CARE MANGEMENT: QUELLING THE CONFUSION

Care Managers Help Clients Access Resources Appropriate To Their Needs

BY LOLA J. WESTHOFF

As the number of chronically ill persons increases and healthcare costs continue to rise, Americans are searching for ways to help the vulnerable access healthcare and social services while controlling utilization. One service delivery model that has proven effective in addressing these issues is care management.

The vast number of available healthcare services can be confusing to those seeking care. What services are available in the community? Which ones are appropriate to help fulfill their needs? How can they access the appropriate services? Care managers can help the vulnerable and their families find and receive the services necessary to meet their needs.

One Element in the Continuum

The Catholic Health Association's 1988 report, *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly-at-Risk*, outlined the elements necessary for a continuum of care. It noted that care management is a significant element if the continuum of care is to be responsive to the person's needs. The National Council on Aging and the American Geriatrics Society also have adopted position statements on the importance of care management.

The term "care management" is preferable to "case management" because it communicates that the process is the management of care, as opposed to the management of the case or cost of services. This process recognizes the client's right to self-determination. Care managers identi-

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Summary The vast number of available healthcare services can be confusing to those seeking care. Care managers can resolve these issues by helping the vulnerable and their families find and receive appropriate services. Care management is not limited to the elderly: Others with special needs also benefit from care management. Care managers integrate and coordinate services, providing a continuum between the client and the providers of acute, long-term, home-based, and community-based care.

The care management model that most organizations adopt at first is the brokering model. In this model care managers identify the appropriate service package from resources in the community.

In the service management model, the care manager authorizes the services provided within specified financial limits. The funding source influences what services he or she can recommend.

Another model is managed care. The carrier of a high-risk group of clients or a group of enrollees in a certain healthcare program prospectively pays the organization providing care management.

In the acute care setting, providers find the transition to care management challenging because they have been oriented to short, episodic care. These providers must adopt new protocols to be able to work with providers and programs within their own organization or at other organizations.

In community-based care, care managers' goal is to help the client and family access appropriate services so the client can function independently within his or her home. Community-based referrals are from family members or agencies and infrequently follow an acute care hospitalization.

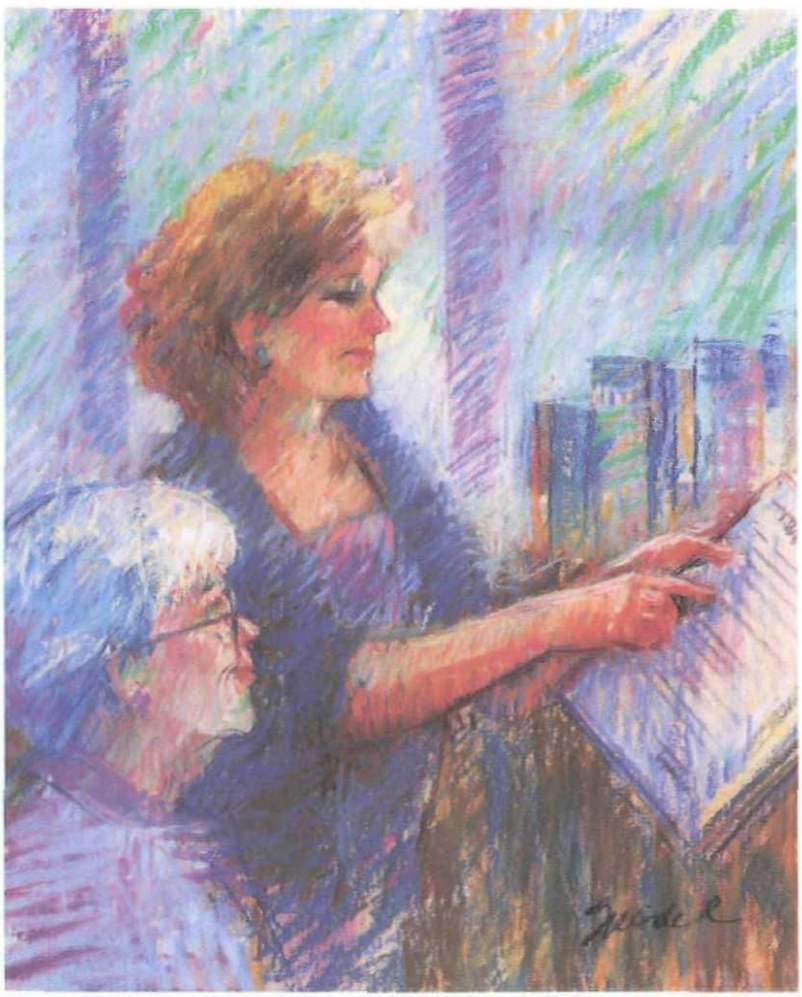
fy clients' needs and coordinate services that will maximize the function and independence of the clients and their care givers. Care managers establish a linkage between clients and the complex, fragmented, and confusing array of services available to meet their needs.

