FILLING THE GAPS

Systems Offer Two Models of Care Management: Community Outreach And Inpatient Care

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Summary The growing number of vulnerable people, such as the elderly and people with long-term disabilities, calls for healthcare providers to offer more programs to ensure a continuum of care. Client-focused care management programs offer access to such a continuum. Care managers understand services and reimbursement and can pull it all together for the client.

The Sisters of Charity Health Care Systems, Cincinnati, have two models of care management. St. Joseph Coordinated Care provides extensive outreach to a large, culturally diverse New Mexico community, serving urban and rural clients. Penrose–St. Francis Healthcare System offers inpatient medical care management in Colorado.

Coordinated Care at St. Joseph Healthcare System in Albuquerque is comprehensive, covering a wide spectrum of client needs—medical, social, and psychological. The program's central goal is to help individuals remain safely at home.

Persistence and devotion to the client are the hallmarks of effective care management and the foundation of the new geriatric care management program at Penrose–St. Francis Healthcare System in Colorado Springs, CO. The program's goals are to improve inpatient geriatric care, smooth the patient's transition to alternative care settings, and ensure efficient and effective resource use during the patient's hospital stay.

A comprehensive network of hospital-based expertise and community resources is helping Catholic healthcare providers extend their mission through client-focused care management (also known as case management). Care management begins with the question, What are our clients' financial, social, medical, psychological, and family needs? Once this question is answered, care managers can locate the resources to fill in gaps in their clients' care.

The Need for Care Management

The growing number of vulnerable people, such as the elderly and people with long-term disabilities, calls for healthcare providers to offer more and more programs to ensure a continuum of care. These vulnerable persons often have limited personal resources and little knowledge about the U.S. healthcare delivery system, which often seems to be a fragmented array of services. Care managers help clients receive appropriate placement, with no overuse of resources, and appropriate care so they can function at the highest level possible.

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Payers are finding it advantageous when persons they cover get appropriate care in the appropriate setting. A nursing home costs more than assisted living, which costs more than homemaker services once or twice a week. Payers are finding that resources are used more wisely when a care manager properly assesses and assists clients in obtaining community-based services.

Clients and their families, who may live hun-

dreds of miles apart, can find the diversity of healthcare and social services confusing. Adult children often seek someone they trust who can monitor their parents' health, help these elders sort through the services available, and help them get through the reimbursement system.

The care manager is the ideal person to do this. He or she can refer elders and persons with disabilities to a number of services. Experienced care managers understand services and reimbursement and can pull it all together for the client.

The Sisters of Charity Health Care Systems (SCHCS), Cincinnati, have two models of care management that illustrate these principles. St. Joseph Coordinated Care provides extensive outreach to a large, culturally diverse New Mexico community, serving both urban and rural clients. And Penrose–St. Francis Healthcare System offers inpatient medical care management in Colorado.

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Coordinated Care in New Mexico

Coordinated Care at SCHCS member St. Joseph Healthcare System in Albuquerque is comprehensive, covering a wide spectrum of client needs—medical, social, and psychological. The program, now in its fifth year, has served clients aged 1 to 107 years. Coordinated Care serves more than 600 clients a year. About 65 percent are elderly, and the others are persons with disabilities or chronic health problems. The program's central goal is to help individuals remain safely at home.

Coordinated Care is the only care management service available to Medicaid *and* private-pay patients in the Albuquerque metropolitan area. Most third-party payers do not cover the program. Currently, two-thirds of the clients are Medicaid patients, and one-third are private-pay patients. Coordinated Care is the only area program that provides patients with a range of care management options, as some move from private

COORDINATED CARE CLIENTS

For five years Coordinated Care at St. Joseph Healthcare System, Albuquerque, has worked with a broad spectrum of vulnerable patients. Here are a few case histories, just three of the many elders and persons with disabilities and chronic health conditions whom the program has served.

Bobby

Bobby is a 15-year-old who is able to live with his family after eight years in a state institution. A birth injury left Bobby blind and severely mentally retarded. Although his parents and two sisters were able to care for him until he was six years old, they had to place him in an institution when he reached school age.

When the family moved to New Mexico, they searched for services that would allow them to bring Bobby home. They found the services through Coordinated Care, whose care manager coordinated the paperwork for Bobby's Medicaid assistance.

Now, Bobby is home with his family, supported by the services of a nursing assistant who bathes and cares for him five afternoons a week after school until his parents return from work. A physical therapist visits weekly, as does an occupational therapist who is training Bobby to feed himself.

