and we started by focusing on physician care, rather than home care or long-term care." The system also worked on internal integration of services. For example, it integrated pharmacy services in the system's hospitals and long-term care facilities, Gorshe said.

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—Nancy Gorshe

External Integration

As the system moved into external integration, it had to let go of the idea that it could own all aspects of the process. In contracting with external organizations, the system looked for partners that could fill gaps in service in its provider network for Medicare managed care. Partners also had to be willing to assume the same level of risk as other network members, Gorshe said. The system has developed two care management partnerships/demonstrations.

Funding for Care Management

Finding adequate funding for care management is a crucial issue, Gorshe said. The system found that the Medicare managed care program offered more financial support for care management than did other sources. Physician groups were also willing to share dollars in order to support care management, Gorshe said, and the system worked to link long-term care and acute care physicians.

Gorshe emphasized that the goals of care management are not limited to utilization management: "Care management's goals are to promote wellness, assess function, prevent disability, and support informal caregivers. We look at care management services to include access services, such as transportation, information, and care coordination."

The Program of All-inclusive Care of the Elderly (PACE), which provides all acute and long-term care services to enable the frail elderly to remain in their homes, has been the most pure model of care management. Gorshe said the three CHI PACE sites in development and five others under feasibility study will demonstrate a multidisciplinary approach that includes assessing needs, planning and providing all care, and monitoring patients in an adult day care setting.

Georgia Creates Program for Frail Elderly

A new case management program is helping residents of Atlanta, Augusta, Savannah, and Hinesville avoid nursing home placement. SOURCE, an expanded version of the PACE program, provides at-risk elderly with comprehensive medical care with in-home support that includes meals, medical transportation, and cleaning. The Department of Medical Assistance of Georgia created SOURCE (Service Options Using Resources in a Community Environment) as a means to reduce the state's growing Medicaid expenditures for nursing home care. Constance T. Dodson, director of case management services, Senior Connections, Decatur, GA, said the program's goals are fourfold:

- Provide fully integrated primary, specialty, and home care
- Reduce inappropriate emergency room use, hospitalizations, and nursing home placements
- Stabilize social and lifestyle factors that affect compliance, health status, and quality of life
- Reduce need for long-term institutional care

All SOURCE programs are required to offer multidisciplinary care management, a 24-hour call center, primary care, service development, community services, and adult day healthcare.

SOURCE is funded through an enhanced case management fee from Medicaid and fee-for-service billing from Medicare, but its goal is to shift to capitated reimbursement in 1998, according to Dodson.

Atlanta Delivery Model

She described how SOURCE is working in Atlanta. Five community partners deliver care. The Atlanta Regional Commission handles client intake; Senior Connections provides social work and case management services, transportation, Meals-on-Wheels, and homemaker services; the Visiting Nurses Health System assists with discharge planning, provides skilled nursing care, medical equipment, and homemaker services; the Weinstein Center offers adult day care, including a program for Alzheimer's patients; and Wesley Woods, Inc., provides primary care, case management, and counseling.

In weekly case conferences, nurse practitioners, social workers, administrators, and others plan care for clients.

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—Constance Dodson

Information systems are being developed to provide patient information to users involved in service delivery. Data will be used to assess clinical outcomes and cost, prepare for capitation, define at-risk populations, and compare SOURCE to other national programs for the frail elderly. Other anticipated uses for data include assessing clients' satisfaction and their functional and cognitive status, evaluating utilization, and improving disease management and care delivery.

SOURCE's Challenges

SOURCE has encountered many challenges, Dodson said. Because case management is time intensive and requires extensive paperwork, managers' work loads had to be carefully organized and restructured. Meetings where service providers could air problems helped them reach solutions. In addition, SOURCE is seeking ways to reduce the time needed for case conferences.

SOURCE found that clients needed breakfast from Meals-on-Wheels and that they were sometimes not eating meals. The program is planning for breakfast delivery and is educating clients about nutrition. Another problem, particularly upsetting to clients, has been turnover among staff providing homemaker services. In looking for a solution, SOURCE is assessing workers' benefits. It is providing counseling and increasing respite services to resolve family problems, which include unresolved conflict and burnout.

Dodson said missed appointments are a "real issue," and SOURCE is providing patient and family counseling and education.

Enrollment in the program has been lower than anticipated. New marketing strategies are being developed that assure potential clients they will have access to geriatricians.

Vision for the Future

Dodson said the six-month-old program has already demonstrated that its expenditures are far less than the state's nursing home expenditures. With capitation and creative resource development (e.g., grants, cost sharing), she hopes the program will add enhanced services and benefits (e.g., glasses) to help clients, whose average income is about $500 a month. *—Judy Cassidy*