Care management is not limited to the elderly population. Others with special needs, such as oncology patients, also benefit from the availability of a care management system.[1] In this approach to managing care, clients become knowledgeable about available services and their appropriateness. Then they can make informed choices of services to meet their specific needs.

Care Management Responsibilities

Care management is not limited to one type of care, such as acute care. The purpose of care management is to integrate and coordinate services, providing a continuum between client and the providers of acute, long-term, home-based, and community-based care.

The care plan addresses both formal and informal services.



Sandra Speidel

Care managers should have the education and experience to carry out the management responsibilities of the job. Persons with backgrounds in nursing, social service, and gerontology are frequently qualified to work as care managers. The target population being served (the frail elderly or chronically ill) defines what professional background best meets clients' needs. If the population is medically unstable, a nurse or physician may be an appropriate care manager. However, the care management team must be multidisciplinary. It must include social workers, physicians, and nurses.

Goals of care management address both the client and system needs and include the following[2]:

- Ensuring services are appropriate to the clients' or families' needs
- Improving clients' ability to access the continuum-of-care services
- Facilitating the development of a broader array of noninstitutional services
- Promoting quality and efficiency in the delivery of services
- Enhancing the coordination of service delivery while reducing duplication of services
- Targeting the most at-risk population to prevent inappropriate delivery of services or care
- Containing costs by ensuring appropriate use of services

Care management activities include the following professional nursing and social work functions:

- Screening clients' need for assistance.
- Completing comprehensive assessments of clients' functional level and social, cognitive, emotional, and physical impairments (including housing and the family situation).
- Developing a plan of care that addresses clients' identified needs and concerns while incorporating services to enhance the family and friend support system. The client, family, and other professionals (such as the physician) should be involved in developing the care plan. The plan addresses both formal and informal services necessary to address clients' and care givers' needs.
- Arranging for and coordinating the delivery of services identified in the care plan.
- Monitoring the services and care being provided. This includes regular contact with the client and family (in person and by telephone) to

observe changes in condition and to make modifications to the care plan as the needs change.

- Reassessing clients' and families conditions and needs.

Models of Care Management

Several care management models exist. Care management models most frequently develop around the allocation of resources. Programs can be sponsored by a social service agency, a primary care facility, a medical-social program, a health maintenance organization, an insurance carrier, an independent provider, or a community. Most frequently care management models are categorized by the extent of service they provide to clients and their families.

Brokering Model The care management model that most organizations adopt at first is the brokering model. In this model the care managers identify the appropriate service package from resources in the community. Care managers do not have service dollars to allocate on behalf of their clients. Rather, care managers negotiate and advocate with various providers to arrange services to address clients' needs. This model relies on multiple providers and has no resource base for covering the cost of services.

In the brokering model, care managers negotiate and advocate with various providers to arrange services.

Service Management Model In the service management model the care manager manages both the services provided and the clients' service budget. The funding source influences what services the care manager can recommend to meet the client's needs. At times the care manager in the service management model will also provide direct services of his or her profession, such as nursing or social work. An example of this model is the Home and Community-based Waiver, funded through Medicaid in 41 states.[3]

Managed Care Model Another model is managed care. The carrier of a high-risk group of clients or a group of enrollees in a certain healthcare program prospectively pays the organization providing care management. The provider is at greater risk to provide services for a prospective price or per diem rate. In the managed care model, care management has the potential of becoming a case management process when a client has a high resource need that may affect the organization's

HOSPITAL-BASED CARE MANAGEMENT

St. Mary's Hospital and Health Center in Tucson, AZ, a member of St. Louis–based Carondelet Health System, established a care management program in 1985. Clients are referred to the program during hospitalization, or community agencies or individuals may make referrals. Referrals are made based on the complexity and acuity of patient and family needs or risk status. High-risk status is determined by the age of the patient, age of the family care giver, number and frequency of previous hospital admissions, and potential for complications based on the presence of health or social problems. St. Mary's care managers are responsible for collaborating with the multi-disciplinary team and with community agencies to help the patient achieve agreed-on outcomes and to evaluate progress toward goal attainment.