The care manager has seen a remarkable change in Bobby's family. His teenaged sisters are free to join extracurricular activities after school instead of rushing home to care for their brother. Both his parents can work, emotionally supported by Coordinated Care's services. "If it weren't for the help, we'd have to put Bobby back in an institution or a nursing home," his mother says. "Having him here with us makes our family complete again."

Sarah

After a 1988 car accident left her paralyzed from the waist down, 32-year-old Sarah has been slowly rebuilding her life with the help of Coordinated Care.

A Native American, Sarah lives on a reservation in the Albuquerque area. Various family members have been caring for Sarah, but because of their frequent rotation, she felt anxious during intervals when she had to be alone.

Coordinated Care provided the necessary constancy in her care, linking her to rehabilitative services and supporting her with personal care at home. This additional help has relieved the family of full-time responsibility.

Sarah is able to use her hands, feed herself, and prepare meals; however, she is unable to shop, bathe, or drive. Personal care services in her home and transportation assistance help Sarah through these activities. Coordinated Care has arranged for Sarah to do volunteer work at the elementary school. Sarah's work with the children has helped bolster her self-esteem.

Mrs. Smith

Coordinated Care is helping 72-year-old Mrs. Smith retain her independence in an atmosphere of safety and dignity after a stroke four years ago. Mrs. Smith lives alone in a wheelchair-accessible apartment. She has recently separated from her abusive husband of 25 years and is adjusting well to her single status.

Because Mrs. Smith is limited by impaired vision that continues to worsen, a homemaker helps her six times a week. Mrs. Smith also has a supportive group of family members and neighbors. In case of emergency she has a Lifeline emergency response system provided through St. Joseph Senior Services. Without Coordinated Care, Mrs. Smith would have had to enter a nursing home.

pay to Medicaid because of reduced resources.

After an initial $75 assessment fee, Coordinated Care's hourly fees are set at $30 to $60, depending on a client's income. In cases of special need, the fees may be lower. This year administrators hope Coordinated Care will break even.

More than 200 clients are on Coordinated Care's Medicaid waiting list. The typical wait is about a year, but sometimes it is twice that long. This shows the dire need for more such managed care programs.

Recently Coordinated Care received a grant from the Sisters of Charity Health Care Foundation to supplement the cost of care management for indigent patients.

SCHCS administrators see Coordinated Care as a direct expression of their mission in the community. The program works within the value-oriented framework of SCHCS and is based on the Gospel values of justice and compassion, in which services that enhance a patient's quality of life are as important as services that maintain life.

Staff A clinical supervisor and six care managers (licensed social workers or nurses) staff Coordinated Care. Two Coordinated Care managers are bilingual, equipped to serve the three-county area's Spanish-speaking population. A Coordinated Care staff member is always on call, so help is always available.

Coordinated Care staff members have experience in gerontology, mental health, developmental disabilities, and psychology. Each client's Coordinated Care manager works with the client's physician to evaluate needs, develop a care plan, and arrange for support services. Coordinated Care managers focus on maintaining clients' independence, dignity, and respect.

Assessing Clients' Needs Care managers' work begins where hospital discharge planners' work ends. Discharge planners provide the links to services patients need at discharge. Care managers develop care plans that include and expand on those resources. Physicians' offices and community agencies refer many clients on an outpatient basis. Care managers monitor clients' needs at home on an ongoing basis. If hospital readmission is necessary, care managers are able to provide hospital personnel with important information about these clients.

Coordinated Care staff assess each client's in-home safety, support systems, benefit entitlements, psychosocial and health status, and ability to perform activities of daily living. The care manager coordinates services such as medical care, meal delivery, transportation to physician appointments, housekeeping, home repair, and assistance with financial and legal matters.

Some clients need a home visit once or twice a month. Others require extensive help from formal services, such as hospital- and community-based programs, as well as informal services provided by volunteers, service clubs, and religious institutes.

Much of the program's success arises from the care managers' positive working relationships with physicians and nonmedical professionals such as attorneys.

Care Manager's Role The care manager is the most consistent presence in some clients' lives. Many of the elderly Coordinated Care clients have no families or regular care givers. Other clients' relatives live hundreds or thousands of miles away. The adult children of many of these clients are relieved to know someone is there to check up on their parents and help them with the chores of daily living. Each month Coordinated Care managers telephone clients' adult children with an update after they visit the parent. If there is a change in the parents' functional status, the care manager calls the adult child immediately.

Much of the program's success arises from the care managers' positive working relationships with physicians and nonmedical professionals such as attorneys and trust officers. After five years in the community, Coordinated Care receives calls from many physicians to help their patients with social needs, such as homemaking, meals, and transportation. Bank trust officers and conservators often turn to Coordinated Care managers to handle their clients' social and medical needs. Care managers also assist clients with financial matters. Sometimes (because of failing eyesight) a person is unable to read his bills, so his care manager reviews them. Other times, a care manager will offer more extensive help.

In addition, Coordinated Care managers often work as advocates for social justice. They help their clients receive benefit entitlements, such as Social Security, and will appeal for such benefits if clients are denied a service in the community.

Other times, a lack of family cooperation can frustrate care management goals. Some clients may have several children who may not have spoken to each other in years. In these cases the care manager becomes a mediator, trying to devise a plan that suits everybody.

Clients with Disabilities In addition to the elderly, Coordinated Care serves persons who have developmental disabilities, such as mental retardation and cerebral palsy, and physical disabilities, such as paraplegia and multiple sclerosis. Coordinated Care offers access to assisted living, homemakers, personal care, respite care, and habilitative services.

Coordinated Care also serves persons who have the human immunodeficiency virus (HIV). Care managers coordinate clients' healthcare, offer support and education for family and service providers, and advocate for persons with HIV in a climate of client confidentiality.

Culturally Diverse Clients Cutting across all Coordinated Care service segments are the multicultural elements of a diverse clientele. The area around Albuquerque, much of which is rural, has large Hispanic and Native American populations. Two of the surrounding counties have residents from local pueblos, which have their own governments. Care managers must work carefully to arrange needed services for clients while working with the pueblo governments.

Penrose–St. Francis Care Management

Persistence and devotion to the client, rooted in the SCHCS healing mission, are the hallmarks of effective care management and the foundation of the new geriatric care management program at an SCHCS member, Penrose–St. Francis Healthcare System in Colorado Springs, CO. The program's goals are:

- To improve inpatient geriatric care and smooth the patient's transition to alternative care settings
- To ensure efficient and effective resource use during the patient's hospital stay

Persistence and devotion to the client are the hallmarks of effective care management.

One of the system's three member hospitals, Penrose, initiated the program. Although the program just began in May, SCHCS anticipates measurable improvements in patient and staff satisfaction levels and in hospital efficiencies.

Geriatric Care Managers Penrose–St. Francis Healthcare System has contracted with United Healthcare Corporation, a Minneapolis-based managed care corporation, to establish a geriatric care management system that will manage 850 to 900 high-risk Medicare patients each year. Two specially trained geriatric care managers are now a part of Penrose Hospital's discharge planning team.

The geriatric care managers are nurses with geriatric and care management experience. They

HOSPITAL-BASED CARE MANAGEMENT: A COMPETITIVE EDGE

Private care management firms would have a hard time competing with a hospital-based program, according to Maryann Higgins, director of Connections Care Management Services of Venice Hospital, Venice, FL. "One of the reasons is our rates can be lower because there are a lot of secondary benefits to being part of a hospital," she explained at a March meeting of the American Society on Aging in San Diego. In addition to reduced overhead and administrative expenses, affiliation with a hospital gives a care management program "a kind of trust that this big hospital reputation stands behind you," Higgins said. "The customer doesn't have to search out your credentials, find out who you are. The trust is just there automatically."

Venice Hospital, a 340-bed hospital with 36 skilled nursing facility (SNF) beds, began the Connections program in 1985 to help meet the psychosocial needs of the elderly and disabled being discharged from the hospital. "One of the reasons I started the program was I felt the affluent community was underserved," explained Higgins. While those less well off learned the system and what services they were entitled to over the years, "the affluent were totally ignorant and would not go to the agencies," she said. They were used to hiring people such as attorneys and accountants to help, so the fee-for-service care management program was a more acceptable way to get them the help they need.

Higgins

Higgins noted that insurance rarely pays for care management, and most of Connections clients pay the $60 per hour fee for care management themselves. Higgins said the program's fees are comparable to those of a private practice psychotherapist.

"We do provide charity care for people who fall between the cracks when there isn't another resource in the community," she added. A grant from the hospital's foundation and donations from the community cover the costs of charity care. In addition, the program gives free information and referrals to help people find free or affordable care.

Another advantage to affiliation with a hospital is that Connections receives referrals from hospital discharge planners and the emergency room (for people who do not need hospital services but do need some help). Other referrals come from people in the community, clergy, attorneys, and bank trust officers. "Bank trust officers are paid for handling people's money—they don't get additional pay for handling their personal lives," Higgins explained. Even though trust officers are hired just to handle clients' finances, often they become aware of other needs they are not equipped to handle. Higgins has developed relationships with bank trust officers by making cold calls and explaining how she could help them, as well as by referring care management clients to the bank.