St. Mary's care managers are registered nurses. The nurse care manager's primary role is to assist the patient as he or she moves through the healthcare delivery system. After hospitalization, patients may require intensive home healthcare or short-term services in an extended-care unit. As the patient recovers, the care manager monitors the progress through visits or is kept up-to-date through the community-based ambulatory care services provided by St. Mary's Wellness Centers.

St. Mary's care management program is one component of the nursing network, but St. Mary's administrators believe this role has had a positive effect in several ways, such as building the patient and family's confidence in their ability to provide care in the home, teaching patients and their families how to adhere to medication and diet regimens, and helping patients and families adjust to chronic illness.

St. Mary's continues to study the direct effect care management has on cost data related to length of stay and in-hospital acuity levels. Initial data indicate that clients participating in care management entered the hospital at a lower acuity level (P. Ethridge and G. Lamb, "Professional Nursing Case Management Improves Quality, Access and Costs," *Nursing Management*, March 1989, pp. 30-35). This reduced their length of stay from the typically high-cost days at the beginning of hospitalization.

The network developed at St. Mary's, with the integrating element of care management, offers advantages to clients and their families, professionals, and the healthcare organization. St. Mary's continues to evaluate the outcomes of care management, to investigate the expansion of the network into a managed care system, and to expand the program for patient populations in addition to the elderly, such as women experiencing high-risk pregnancies.

financial success. This model may also threaten clients' ability to choose services to best meet identified needs.

Acute Care–based Care Management

Frequently, acute care providers find the transition to care management challenging because they have been oriented to short, episodic care. The long-term involvement that care management requires calls acute care providers to adopt new protocols to be able to work with providers and programs within their own organization or at other organizations. Providers must work to avoid conflicts, misunderstandings, and competitiveness.

Many acute care facilities have diversified their services to overlap with those in the community: home health, hospice, adult day care, skilled nursing, and preventive healthcare. Therefore many facilities have begun referring clients to services within their own organization rather than to community-based services. Although many services may be available from one provider, this does not necessarily mean the clients have a better opportunity to receive the most appropriate services to meet their needs.

Diversification was meant to result in services that are responsive to newly discharged acute care patients' needs and to allow administration to better control the services and quality of care available. But frequently coordination between services from one provider is limited. Care management provides a process to be responsive to the clients' and organization's need to receive and provide long-term continuity of care. For an example of hospital-based care management, see the **Box** on p. 45.

Community-based referrals are from family members or agencies and infrequently follow an acute care hospitalization.

A hospital's care management goals may include the following[4]:

- Helping professionals and the highest-risk patients access appropriate (and, ideally, fewer) resources
- Enhancing discharge planners' ability to discharge patients earlier or after an appropriate length of stay
- Achieving clinical outcomes that are "expected" or "standardized"
- Promoting collaborative practice, coordinated care, and continuity of care
- Promoting professional development and satisfaction
- Empowering patients' and families to make healthcare decisions.

Community-based Care Management

The primary role of community-based care management is to help the client and family access appropriate services so the client can maintain or maximize function and independence within the home. The community-based program ensures the population a choice of services in appropriate settings. Differing from acute care-based care management, community-based referrals are from family members or agencies and infrequently follow an acute care hospitalization. The **Box** on the left describes a community-based care management program in Flint, MI.

Frequently community care management programs contract with agencies (such as Medicaid or an Area Agency on Aging) to provide care management for a specific population or geographic area. However, many community agencies do provide both care management services and the administration of home care benefits, such as eligibility determination, quality assurance, contracting with providers, authorization of payment for services, and reimbursement of providers.[5]

Unaddressed Issues

As the number of care management programs increases, issues arise related to sponsorship,

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COMMUNITY-BASED CARE MANAGEMENT

In the late 1970s St. Joseph Health Systems' Center for Gerontology in Flint, MI, developed a community-based care management program to meet the needs of the frail elderly and their families. Within a three-county service area, 17 agencies worked together to develop the program for the elderly. The administration of the care management program is through St. Joseph Hospital, but the care management teams are local professionals within the community. By coordinating such a system, the collaborative group was able to access funding that would not have been available to one entity.

The St. Joseph care management team is multidisciplinary, including a geriatrician, nurses, and social workers. Care management teams of nurses and social workers are established within the local communities. Clients may access services through local healthcare organizations such as home health agencies and public health or other hospitals. The St. Joseph care management team is expanding its scope by contracting with employers and managed care plans to provide care management services for retirees or Medicare enrollees. The team continues to study the effect care management has on appropriate utilization of services.

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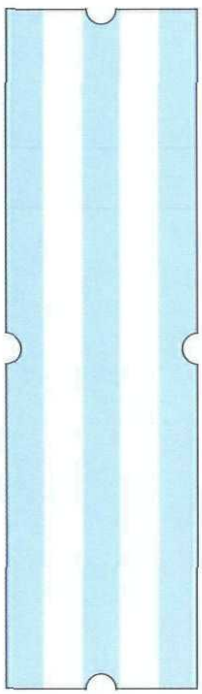

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PREVAILING ISSUES IN LONG-TERM CARE

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among sponsoring groups and between Catholic hospitals and long-term care facilities in the next five years. On the other hand, about 8 out of 10 long-term care CEOs thought that significant collaboration is *not* very likely between sponsors and dioceses, between Catholic acute care hospitals and Catholic charities, and between Catholic and non-Catholic organizations.

MEDIATING PRESENCE

Aside from the high degree of concordance among CEOs of Catholic long-term care facilities on the importance of certain issues, one other result warrants attention. As a group, the degree of emphasis that long-term care CEOs placed on a number of issues fell midway between that of bishops and sponsors on one hand, and hospital CEOs on the other. This applied to management and governance issues, ethical dilemmas, and other Church-related issues. Bishops and sponsors were at times distinctively different from hospital CEOs (especially lay CEOs) in the emphasis they placed on certain issues. Thus CEOs of Catholic long-term care facilities, because they tend to occupy the middle ground, may be better able to empathize with either extreme, mediate differences of opinion, and help improve communications between these important groups of leaders.

The collective ability of this growing community of leaders to advocate improvements in the healthcare system, as well as to unify sponsors, bishops, system CEOs, and hospital CEOs, may be a key to strengthening the Church's mission of ensuring the dignity of the infirm elderly. Regrettably, at least in the short term, the Catholic long-term care ministry can expect to come under even greater pressure, if for no other reason than that the number of elderly Americans will increase dramatically in the coming decades. □

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organization location (provider-based or freestanding care management agency), professional groups to be care managers, and identification of at risk populations.[6] If care management is a function of a provider agency, such as home health, the care manager's challenge is to provide a service package that does not inequitably benefit the provider and infringe on the care manager's role as client advocate.

Care management is moving rapidly out of the broker model and into the service management and managed care models. As a result, many ethical issues related to persons' freedom of choice or autonomy, admission criteria, informed consent, assessment of need, financial negotiation, conflict of interest, service planning, and coordination of services need to be addressed through policy development or ethical decision-making processes.

Care management implies client advocacy so that the care plans meet needs in a manner acceptable to them. The risk to managed care clients is in whether the care manager has the ability to be both an advocate and a controller of the financial liability for services. □

NOTES

1. M. Wool et al., "Negotiating Concrete Needs: Short Term Training for High Risk Cancer Patients," *Health and Social Work*, August 1989, pp. 184-193.
2. R. Applebaum and C. Austin, *Long-Term Care Case Management: Design and Evaluation*, Springer Publishing, New York City, 1990, pp. 6-10.
3. *Applebaum and Austin.*
4. C. McKenzie, N. Torkelson, and M. Holt, "Care and Cost: Nursing Care Management Improves Both," *Nursing Management*, October, 1989, pp. 30-34.
5. P. Kemper, "Case Management Agency Systems of Administering Long-Term Care: Evidence from the Channeling Demonstration," *Gerontologist*, vol. 30, no. 6, 1990, pp. 817-824.
6. Applebaum and Austin, p. 16.