Connections also gets out-of-state referrals through the National Association of Private Geriatric Care Managers (and likewise can locate care managers for clients going to other parts of the country).

Higgins emphasized that even for a not-for-profit care management program, the ability to compete with private firms is important. Among the many qualities needed for successful care management are salesmanship, she said. "You need to operate like a business and pay attention to the bottom line or you won't survive," she advised. —*SH*

work as problem solvers and system coordinators, focusing exclusively on those Medicare patients for whom the hospital anticipates greater lengths of stay, higher resource use, or difficulty upon discharge for other reasons.

The geriatric care managers support other hospital personnel who are working with high-risk Medicare patients; they help to ensure that tests and treatments are conducted in a timely manner. The geriatric care managers also educate nurses about the elderly. For example, when an 89-year-old woman recovering from a total hip replacement begins to have swelling in her legs, the care manager questions whether it is from the surgery or from any 1 of the 10 medications she has been taking. The nursing staff welcomes the help of the geriatric care managers on cases such as this. Such cases are increasing as more elderly persons have major surgeries. The geriatric care managers will eventually work in collaborative practice with physicians as well.

The Process From the day of admission, the geriatric care manager works with the hospital's discharge planner to prepare the family and patient for postacute care and to act as a liaison between the discharge planner and the elder's physician.

On admission, the patient or a family member completes a 12-item high-risk identification questionnaire that focuses on the activities of daily living and the patient's support systems. Once hospital personnel identify a high-risk patient, a geriatric care manager works with the medical and nursing staffs, discharge planners, the patient, and the family to ensure that the treatment proceeds smoothly and efficiently.

Along with a geriatric care manager, the family is part of the discharge planning team. The care manager ensures that the family gets information quickly. The family benefits because they can review the elder's health status and care needs with someone knowledgeable about geriatrics.

For the patient, family, and hospital, the focus of geriatric care management is increased efficiency through identification of high-cost, high-risk elderly patients and through the provision of their care as cost-effectively and efficiently as possible, while preserving the high quality of care. This is a resource utilization issue with a strong mission component because it is focused on some of our most needy, the elderly.

Utilization Service Line Penrose Hospital's new geriatric care management approach is dovetailing with an existing in-house initiative that has already proven successful. Formed in 1990, the utilization service line (USL) has saved money and reduced average lengths of stay at Penrose–St. Francis Healthcare System while guiding elderly patients through the continuum of care.

> What distinguishes the utilization service line from traditional quality assurance–utilization review functions is its coordinated, programmatic approach to discharge planning.

The USL team comprises representatives of several hospital disciplines: utilization review, patient and family services, registration, discharge planning, and senior services. These representatives serve as an internal managed care department, proactively identifying patients' needs, often before admission. The USL team is assisted by other hospital departments: nursing, home care, and pastoral care.

The USL has already achieved a 2.01 day decrease in average lengths of stay for the 15 most troublesome Medicare diagnosis-related groups (DRGs) and an average cost savings of $4,259 per case for these DRGs.

In addition to its effect on length of stay and cost, USL's focus has expedited elderly patients' movement through the system. Each week the USL team reviews all outlier cases (defined by the system as any patient bills exceeding $15,000).

What distinguishes USL from traditional quality assurance–utilization review functions is its coordinated, programmatic approach to the process and involvement in discharge planning. The USL team follows specific steps–similar to procedures commercial insurers follow–that ensure high-quality, efficient care for the elderly and other government-payer patients. USL and the geriatric care managers form a strong continuum of care at Penrose Hospital. As the programs mature, administrators believe the continuum will be enhanced further by increased efficiencies. As a part of Penrose–St. Francis's ongoing quality assurance program, geriatric care management will be evaluated through patient, nurse, and physician surveys, to further progress toward greater efficiency and better patient experiences.

Ultimately, better efficiency means better stewardship. Better stewardship means that in the future Penrose–St. Francis will be able to serve its elderly constituency in a way that allows the hospital to remain financially viable.

Working within the Reimbursement System

Currently, Medicare represents about 47 percent of inpatient days for SCHCS members–about 40 percent of gross revenue. To care for the elderly, providers have to work efficiently within the reimbursement system. Excess costs will force providers to drop services; or the private-pay patients will absorb those costs, an option that is becoming limited as more private-pay individuals join managed care organizations.

SCHCS is planning to expand care management at other member hospitals by using the expertise developed at St. Joseph and Penrose–St. Francis. Collaboration has already begun as SCHCS explores and expands care management to further its healing mission. □